

## MINUTES OF THE FEBRUARY 25, 2005 MEETING OF THE MJCSG PRINCIPALS

**LOCATION:** Pentagon, Rm 2C554

**Attending:** LtGen Taylor – Chair; VAdm Arthur- USN/SG; MGen Webb USA/SG; Mr. Chan – ASD (HA)/CP&P; RAdm Cullison – USMC/SG; Col Hamilton – Secretary; Mr. Yaglom – USA/SG; Dr. Opsut – OSD/HA; CAPT Hight – BUMED; Mr. Mahalek – GAO; Ms. Shifflett – SAF/IEBJ; Dr. Christenson – CNA; Maj Fristoe – HA/TMA; Maj Guerrero – AF/SG; Mr. Porth – OSD/BRAC; Maj Cook – HA Analyst; CDR Bradley – Navy Analyst; Maj Coltman – AF/Recorder

### **Decisions:**

- Approved** the proposed RDA formula for/use of sub-functional military value scoring methodology in evaluating Med/Den RDA scenarios/recommendations (**MJCSG approved with 5-0 vote**)
- Approved** the joint/consolidated basing medical analytical framework to analyze smaller MSM scenarios for additional recommendations (**MJCSG voted 5-0 to approve**)
- Approved** the methodology used to analyze impact of enabling scenarios on medical operations (**MJCSG approved with 5-0 vote**)

### **Action Items:**

- 0-6 Lead Follow-up:
  - Continuous validation of scenario data
  - De-conflict and integrate medical functions across all proposed recommendations
  - HCS to develop joint/consolidated proposals for the smaller MSMs scenarios

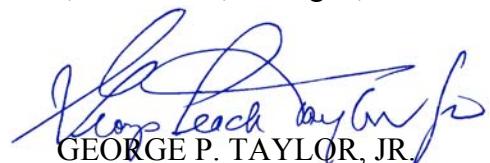
### **Meeting Overview:**

- Voting Members: 5 present/1 absent
- Chair informed the group that the NCR and SA recommendations were briefed to the ISG this morning and there were no issues with the SA proposal. The Army voiced concern with NCR recommendation stating that closing Walter Reed Medical Center (WRMC) hinders their ability to meet surge requirements and appropriately care for soldiers and their families. The Chair stressed that by closing WRMC no capability is loss when you consider the proposed expansion of services and facilities at Bethesda and Fort Belvoir. Both recommendations will move forward to the IEC with the Army's concerns noted. The Chair requested that WRMC's infrastructure replacement be calculated, since the facility will need to be replaced in the next 10-20 years, to have on hand for comparison. The Armed Forces Institute of Pathology (AFIP) (MED-0029) is ready for briefing the ISG this week. And three MJCSG RDA recommendations are in legal review in preparation for briefing to the ISG next week, along with Aerospace Medicine Training (MED-012). The Chair informed the group that the 11 Mar 05 is the last day to submit recommendations to the ISG and to continue to work to finish all MJCSG recommendations. The Secretary stated that the only activities left that are being worked are AF Institute for Operational Health (AFIOH), which clears Brooks City Base, and Naval Aerospace Research Laboratory (NAMRL); both proposed to be moving to Wright Patterson AFB. (**Info**)

- The RDA rep presented for MJCSG approval the sub-function military value scoring methodology and its use in evaluation of Med/Den RDA scenarios and recommendations. Supporting background, justification, and proposed formula was presented and discussed (see slides). The RDA rep emphasized that this methodology provides the ability to analyze and rank-order within a specific sub-function as opposed to an overall measurement. It is used as a data organizational tool and does not change the overall scoring matrix nor does it influence the results. The RDA rep recommends the following:
  - Approve the proposed formula for and use of sub-functional military value scoring methodology in evaluating the Med/Den RDA scenarios and recommendations. **(MJCSG approved with 5-0 vote)**
- The Secretary presented the Joint Basing Concept brief to establish precedence for medical joint basing initiatives and provide the analytic framework to apply to selected MJCSG scenarios (see slides). He further described how the HS&A JCSG developed a Joint/Consolidated basing initiative which initially excluded medical; by developing an acceptable medical framework it provides an opportunity to include the MHS in these joint initiatives. The Secretary then highlighted HS&A's proposed joint base and consolidations scenarios and described how the Lead Service was determined which led to discussions specific to medical facilities. The Pearl Harbor/Hickam MSM was used as an example to demonstrate this joint construct. Pearl Harbor would operate Hickam as a satellite clinic, making the Navy the Lead Service and would assume operational costs. The mix of clinical/Service staff could be decided at the end once the framework is established. The Chair compared this to the Landstuhl model except one step beyond where the facility is located on another base but owned and operated by the Lead Service. The basic idea for execution would be that the real property assets would be transferred to the Lead Service. The analytic framework specifics were presented for MJCSG approval to include definitions, manpower savings for joint/consolidated bases and associated assumptions and benefits. The Chair stated by applying this concept it allows for right sizing and redirecting workload to increase efficiency while reducing excess infrastructure and cost. The MJCSG also requested HCS to develop proposals for the smaller MSMs scenarios. **(Action Item; HCS Follow up)**
  - The Secretary recommended approval of the joint/consolidated basing analytical framework to better analyze smaller MSMs for additional recommendations. **(MJCSG voted 5-0 to approve)**
- The HCS rep presented the Enabling Scenario Analysis brief (see slides) with the purpose of obtaining MJCSG approval for the methodology used to analyze the impact of enabling scenarios on medical operations. In general, the recommendation is to analyze all troop movements greater than 1,500 AD develop medical recommendations to provide back to the scenario owner. Also, the issue of providing recommendations to the Army based on troop movements from the Integrated Global Presence and Basing Strategy (IGPBS) was discussed. The group agreed that if the Army presented the request and the numbers that HCS could calculate and respond back with recommendations the same way as the BRAC scenarios. The HCS rep reviewed and led discussion on the proposed assumptions, calculation of ADFM/AD radio and its use to calculate # ADFM & Total population shift. In addition, he led decision on calculating the RVUs per enrollee and comparing it to the demand at the specific gaining facility or MSM capacity. The HCS further recommended absorbing the additional workload into the gaining facility(ies) if the excess capacity exists.

The Chair requested that the group also consider excess capacity at other nearby Service sites as well as to minimize building more infrastructure. If no excess capacity exists at the gaining site then the calculations for providers, support staff, and rooms (Primary Care/Specialty Clinics) would be done and the results presented to the MJCSG for approval. At the losing bases, the calculations would be used to determine recommended maintenance, and reduction or elimination of services. The MJCSG agreed that the following matrix be used in determining the need for MJCSG approval. If the results indicate that there is enough excess capacity to absorb the additional workload and, therefore, requires no additional building the results would not need formal approval. However, if the receiving site calculations result in additional infrastructure requirements then the recommendations must be presented and approved by the MJCSG prior to reporting the information to the original requester and/or scenario owner.

- The HCS recommends the MJCSG approve the following:
  - Methodology used to analyze impact of enabling scenarios on medical operations  
**(MJCSG approved with 5-0 vote)**
- Closing: The Chair shared that the AF Chief of Staff's direction is on the wartime mission, so the primary focus would be ensuring medical care is available for the AD troops. The Army Member also wanted to ensure that dental was included as part of the enabling scenario calculations and responses. The Chair voiced that most of what the MJCSG has approved has not affected the large Service moves but cautioned that there are still some major Service moves in the planning stages, especially by the Army; so be prepared to respond. The biggest concern will be the overall picture, the leadership expects an overall 22 percent savings associated with BRAC moves and thus far have only identified 10 percent. The Secretary reviewed the MJCSG recommendations status, and the only ones remaining are the AFIOH and Joint Basing scenarios. The last of the RDA scenarios are ready to be briefed at the ISG next week. Continue to work action items and follow up as required.
- NEXT MEETING: MJCSG Principals, 4 Mar 05, 1500-1700, Pentagon, Rm 2C554



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

Attachments:

1. Agenda with Combined Briefing Attached

# MJCSG Principals Meeting

**02/25/2005  
2:30 PM to 3:30 PM  
Location 2C554, Room 2**

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

## Agenda

Chair Comments	Lt Gen Taylor	5
Recommendation Update	Col Hamilton	10
RDA Mil Val Change	Mr. Glenn	
		
		"Med-Dent RDA Status - 14 Decembe
Joint Basing Brief	Col Hamilton	10
		
		"Joint Basing_22feb05.ppt"
Status of Following Scenarios	Col Hamilton	10
Around the Table	All	10
Closing	Chair	5

## Additional Information

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

DCN: 11388

# MJCSG Principles Meeting

25 Feb 05





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- RDA Mill Value Sub-Function
  - Joint Basing
  - Enabling Scenario Methodology

# Use of Sub-Function Military Value Scores for Medical Dental Research, Development & Acquisition

## Decision Briefing





# Purpose

- Obtain formal approval of MJCSG for previously briefed sub-function military value scoring methodology and use of sub-function military value scores in evaluation of Medical Dental RDA scenarios and recommendations



# Background

- The Medical Dental RDA Working Group developed a military value scoring plan, approved by the MJCSG and ISG, that is based on 7 attributes and 19 associated metrics pertaining to the 4 Military Value Final Selection Criteria
- The approved military value score measures the overall military value of an activity with respect to the Medical Dental RDA function – encompasses ability of an activity to address the complete scope of the RDA mission across all capability domains

# Need for Sub-Function Military Value



- Transformation requires analysis and realignment of organizations at the sub-function level of detail:
  - Co-locates similar and complimentary personnel expertise to improve critical mass and synergistic collaboration
  - Allows most efficient use of specialized facilities and equipment uniquely required for performance of the sub-function
- Overall RDA military value score provided by original scoring plan does not necessarily reflect the value of an activity with regard to performance of a particular sub-function:
  - Overall RDA MV score is partially dependent on the number of sub-functions that are performed by an activity
  - Activities that perform a relatively broad range of sub-functions tend to receive higher scores, even though they may have a very limited number of personnel and few facilities relevant to a particular sub-function

# Proposed Sub-Function Military Value Formula

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- Sub-function military value score is derived from overall RDA military value score:

$$MV_{SF} = MV_{RDA} \times \frac{FTE_F}{FTE_T}$$

Where  $MV_{SF}$  is the sub-function military value score of the activity,  
 $MV_{RDA}$  is the overall medical/dental RDA military value score of the activity,

$FTE_F$  is the number of full time equivalents working within the sub-function in FY03 within the activity, and  
 $FTE_T$  is the total number of full time equivalents working within the activity in FY03

- Sub-function MV score is computed using FTE data collected at capability domain level of detail in Capacity Data Call
- Sum of an activity's sub-function MV scores across all sub-functions equals overall RDA MV score for the activity





# FindingS

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- Proposed sub-function military value score provides ability to analyze potential transformational options from a military value perspective
- Rank-orderings of activities within a sub-function according to proposed sub-function military value score are generally consistent with independent assessments of Medical Dental RDA Working Group subject matter experts on the relative capabilities of organizations to perform each sub-function

# Recommendation

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- Approve for the record proposed formula for and use of sub-function military value scores in evaluation of Medical Dental RDA scenarios and recommendations.



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# Back-up Slides





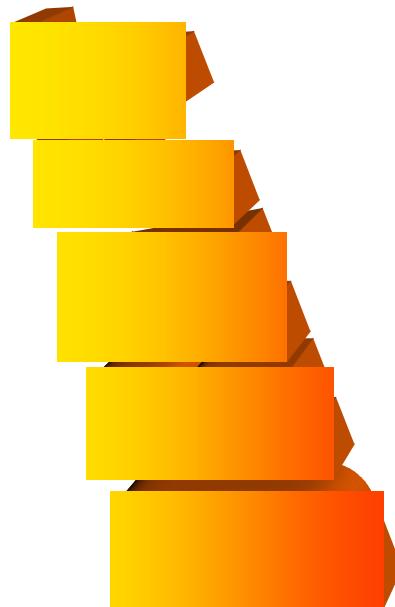
# Example

## Medical Dental RDA Sub-Function: *Infectious Diseases Research*

Activity	Sub-function RDA MV score*	Total RDA MV score
Walter Reed Army Institute of Research - WRAMC	16.40	41.69
Naval Medical Research Center - Silver Spring	13.71	26.86
Naval Health Research Center - San Diego	11.89	19.79
Army Medical Research & Materiel Command - HQ	7.84	41.51
Naval Institute for Dental & Biomedical Research	0.88	17.63
Army Medical Research Institute of Infectious Diseases	0.80	30.23
Army Medical Materiel Development Activity	0.46	13.78

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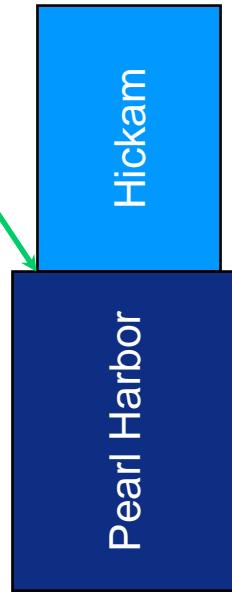
# *Joint Basing*



# Issue

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

Fenceline



Joint

Consolidated

Langley

Eustis





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



# Proposed MJCSG Scenario

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



## Example - Pearl Harbor/Hickam

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- 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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## Additional Issues

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- Modify Medical Lead?
  - Guam – Navy has the hospital
  - Charleston – Navy current market manager
  - San Antonio – BAMC is med center
  - Others?
- Issues with different Installation and Medical Leads

# Execution

- Real property assets will transfer to the Lead Service
  - Lead service will claim inventory for SRM and other inventory based funding
- Other funding issues
- Manpower issues





# Analysis

## ■ Definitions

- Major installation is the Lead Service
- Minor installation is being absorbed
- Joint Basing
  - Minor medical activity takes a 50% manpower savings
  - Will also run 20% savings similar to other MJCSG scenarios
- Consolidated Bases
  - Minor medical activity takes a 20% manpower savings (similar to other MJCSG scenarios)

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# Analysis – Manpower Savings



## ■ Support Services

- Facilities Management, Logistics, IM/IT, Resources, Tricare, Command & Admin
- Anticipate a significant reduction in overhead management duplication
- Minimal reductions in the staff doing work – no reduction in inventory
- More savings at Joint locations rather than consolidations
- Contract savings (e.g. facility maintenance, housekeeping, etc.) possible with consolidation to one contract (reduced administration fees, increased purchasing power)

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# Analysis – Other Benefits

## ■ Support Services

- Anticipate better capital investment planning for facilities, equipment and IM/IT
  - Avoids duplication
  - Maximizes existing assets





# Analysis

## ■ Ancillary Services

- Pharmacy
- Lab
- Radiology

## ■ Patient Care



# Analysis

## ■ Medical Joint Basing - Pearl/Hickam example (Navy lead)

- Manpower:

- NAVMEDCL PEARL HARBOR - 67 OFFICERS, 181 ENLISTED AND 102 CIVILIANS
- HICKAM: 58 OFFICERS, 142 ENLISTED AND 24 CIVILIANS

- COBRA:

- 50% HICKAM REDUCTION
  - 2008: 50% military realignment to Base X; 112 Civ eliminations from Base X
  - NPV 2025 (savings): 103M
  - One time cost: 5M
  - Annual savings: 9M
  - Payback Year: 1 year
- 20% HICKAM REDUCTION
  - 2008: 20% military realignment to Base X; 45 Civ eliminations
  - NPV 2025 (savings): 41M
  - One time cost: 2M
  - Annual savings: 3M
  - Payback Year: 1 year

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# Analysis

## Medical Consolidated Basing – Charleston example (NAVY LEAD)

- **MANPOWER:**

- NH CHARLESTON - 57 OFFICERS, 173 ENLISTED AND 237 CIVILIANS
- DEPMED NH CHARESTON DET - 36 ENLISTED
- NH CHARLESTON FH JAX DET - 46 OFFICERS, 66 ENLISTED
- Charleston AFB: 58 OFFICERS, 136 ENLISTED, 37 CIVILIANS

- **COBRA**

- 20% CHARLESTON AFB REDUCTION
  - 2008: 20% military realignment to Base X; 46 Civ eliminations
  - NPV 2025 (savings): 38M
  - One time cost: 3M
  - Annual savings: 3M
  - Payback Year: 1 Year

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# Back-Up Slides





# Additional Issues

## ■ Locations

- Add MSMs? (Col Hamilton's position is that we don't want to go here – outside scope of original scenario)
  - NCR
  - Keesler
  - San Diego – all Navy
  - Jackson/Shaw – distance?
  - Hawaii – include Trippler – what about others (Shaffer)
  - Alaska – Ft Wainwright/Eielson
  - Colorado Springs

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# Enabling Scenario Analysis





# Purpose

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- Gain approval for methodology used to analyze impact of enabling scenarios on Medical operations
  - Precludes need to brief individual results from analysis on each enabling scenario



# Assumptions

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- Certified data is correct
- Enabling scenario data provided by service(s) is accurate and complete
- Same assumptions for MJCSG Capacity Report
  - RVUs per Provider
    - $PC = 3,729$  per yr
    - $SC = 4,257$  per yr
  - Rooms per Provider
    - $PC = 2$
    - $SC = 1.5$
  - Support Staff per Provider – 2.5



# Analysis of Medical Impact

- Calculate ADFM/AD Ratio

	AD	ADFM	ADFM/AD Ratio
Fenceline			
NAVAL SUB BASE NEW LONDON	9,718	9,511	0.98
NAVSTA INGLESIDE	7,626	3,393	0.44

- Use ratio to Calculate # ADFM & Total shift

	AD	ADFM	Total
DON-0033			
NAVAL SUB BASE NEW LONDON TO NAVSTA NORFOLK	3,084	3,018	6,102
NAVAL SUB BASE NEW LONDON TO NAVAL SUB BASE KINGS BAY	3,142	3,075	6,217
DON-0032			
NAVSTA INGLESIDE TO NAVSTA NORFOLK	726	227	953
			11388

# Analysis of Medical Impact



## Gaining Base

- Calculate additional demand in RVUS
  - Use Losing facility's RVUs per enrollee

	Total Pop Increase	PC RVUs per Enrollee	PC RVUs Additional Demand	SC RVUs per Enrollee	SC RVUs Additional Demand
GAINING BASE					
NAVAL SUB BASE KINGS BAY	6,217	0.68	4,215	0.899	3,789
NAVSTA NORFOLK	7,055	0.68	4,784	0.899	4,300

- Compare additional demand to specified facility or MSM capacity
- Recommend absorbing workload into gaining facility(ies) if excess capacity exists



# Analysis of Medical Impact

## Gaining Base

- If no excess capacity, calculate # of PC Providers, Support Staff & Rooms needed to support additional demand
  - 3,729 RVUs per Provider for
  - 2.5 Support Staff per Provider
  - 2 Rooms per Provider

GAINING BASE	Total	# Providers	# Spt Staff	# Rooms
	RVU Increase	RVUs/Prov	PCM * 2.5	PCM * 2
NAVAL SUB BASE KINGS BAY	4,215	2	5	4
NAVSTA NORFOLK	4,784	2	5	4

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- Calculate # SC resources using same method
- Recommend use of network if capacity exists
- If no capacity, recommend increase medical personnel, number of rooms (1,060 PC square feet, 732 SC square feet) with MJCSG approval



# Analysis of Medical Impact

## Losing Base

- Calculate # and % ADFM & Total beneficiaries leaving
  - Includes transfers and eliminations

	AD	ADFM	Total
DON-0033			
SUB BASE NEW LONDON ELIGIBLE POP	9,718	9,511	19,229
MOVING FROM NAVAL SUB BASE NEW LONDON	6,969	6,821	13,790
PERCENT MOVING	72%	72%	72%

- Recommend maintenance, reduction or elimination of services as supported by analysis