

**Statement of Hon. Gene Taylor
Presented to the
BRAC Commission Regional Hearing
New Orleans, LA
July 22, 2005**

Good morning General Newton and General Turner:

I represent the South Mississippi, which is home to several military installations—three of which are adversely affected by the BRAC recommendations of the Department of Defense (DOD). As most of you are aware, I strenuously opposed authorization for the 2005 round of BRAC because in past rounds projected savings were not realized and several bases were closed that the services and DOD later regretted closing. NAS Cecil Field is a perfect example of this. After reviewing the recommendations in this round, I see that my continued opposition to BRAC is equally well-founded.

As commissioners, you have a unique opportunity to take a hard look at the DOD's analysis and recommendations. I urge you to question everything. Take nothing for granted. With proper scrutiny, I am certain that you will reach the same conclusions that we, in South Mississippi, have. I am hopeful that you will then take action to correct the gross mistakes made by the DOD in its recommendations. The evidence that my fellow Mississippians and I will present will demonstrate that the DOD's recommendations contained egregious flaws, substantial deviations from the BRAC criteria, and in some instances went well beyond the scope of authority provided under the BRAC statute.

The proposal to eliminate inpatient care at Keesler Medical Center is one of the most outrageous items on the entire BRAC list. DOD made an inexcusable error in calculating

Keesler's military value. An incorrect figure in a spreadsheet resulted in Keesler receiving zero points for the condition of the facility when it should have received 11.25 points out of a possible maximum score of 12.5. After we pointed this out, the Secretary of the Medical Joint Cross Service Group admitted the error verbally, but we are still waiting for the written response. The DOD's shoddy work caused Keesler Medical Center to rank 44 places lower in health care services than its correct place. That poor ranking had been cited as the main justification for closing the Keesler hospital. So, essentially, DOD has proposed to close the Keesler hospital, cripple its graduate medical education programs, and force military personnel, their families, and retirees off-base where there is a severe shortage of physicians, all because someone in the Pentagon apparently hit the wrong key on his computer.

Keesler should be the model for the military health care system. The medical center fulfills every major requirement of military health care. It provides outstanding medical care for active duty personnel, helping to ensure their readiness. It provides comprehensive care to military families, contributing to the quality of life that is so important to recruitment and retention. The medical center has exemplary medical education programs that trains surgeons, specialists and other medical personnel for military missions. Keesler fulfills the military's promise of medical care to thousands of retirees, and those retirees provide the complex case mix that is needed to hone the clinical and surgical skills that military specialists need in their mission to support warfighters.

Keesler Medical Center has benefited from excellent leaders who have carefully established a patient mix that perfectly matches the graduate medical education and medical readiness missions of the 81st Medical Group. The elimination of inpatient services would destroy the graduate medical education programs and would decimate the medical care of more than 56,000 military personnel, family members and retirees. There is no civilian medical capacity to absorb so many new patients. In fact, South Mississippi has a severe shortage of primary care and specialty care physicians. The Biloxi-Gulfport metropolitan area has only 72 percent of the US average of specialists per population and only 64 percent of the US average of family and general practice physicians per population.¹ The VA medical facility has no excess capacity or personnel to treat the thousands of retirees who would be thrown out of Keesler. In fact, the VA CARES Commission proposed a reorganization that is heavily dependent on the promise of expanding the existing cooperative arrangements with Keesler.² The Medical Joint Cross-Service Group made no attempt to communicate with the VA, with any local hospital or with local physicians about inpatient capacity, about the availability of surgery and specialty care, or about hosting Keesler's graduate medical education.³

The proposal of the Medical Joint Cross-Service Group to eliminate inpatient services is the product of a seriously flawed process using incorrect and misleading data. It is clear that the Air Force is using the BRAC process to close hospitals and eliminate graduate medical education well beyond the authority of the BRAC statute. Back in June of 2004, the Air Force Surgeon General tried to get the Medical Joint Cross-Service Group to approve Transformational Options

¹ Congressional Research Service, *Health Care Resources in the Biloxi-Gulfport-Pascagoula Metropolitan Area*, June 20, 2005.

² CARES Commission Report to the Secretary of Veterans Affairs, February 2004, p. 5-239.

³ Col. Mark A. Hamilton, USAF, *Memorandum for BRAC Clearinghouse*, June 27, 2005

that included a goal to "Close all hospitals/retain clinics/outsource GME." The representatives from the other services correctly objected that the proposals exceeded their authority under BRAC law.⁴ After the questionable military value formula placed many military hospitals at risk for closure or realignment, the other services had several facilities removed from the list for concerns about civilian capacity, medical education, or maintaining control of trainees, all factors that are present in Keesler's case.⁵ The Air Force representatives, in contrast, showed little concern for the effects that hospital closures would have on medical care, medical education, or the training environment. The Air Force obviously hopes to dump its medical responsibilities onto TRICARE, the VA, Medicare, and the local community without regard for the consequences.

Any reasonable rating based primarily on the quality of the medical treatment and the medical education programs would award very high marks to Keesler, but the military value formula used by the Medical Joint Cross-Service Group is horribly flawed. It gives little credit to the graduate medical education programs, which are an essential part of any accurate accounting of the true military value of Keesler Medical Center. Their formula gives no credit at all for the treatment of retirees who are 65 and older, despite the fact that treating those retirees is essential to provide the complex cases for training surgeons and clinicians. Their formula gives very little weight to the actual medical care being performed at Keesler.⁶ Their flawed process tries to compare comprehensive medical centers like Keesler that receive complex cases from other hospitals with the costs at much smaller hospitals that transfer all their serious cases elsewhere. The savings estimates are way off the mark because DOD used absurdly low assumptions about

⁴ *Minutes of the July 6, 2004 Meeting of the MJCSG Principals.*

⁵ *Minutes of the January 4, 2005 Meeting of the MJCSG Principals.*

⁶ Office of Rep. Gene Taylor, *Analysis of Keesler COBRA Report.*

what TRICARE would pay civilian hospitals for the complex case mix that would be tossed out of Keesler.⁷ Then, they compounded that mistake by assuming that treatment of retirees would cost the same amount per patient as treatment of active-duty personnel and their families, despite overwhelming evidence to the contrary.

We are a nation at war. The Pentagon has had to increase bonuses and other incentives to try to recruit surgeons and other medical professionals into the military.^{8,9} Yet the DOD is proposing to decimate the kind of program that is proven to be valuable in the recruitment and retention of military doctors. Almost every study of military medical care has documented the desire of military physicians to perform the full range of procedures within their specialties. A GAO report on implementation of the Medicare Subvention Demonstration project found that "treating seniors helps indirectly with the readiness mission and ... treating the more complex cases indirectly aids the retention and recruitment of doctors."¹⁰ Another GAO report determined that "the services view (Graduate Medical Education) as the primary pipeline for developing and maintaining the required mix of medical provider skills to meet wartime and peacetime care needs. They also view GME as important to successful recruitment and retention."¹¹ The need to match a diverse mix of patients with the medical education and training requirements of military medical personnel is a substantial factor in medical readiness, but was completely ignored by the Medical Joint Cross-Service Group.

⁷ Col. Mark A. Hamilton, USAF, *Memorandum for OSD BRAC Clearinghouse, June 14, 2005.*

⁸ Atul Gawande, M.D., *Casualties of War-Military Care for the Wounded from Iraq and Afghanistan*, *New England Journal of Medicine*, Dec. 9, 2004, pp. 2471-2475

⁹ Michael Moran, *Military looking for a few good medics...and surgeons, and RNs, and radiologists, too*, MSNBC, June 10, 2005.

¹⁰ *Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues*, GAO/GGD/HEHS-99-161, p. 18.

¹¹ *Defense Health Care: Collaboration and Criteria Needed for Stizing Graduate Medical Education*, GAO/HEHS-98-121, p. 4.

I am especially bothered by the manner in which the Keesler facility was presented to the full Medical Joint Cross-Service Group on January 4, 2005. The background information presented by the Air Force staff contained major misstatements of fact. Keesler is described as having 154 beds when it actually has 95 staffed beds. Worse, the VA is described as having 552 beds with an average daily census of 394. These figures give the impression of excess capacity at Keesler and enormous inpatient capacity at the VA facility. In fact, this is how the Department of Veterans Affairs described its facilities in Biloxi and Gulfport:

The Biloxi VAMC is a 48-bed acute medical and surgical inpatient unit including intensive care. Biloxi VAMC provides health care for 124 nursing home and intermediate care beds, 171 domiciliary beds, and outpatient mental health. ... The Gulfport VAMC serves as an inpatient psychiatric care unit with 144 operating beds. ... The Gulfport VAMC has a 56-bed nursing home and dementia unit.¹²

The VA has 48 acute care beds, not 552 as suggested by the Air Force staff presentation to the Medical Joint Cross-Service Group deciding Keesler's fate. The other beds are psychiatric beds, nursing home beds, and domiciliary beds. I believe that the Air Force representatives knew or should have known that they were including nursing home beds and domiciliary beds in the VA capacity that they implied would be available for active duty personnel, families, and retirees. The Air Force and the Medical Joint Cross-Service Group also should have known that the VA plans to close the aging Gulfport facility, but that plan is contingent on expanding collaborative arrangements with Keesler and new construction at the Biloxi VA campus.

¹² CARES Commission Site Visit Report, Biloxi and Gulfport, Mississippi, July 2, 2003.

Although I disagree with the VA's decision to close the Gulfport facility, I do appreciate that the CARES Commission under then-Secretary Principi made site visits to the VA facilities and to Keesler, held open hearings, and made the reorganization proposal contingent on assurances that the patients would be treated at Keesler or a new VA facility. The DOD recommendation's total disregard for the obligations to active-duty personnel, their families, and retirees stands out as especially callous in comparison. I implore the commission to disapprove the recommendation to close the hospital at Keesler.

The decision to close Naval Station Pascagoula is another example of significant deviation from the BRAC criteria related to military value. You know and I know that the BRAC recommendations are completely biased in favor of the mega-bases. NS Pascagoula isn't Norfolk or Mayport. Rather, it is precisely what the Navy's strategic homeports were intended to be—strategically-located in relation to the Navy's area of operations, dispersed from large fleet-concentration areas, and lean, efficient, and cost-effective to operate. The mega-base bias was evident in our examination of data calls and minutes of the DOD's Navy Analysis Group. This body considered only two scenarios regarding NS Pascagoula—neither of which considered retaining the facility. This very limited approach prevented a proper evaluation of the military value of permanently stationing Navy surface assets at a port in the Gulf of Mexico.

Let me be clear, if the DOD's BRAC recommendation remains unchanged, there will be no Navy homeport in the Gulf of Mexico. Abandoning the Gulf of Mexico will create a huge gap in US national security and homeland defense capability. This is a decision of tremendous strategic importance, and should only be debated by the Congress and the President. It certainly

should not be decided as part of a bureaucratic process intended to reshape DOD infrastructure. How important is the Gulf of Mexico? Sixty-three percent of the U.S. commercial shipping trade transits through the Gulf of Mexico. The Gulf is home to 14 of the top 25 U.S. ports and represents 35 percent of the nation's tidal coastline. The Gulf is populated with thousands of critical infrastructure sites, including oil and gas production platforms and refining facilities, vital sea lanes, and important elements of the US' defense industrial capability. Knowing all this, what is the military value of the last pier at the last homeport in the Gulf of Mexico compared to one more pier at a mega-base on the Atlantic?

The DOD's BRAC recommendation also fails to address the emerging requirements of the homeland defense mission through the closure of the Navy's Gulf Coast homeports. According to the Strategy for Homeland Defense and Civil Support released late last month, it is now DOD policy to have an active and layered defense capable of defending the maritime approaches to the U.S. and possessing maritime interception capabilities necessary to maintain freedom of action and protect the nation at a safe distance.¹³ It is unimaginable that the DOD could accomplish this critical mission with no naval homeport in the Gulf of Mexico. In fulfillment of its homeland defense mission, the DOD must work together with the Coast Guard to strengthen the security in our ports and littorals and expand maritime defense capabilities further seaward.¹⁴ It is painfully obvious that the BRAC analysis did not consider the DOD's role in homeland defense when NS Pascagoula was considered for closure. NS Pascagoula is centrally located in the Gulf and possesses the ideal capabilities to accomplish the core DOD requirements of homeland defense and jointness.

¹³ Department of Defense, *Strategy for Homeland Defense and Civil Support*, June 2005, pp. 24-25.

¹⁴ Department of Defense, *Strategy for Homeland Defense and Civil Support*, June 2005, p. 25.

We must also not forget that the Gulf of Mexico is a major gateway to Latin America and the Caribbean. By retaining NS Pascagoula, the nation would continue to have a permanent naval presence near the area of operations that is capable of responding in hours, not days, to threats in this hemisphere of escalating importance. The stability and prosperity of the SOUTHCOM AOR are threatened by transnational terrorism, narcoterrorism, illicit trafficking, forgery and money laundering, kidnapping, urban gangs, radical movements, natural disasters and mass migration.¹⁵

Another challenge to U.S. interests in this region is the emerging influence of extra-hemispheric actors, particularly China. In testimony provided before the House Armed Services Committee on March 9, 2005, General Bantz J. Craddock, Commander of U.S. Southern Command, described the increasing presence of the People's Republic of China (PRC) in the region as, "an emerging dynamic that must not be ignored." In 2004, national level defense officials from PRC made 20 visits to Latin America and Caribbean nations, while Ministers and Chiefs of Defense from nine countries in our AOR visited the PRC.¹⁶ In short, a permanent U.S. Naval presence is required in the Gulf of Mexico because "virtual presence is actual absence." NS Pascagoula is the lowest cost option from which to project and maintain that presence.

One of the strange ironies of this BRAC is that while some installations are being recommended for closure because they are too old and maintenance intensive, the DOD is

¹⁵ House Armed Services Committee, Posture Statement of Gen. Bantz J. Craddock, US Army, Commander, US Southern Command. March 9, 2005. P.4.

¹⁶ House Armed Services Committee, Statement of Gen. Bantz J. Craddock, US Army, Commander of US Southern Command. March 9, 2005. P.7.

recommending closing NS Pascagoula—one of the nation's newest military facilities. It has many buildings newer than three years of age, including a recently completed \$25.4 million 160-unit DOD funded family housing area for which no credit was awarded by the DOD's BRAC analysis. NS Pascagoula was built with a significant investment from the local community and state. In fact, the State of Mississippi donated the land on which the facility sits and paid \$24 million to build the causeway to it. The citizens of Jackson County also financed the costs of running utilities to Singing River Island where NS Pascagoula is located. NS Pascagoula also has a significant amount of undeveloped acres capable of expansion to meet the DOD recognized increasing requirements regarding maritime homeland defense or for future Navy platforms like the Littoral Combat Ship. NS Pascagoula is a value for the Navy today, and in the future.

The installation has full weapons handling, transport and bunker capabilities, and a double-decker (ZULU) pier with full ship services dockside and on-site maintenance capabilities. These on-site capabilities are augmented by NS Pascagoula's close proximity to mature defense industrial base activities which support Navy shipbuilding and the manufacturing of UAVs. Pascagoula is home to Northrop Grumman's Ingalls Shipyard and several first and second-tier suppliers which provide great utility to the Navy. These industrial neighbors provide NS Pascagoula with capabilities such as heavy-lift dry docks, heavy-lift cranes, and repair parts without the Navy having to foot the bill for them. Why pay for these capabilities full-time when they are only required on a part-time basis?

My final point on NS Pascagoula is a critical one--closing this facility will not save money. In response to my inquiry about purported cost savings from this closure, the Navy

responded the COBRA report on NS Pascagoula showed that all of the "recurring net savings" estimated from this recommendation are a result of military and civilian personnel costs and the "Sustainment, Recapitalization, and Base Operations and Support (BOS) net savings" is almost completely offset by the annual recurring cost of per diem for pre-commissioning units that use the facility.¹⁷ One of the DOD's primary justifications for having another round of BRAC was to reduce excess capacity in military infrastructure and to direct the savings to other defense priorities. As you may be aware, a report recently released by the Government Accountability Office (GAO) on the DOD's BRAC process and recommendations (GAO-05-785) raises similar concerns. According to the report, "Much of the projected net annual recurring savings (47 percent) is associated with eliminating jobs currently held by military personnel. However, rather than reducing end-strength levels, DOD indicates the positions are expected to be reassigned to other areas..."

In summary, NS Pascagoula is the Navy homeport in the Gulf of Mexico, it is a value to the taxpayer, and closing it saves no money. I strongly urge you to overturn this decision.

Lastly, I would like to address the DOD recommendation to relocate the Navy Human Resource Service Center Southeast (HRSC-SE) from Stennis Space Center to the Naval Support Activity, Pennsylvania. This decision also is rife with flaws that easily meet the standard of a substantial deviation from the BRAC criteria.

¹⁷ Ms. Anne Rathmell Davis, Special Assistant to the Secretary of the Navy for Base Realignment and Closure, June 23, 2005. p. 1-2.

HRSC-SE is located within a secure federal installation the Stennis Space Center. This activity is in a building that was originally built by the U.S. Army to support the production of 155mm artillery rounds (Mississippi Army Ammunition Plant). This site was completely renovated in 1999 to accommodate HRSC-SE. Despite being in a new facility in a safe and ideal location for expansion, the DOD made an error in assessing the cost and military value of HRSC-SE. In its July 2005 report on the BRAC processes and recommendations, the GAO found that the Navy did not consider whether existing leases at Stennis met force protection standards. This led the Navy to apply \$2 million in cost avoidance, when in fact Stennis Space Center is as secure as any military installation.¹⁸ The Navy did not consider to consolidate the human resources activity at Stennis, which has nearly rent free-lease with NASA on a level 1 Force Protection Federal Facility.

I think that it is also worthwhile to provide a brief description of how unique the Stennis Space Center is. Although a NASA facility, Stennis exemplifies jointness and synergy. The HRSC-SE is co-located with several joint service tenants at Stennis including three other major Naval activities including the Naval Meteorology and Oceanography Command and Commander, the Naval Oceanographic Office, and the Naval Research Laboratory. Additionally, there are two significant Special Operations Command activities at Stennis—the Special Boat Team 22 and Naval Small Craft Instruction and Technical Training School. Actually, Stennis has more military civilian employees and uniformed personnel than NASA has employees at this installation.

¹⁸ GAO/05-785 *Military Bases: Analysis of DOD's 2005 Selection Process and Recommendations for Base Closures and Realignment*, p. 159.

I urge you to look carefully at the information my fellow Mississippians and I are providing you today, and I implore you to remove the realignment of inpatient care at Keesler AFB, the closing of NS Pascagoula, and the relocation of the Navy Human Resource Center at Stennis Space Center from the DOD BRAC recommendation lists. These Mississippi recommendations do not save the taxpayers the money claimed. Rather, they weaken our national security, ignore the emerging mission of homeland defense, and deviate significantly from the BRAC criteria and statute. Again, I want to thank you for allowing me to testify before you today.



GENE TAYLOR
4TH DISTRICT, MISSISSIPPI

COMMITTEE ON ARMED SERVICES

COMMITTEE ON TRANSPORTATION
AND INFRASTRUCTURE

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Rep. Gene Taylor
4th District of Mississippi

Base Realignment and Closure Commission Hearing
New Orleans, Louisiana
July 22, 2005

ATTACHMENTS FOR THE RECORD

- I. Responses to Requests for Additional Data Regarding Keesler Medical Center**
- II. Rep. Gene Taylor Analysis of Cost and Savings Estimates for Recommendation to Disestablish Inpatient Services at Keesler**
- III. Minutes of the Medical Joint Cross-Service Group Meetings of July 2, 2004 and January 4, 2005**
- IV. Site Visit Reports, Minutes, and Recommendations from the CARES Commission Regarding Veterans Affairs Medical Facilities in Biloxi and Gulfport and Arrangements with Keesler Medical Center**
- V. Articles from the New England Journal of Medicine and from MSNBC Regarding Medical Personnel and Training Needs for Wartime**
- VI. Rep. Gene Taylor Analysis of Cost and Savings Estimates for Recommendation to Close Naval Station Pascagoula**
- VII. Department of Defense Report: Strategy for Homeland Defense and Civil Support, June 2005**
- VIII. March 9, 2005 Testimony of Gen. Bantz J. Craddock, Commander of U.S. Southern Command Regarding U.S. Interests in Latin America**
- IX. Rep. Gene Taylor Analysis of Cost and Savings Estimates for Recommendation to Realign Navy Human Resource Service Center**





DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

August 1, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: AF/SGE
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: ODS BRAC Clearinghouse Tasker 0601/ Follow-up re Keesler FCI

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.

A handwritten signature in cursive script that reads "Mark A. Hamilton".

MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query

Query: Brian Martin, Office of Rep. Gene Taylor, inquired as follows:

The score of 0.0 for Keesler's Facility Condition Index appears to be an enormous error that cost Keesler Medical Center 11.25 points in the Military Value score. When I plug in the numbers from the data call into the formula in the Military Value Framework Report I get a FCI of 0.135, which should be good for 11.25 of the 12.5 possible points for FCI. The formula also reveals some strange logic involved in eliminating the inpatient mission at hospital because the dental clinic is in poor condition.

Can I get an explanation of this ASAP? Our BRAC hearing in New Orleans was postponed to Thursday. If possible, I need this by close of business Tuesday, because I will be traveling to N.O. on Wednesday.

Here is my calculation using your formula and Keesler's response to Question 2632:

Step 1: Calculate the Building Medical Facilities Condition Index (BMFCI) for each medical facility greater than 2,000 SF.

$BMFCI = \text{Total cost of unexecuted projects for that building} / \text{Plant Replacement Value (PRV)}$
for that building

Medical Center

| | |
|-------------------------|---------------|
| Unexecuted project cost | \$21,500,000 |
| Plant Replacement Value | \$196,543,236 |

BMFCI of 0.11

Dental Clinic

| | |
|-------------------------|-------------|
| Unexecuted project cost | \$7,900,000 |
| Plant Replacement Value | \$8,852,075 |

BMFCI 0.89

All Other Buildings > 2,000 Sq Ft (see below) *

| | |
|-------------------------|--------------|
| Unexecuted project cost | \$0 |
| Plant Replacement Value | \$12,517,234 |

BMFCI 0.00

Step 2: Calculate the Installation Medical Facilities Condition Index (IMFCI):

$IMFCI = (\text{BMFCI} * \text{PRV for that building}) / \text{Total of all Buildings PRV}$

$(0.11 \times \$196,543,236 + 0.89 \times \$8,852,075) / \$196,543,236 + \$8,852,075 +$
 $\$12,517,234$ $(\$21,619,756 + \$7,878,347) / \$217,912,545$
 $\$29,498,103 / \$217,912,545 = 0.135$

.0135 Score should receive 0.9 credit or 11.25 of 12.5 possible points. Instead, Keesler received 0.0 points for FCI

*** Other Buildings Plant Replacement Value:**

Bioenvironmental \$1,126,334

Med Comd + Administration \$7,359,896

Medical Readiness Storage \$262,175

Military Public Health/Vet Clinic \$846,760

Patient Welfare (Sablich Center)\$450,844

Satellite Pharmacy \$511,021

WRM Warehouse \$1,636,837

WRM Warehouse \$323,367

Response to Query:

Thank you for bringing this error regarding the scoring for the Keesler Medical Center to our attention. In spite of the changes from correcting this error, however, the Keesler Medical Center would still have been identified for further analysis under the processes and with the same agenda used by the Medical Joint Cross Service Group in its original analysis.





DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

July 1, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: HQ USAF/SGE
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Response to Medical Capacity Request – Congressman Taylor

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.

A handwritten signature in black ink that reads "Mark A. Hamilton".

MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query

Query:

Linda,

Thank you for obtaining responses to Congressman Taylor's previous requests regarding the data used in the Medical Joint Cross-Service Group's BRAC process. Please help us clarify another data question.

In my attempt to verify the data used by the Medical Joint Cross-Service Group, I asked the Congressional Research Service of the Library of Congress for the hospital and physician capacity data for the Gulfport-Biloxi-Pascagoula MSA. I specifically requested data from the Area Resource File compiled by the Health Resources and Services Administration of HHS, the source specified in the Military Value Framework Report. Attached please find the response from the Congressional Research Service.

Despite the specification to use the ARF, the MJCSG deliberative documents use different figures that yield a different result in the military value formula.

Area Resource File bed ratios:

Gulfport-Biloxi-Pascagoula MSA: 510 beds per 100,000 population or 1:196 ratio;

USA: 307 beds per 100,000 population or 1:326 ratio.

MJCSG-reported bed ratios:

G-B-P MSA: 1 bed per 264 people;

USA: 1 bed per 373.7 people.

Using either source, the MSA has a better ratio than the national average, so Keesler would receive 0 points of the 7.2 points available for beds/population in the military value model.

Area Resource File physician ratios:

MSA: 60 specialists per 100,000 population or 1:1,667;

34 family/general physicians per 100,000 or 1:2,941;

36 dentists per 100,000 people or 1:2,778.

USA: 83 specialists per 100,000 or 1:1,205

53 family/general physicians per 100,000 or 1:1,887

48 dentists per 100,000 or 1:2,083

MSA has 72% of the US average of specialty care physicians per population. Anything less than 82% receives full credit of 2.25 points in military value model.

MSA has 64% of the US average of family & general practice physicians per population. Anything less than 82% receives full credit of 5.4 points in military value model.

MSA has 75% of the US average of dentists per population. Anything less than 82% receives full credit of 1.35 points in military value model.

Thus, Keesler should have received all 9 points available in the measurement of civilian provider capacity. Instead, it appears that Keesler receive only 5.4 points of the 9 available.

MJCSG-reported physician ratios:

MSA: 1 physician per 476 people or 210 per 100,000.

USA: 1 physician per 421.2 people or 237 per 100,000.

No separate accounting of primary, specialty, and dentists, despite the formula.

MJCSG's data would have MSA with 88.6% of the national average of physicians per population. Ratio between 88.0 and 89.9 is worth 0.6 credit of the 9 possible points or 5.4 points.

Therefore, Keesler should have received 3.6 additional points in military value had the correct numbers been used. Also, the severe shortage of civilian physicians compared to the national averages should have raised a red flag had it not been understated by the MJCSG data.

Can you please identify the source of the MJCSG's figures for the number of hospitals beds and physicians, and explain why the number of primary care physicians, specialty care physicians, and dentists are not listed separately as required by the Military Value Framework?

Finally, I have unzipped and searched through dozens of files in search of data that should be readily available. Is there any one source that would simply show Keesler's score on each component of the military value formula? The attached document is my attempt to determine how Keesler scored on various components of the formula. If this data is available in one of the DOD files, could someone please point me to it? Since the military value scoring is the primary basis for the recommendation, can you supply an itemization of Keesler's score?

Brian Martin

Office of Rep. Gene Taylor

Response to Query:

The BRAC analysis considered the number of primary care, specialty care, dentists, and inpatient beds available within a 40-mile radius of the medical treatment facility. This includes both network and non-network participants. This includes both network and non-network participants. The sources for this information include (1) American Medical Association Physician Professional Record (AMA-PPD), December 31, 2003; (2) American Dental Association 2002 Survey; (3) American Hospital Association Annual Survey Database FY2002. These data points were utilized to compute the military value score and to assess the impact of the recommendation on the local community.

Compared to the national average, the Medical Joint Cross Service Group analysis noted, Keesler's catchment area is underserved in Primary Care, Specialty Care, and Dental providers. The same analysis showed the Keesler area to be over-served in inpatient bed availability.

The MJCSG chose only to close the inpatient infrastructure at Keesler, while retaining Primary Care, Specialty Care, and Dental capabilities. Creating an opportunity to leverage the available inpatient infrastructure in the local community by enabling military providers to continue to primary care and specialty care healthcare delivery within the Keesler medical facility, while performing surgeries and attendant inpatient care at local facilities.

The details of the scores assessed for Keesler, using the Medical JCSG approved methodologies, is attached.

KEESLER AFB **Weighted
Score**

| | | |
|------------|--------------------|--------------|
| Criteria 1 | AD Elig | 6.48 |
| | ADFM Elig | 0.41 |
| | Other Elig | 0.41 |
| | ADFM Enrollee | 3.24 |
| | Other Enrollee | 2.16 |
| | Hospital | 0.00 |
| | Beds per Pop | 0.00 |
| | PC Phys per Pop | 5.40 |
| | SC Phys per Pop | 1.80 |
| | Dentists per Pop | 1.35 |
| | SUBTOTAL | 21.24 |
| Criteria 2 | FCI | 0.00 |
| | AWA | 5.00 |
| | SUBTOTAL | 5.00 |
| Criteria 3 | Blood Score | 0.00 |
| | Warehouse Prox | 0.00 |
| | Beds (Contingency) | 1.20 |
| | SUBTOTAL | 1.20 |
| Criteria 4 | Cost per RWP | 2.24 |
| | Cost per RVU | 0.00 |
| | Cost per DWV | 1.20 |
| | RWP | 1.80 |
| | RVU | 3.84 |
| | DWV | 0.96 |
| | Prescription | 1.20 |
| | Rad Proc | 0.55 |
| | Lab Proc | 0.17 |
| | SUBTOTAL | 11.96 |
| | Total | 39.40 |



KEESLER MEDICAL CENTER Military Value Score by Criteria

| | |
|---|--------------------|
| Active Duty Eligibles: (14,001 – 17,500) | 6.48 of 16.2 |
| AD Family Member Eligibles: (13,501 – 18,000) | 0.41 of 1.35 |
| Other Eligibles (under 65) (21,001 – 28,000) | 0.41 of 1.35 |
| AD Family Members Enrolled in Prime: (12,001 – 14,000) | 3.24 of 5.40 |
| Other non-AD (under 65) Enrolled in Prime: (12,001 – 13,500) | 2.16 of 2.70 |
| DEMAND Subtotal | 12.70 of 27 |
| # of Civilian/VA Hospitals (2 or more) | 0.00 of 1.80 |
| # of Civilian/VA Beds per population (100% or more of civilian average) | 0.00 of 7.20 |
| # of Primary Care providers per population (Less than 81.9% of civilian average) | 5.40 of 5.40 |
| # of Specialty Care providers per population (84% – 85.9% of civilian average) | 1.80 of 2.25 |
| # of Dentists per population (Less than 81.9% of civilian average) | 1.35 of 1.35 |
| CIVILIAN CAPACITY Subtotal | 8.55 of 18 |

Office of Rep. Gene Taylor, July 11, 2005. Itemized scores provided by July 1, 2005 Memorandum from Col. Mark Hamilton, Secretary of MJCSG. Corresponding data ranges from MJCSG Military Value Framework Report, February 11, 2005.

| | |
|--|----------------------|
| Facility Condition Index (FCI greater than 0.9, i.e. unexecuted projects = to more than 90% of replacement value) | 0.00 of 12.50 |
| Average Weighted Age (31 – 35 years) | 5.00 of 12.50 |
| FACILITIES Subtotal | 5.00 of 25 |
| On-site FDA Blood Testing | 0.00 of 4.00 |
| Warehouse Proximity (Less than 50% of storage space attached to primary medical facility) | 0.00 of 2.00 |
| Contingency Beds (1 – 49 Beds) | 1.20 of 4.00 |
| CONTINGENCY Subtotal | 1.20 of 10.00 |
| Inpatient Costs (\$8,001 - \$8,500 per RWP) | 2.24 of 2.80 |
| Outpatient Costs (More than \$215 per RVU) | 0.00 of 4.00 |
| Dental Costs (Less than \$126 per DWV) | 1.20 of 1.20 |
| Inpatient Care Throughput (5,001 – 6,000 total RWPs) | 1.80 of 3.60 |
| Outpatient Care Throughput (360,001 – 405,000 total RVUs) | 3.84 of 4.80 |
| Dental Care Throughput (80,001 – 90,000 total DWVs) | 0.96 of 1.20 |
| Pharmacy Throughput (More than 800,000 total prescriptions) | 1.20 of 1.20 |
| Radiology Throughput (180,001 – 210,000) | 0.55 of 0.92 |
| Laboratory Throughput (1,200,001 – 1,400,000) | 0.17 of 0.28 |
| COST & THROUGHPUT Subtotal | 11.96 of 20 |

Office of Rep. Gene Taylor, July 11, 2005. Itemized scores provided by July 1, 2005 Memorandum from Col. Mark Hamilton, Secretary of MJCSG. Corresponding data ranges from MJCSG Military Value Framework Report, February 11, 2005.



DEPARTMENT OF THE AIR FORCE
AIR EDUCATION AND TRAINING COMMAND

JUL 18 2005

MEMORANDUM FOR SAF/LLI

FROM: 81 TRW/CV
720 Chappie James Ave Rm 204
Keesler AFB MS 39534-2604

SUBJECT: Congressional Inquiry – Keesler AFB Medical Center, BRAC

This memo is in response to four questions from Senator Trent Lott's office. They are all regarding the impact of the BRAC recommendation to realign the Keesler Medical Center.

1. Describe the Keesler Medical Center's Graduate Medical Education (GME) Program. Specifically, how many students, specialties, professors, and graduates are produced each year? Also, what is the quality of the program? What do the inspectors and other accreditation agencies say about the Keesler program?

- There are 10 GME programs offered at Keesler Medical Center:
 - General Dentistry (1 year program) 14 Residents (combined for Dental program)
 - General Practice Residency (Dental) (2 year program)
 - Endodontics (2 year program)
 - Internal Medicine (3 year program) --24 students
 - Obstetrics and Gynecology (4 year program) -- 11 students
 - Nurse Anesthetists (CRNA) (18 month program) -- 5 students
 - Pediatrics (3 year program) -- 23 students
 - General Surgery (5 year program) -- 24 students
 - General Thoracic Fellowship (VA) (1 year program) -- 1 student
 - Orthopedic Physician Assistant (1 year program) -- 1 student
- There are currently 79 physicians (students) assigned obtaining their specialty training (GME)
- There are approximately 85 professors (in most cases a 1 to 1 student to instructor ratio)
- There are approximately 69 graduates per year
- The Keesler GME program is a fully accredited educational program. Keesler GME has been rated excellent (no marginal or poor write-ups) and successfully passed all surveys.

2. How many personnel would be lost if the GME program was lost due to the BRAC decision to shut down inpatient services at Keesler? Also, what specialties would be lost and are these available in the 40 mi radius that TRICARE uses?

The BRAC recommendation that Keesler Medical Center becomes an "ambulatory care center" with outpatient surgery capability assumes 212 medical professional (provider) staff positions (according to the Consolidated Omnibus Budget Reconciliation Act (COBRA) file dated May 20, 2005) will be eliminated at Keesler Medical Center, as typical Air Force ambulatory care centers do not require inpatient-specific services and most specialty services.

Inpatient-specific and GME-related medical staff positions which would be eliminated include:

- *All positions in the Graduate Medical Education Office and the residency program director offices*
- *Intensive Care Medicine*
- *Trauma/Critical Care*
- *Emergency Medicine (unless reconfigured as "Urgent Care Service")*
- *Nutritional Medicine*

Specialty services which are commonly not present in Air Force ambulatory facilities and thus would be eliminated include:

Pediatrics

Adolescent Medicine
Allergy
Cardiology
Clinical Genetics
Clinical Genetics and Clinical Cytogenetics
Developmental/Behavioral
Endocrinology
Gastroenterology
Hematology-Oncology
Infectious Diseases
Neonatology
Neurology

Internal Medicine

Allergy
Cardiology
Dermatology, General
Dermatology, Mohs Surgery
Endocrinology
Hematology-Oncology
Infectious Diseases
Nephrology
Neurology
Pulmonology
Rheumatology

Surgery

Cardiothoracic
Colorectal
Laparoscopic
Neurosurgery
Orthopedics, Hand
Orthopedics, Pediatric
Plastics

Urology

Vascular

Obstetrics-Gynecology

Obstetrics
Reproductive Endocrinology and Infertility
Maternal Fetal Medicine
Molecular Genetics
Gynecologic Oncology
Gynecologic Pathology
Urogynecology and Pelvic Reconstructive Surgery

Radiology

Chest/Cardiac
Neuroradiology
Nuclear Medicine
Radiation-Oncology

Pathology

General
Cytopathology
Dermatopathology
Transfusion Medicine/Bloodbanking

Surgical services which can operate from an ambulatory facility providing limited "high volume" procedures include:

- *General Surgery*
- *Gynecology*
- *Orthopedics*
- *ENT*
- *Ophthalmology*

Medical services suited for operation in an ambulatory setting in which limited "high-volume" procedures can be offered include:

- *General Internal Medicine and Pediatrics, Family Medicine, Flight/Occupational Medicine*
- *General Allergy Services*
- *Gastroenterology*
- *Women's Health*
- *Immunizations*
- *Optometry*
- *Health and Wellness Services*

Some surgical specialty services can continue with primarily ambulatory surgery center support, as long as referral hospitalization can be arranged through a civilian facility if required, and inpatient practice opportunities are available for skills maintenance of Keesler Medical Center providers. And, some medical specialties can offer high-volume consultative capability and limited procedure work, as long as support is present from a local inpatient facility and, again, cross-privileging and credentialing are available. However, such referral arrangements may depend on the receiving hospital's capacity and willingness to accept these patients (with TRICARE reimbursement), the willingness of the medical staff of the receiving hospital to credential and privilege Keesler providers to provide on-going care and the willingness of individual civilian physicians to provide cross-coverage (problematic due to the limited beneficiary population which Keesler providers may see).

The following medical/surgical specialties are available presently at Keesler Medical Center, but are lacking in the Gulfport-Biloxi civilian community. These services, as noted above, can be expected to close if Keesler Medical Center becomes an ambulatory care center typical of the others in the Air Force.

Pediatrics

Adolescent Medicine
Clinical Genetics
Developmental/Behavioral
Endocrinology
Gastroenterology
Hematology-Oncology

Infectious Diseases

Neurology

Internal Medicine

Dermatology, Mohs Surgery
Infectious Diseases is present on the coast but does not care for HIV patients

Surgery

*Colorectal
Laparoscopic
Orthopedics, Hand
Orthopedics, Pediatric
Trauma/Critical Care*

Maternal Fetal Medicine

*Molecular Genetics
Gynecologic Oncology
Gynecologic Pathology
Urogynecology and Pelvic Reconstructive
Surgery*

Obstetrics-Gynecology

Reproductive Endocrinology and Infertility

Dental

Hospital Dentistry

Note:

The only dental services that would definitely be affected would be Hospital Dentistry. The 2 residents in the 1-year General Practice Residency would have to do their hospital training at the VA Hospital. This is only about 20% of their training and we already have our residents do some of the training at the VA. This would just have to be expanded. We do not see this as a major problem as some of our dental providers are already credentialed at the Biloxi VA.

Oral Pathology could be affected but would most likely stay the same. There will still be a requirement for pathologists for outpatient surgery. The number of pathologists assigned would most likely decrease, but dental pathology requirements would stay the same.

Listing of hospitals, including VA medical centers, within 40 miles of your facility:

Biloxi Regional Medical Center
Singing River Hospital System
VA Medical Center Biloxi
VA Medical Center Gulfport
Gulf Coast Medical Center
Singing River Hospital
Garden Park Medical Center
Gulf Oaks Hospital
Gulfport Medical Center
Hancock Medical Center
Gulfport Memorial

Keesler Medical Center would maintain limited bedded capability to support "same-day" surgical operations (that is, to support post-operative care lasting less than 24 hours); however, without longer-term admitting capability, even outpatient surgery case selection would be limited to procedures on primarily young, healthy beneficiaries with few (if any) co-morbidities (pre-existent medical conditions which place patients at higher surgical risk and need for direct inpatient support, such as advanced diabetes, hypertension, heart disease, or obesity; note that these conditions are prevalent in the retiree population serviced by Keesler Medical Center). Based on other Air Force ambulatory surgery centers and the Keesler population base, between

15 - 20 "23-hour observation" beds would be required. All other active beds designed for longer-term care would be eliminated.

Other bedded facilities with full-service 24-hour Emergency Departments (for Keesler Medical Center referral stabilization and disposition) in the immediate Gulfport-Biloxi area (with numbers of beds, from the latest American Hospital Association reference guide) include:

BILOXI REGIONAL MEDICAL CENTER (150 Reynoir Street, Biloxi) - 153 beds

VETERAN'S ADMINISTRATION GULF COAST VETERAN'S HEALTHCARE SYSTEM/MEDICAL CENTER (400 Veteran's Avenue, Biloxi) – Currently only provides 10 psychiatric service beds to active-duty members only (Gulfport campus only) – Biloxi VA has 66 acute beds in main facility

GULF OAKS HOSPITAL/GULF COAST MEDICAL CENTER (180 DeBuys Road, Biloxi) – 189 beds

GARDEN PARK MEDICAL CENTER (15200 Community Road, Gulfport) – 130 beds

MEMORIAL HOSPITAL (4500 13th Street, Gulfport) – 445 beds

OCEAN SPRINGS HOSPITAL (3109 Bienville Blvd, Ocean Springs) – included in "Singing River" Hospital System

SINGING RIVER HOSPITAL (2809 Denny Boulevard, Pascagoula – 20 miles east) – 388 beds

HANCOCK MEDICAL CENTER (149 Drinkwater Blvd, Bay St. Louis – 30 miles west) – 104 beds

Note that several of these hospitals, notably the large Biloxi Regional Medical Center (which is the nearest civilian hospital to Keesler Air Force Base), are not a part of the TRICARE network, and thus may charge (15-35%) higher prices for services to TRICARE beneficiaries than TRICARE network hospitals. Also note that not all services presently available at Keesler Medical Center are available at the smaller community hospitals in the area, and many services are available at Keesler Medical Center alone.

- Emergency care would be diverted if the hospital becomes a clinic and ambulatory surgical center to the following locations:

Gulf Coast Medical Center - 3.3 miles

Singing River Hospital System - 10 miles

VA Medical Center Gulfport - 9.2 miles

Gulf Coast Medical Center - 5.4 miles

Singing River Hospital - 27.5 miles

Biloxi Regional Medical Center - 2.8 miles

Biloxi VA Medical Center - 1 mile

3. What will be the increased costs to our military members, their dependents, and retirees that Keesler currently serves if both the inpatient care and GME program is closed at Keesler?

There is no inpatient cost for AD members or their Prime enrolled dependents; Prime enrolled retirees and their dependents will pay an \$11 subsistence fee per inpatient day. Patients have the option of choosing balanced billing, which involves paying the balance of the bill resulting from seeing a non-network provider should they choose to do so to avoid a longer driving distance to see a network provider.

See attached matrices for specific cost sharing percentages based upon TRICARE enrollment status: Attachment 1 is for Active Duty Dependents, Attachment 2 is for Retirees and dependents under 65, and Attachment 3 is for TRICARE for Life beneficiaries

What will be the price adjustments that HUMANA will have to make to the current contract when this additional case load is added to TRICARE?

This cannot be determined at the MTF level. HUMANA has contracted with TRICARE Regional Office-South (TRO-South) in San Antonio, TX, to provide an adequate network of facilities and providers based upon the complete regional requirements. This answer would need to come from either TRO-South or TRICARE Management Activity (TMA) in Washington DC, as they are the POCs for the regional contact with HUMANA. Keesler Medical Center has never been a part of the regional contract negotiation process and is not privied to any of that financial data.

Again, are the specialties and medical facilities available in the current TRICARE system to handle this case load?

Please see the response to Question 2.

What will be the additional costs that will result from having to expand the TRICARE system?

Keesler Medical Center is not in a position to answer this question.

4. How many Keesler Medical personnel have been deployed in the last 5 years? What are the specialties? Where were they deployed, and what does the after action reports say of their performance.

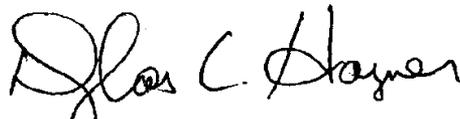
Keesler Medical Center has deployed 1,068 medical personnel over the past 5 years, from July 19, 2000 - July 9, 2005 for a combined total of 95,581 deployment days.

Every medical specialty within Keesler Medical Center has been tasked for some form of deployment. All personnel must be cleared for deployment readiness and stand ready to fill Primary or Alternate mobility slots (see attachment 4).

Keesler Medical personnel have deployed to various regions around the world. They have completed or are currently performing duties in CENTCOM, PACOM, EUCOM, and SOUTHCOM regions. Deployment taskings have ranged from 13 days to 365 days in duration. Keesler Medical Center Readiness staff just recently started surveying post-deployers from AEF's 3 and 4.

After Action Reports (AARs) are now accomplished electronically and filed in theater. Our Keesler medical personnel have been repeatedly lauded for superior performance while serving at various deployed location.

Especially noteworthy were the five Keesler medical personnel awarded the Bronze Star Medal for duty performance while supporting Operation ENDURING FREEDOM and IRAQI FREEDOM contingencies. The Bronze Star is the nation's fourth highest combat decoration. It is awarded to U.S. service members who distinguish themselves by heroic, meritorious achievement or service, not involving aerial flight participation, while engaging in military operations against any armed adversary.



DOUGLAS C. HAYNER, Colonel, USAF
Vice Commander
81st Training Wing

Attachments:

1. TRICARE Health Plan Comparison (Active Duty)
2. TRICARE Health Plan Comparison (Retirees, Families & Survivors)
3. TRICARE for Life Health Plan Comparison
4. Deployed Specialties

cc:

AETC/CCX
Senator Lott

**ATTACHMENT 1
TRICARE Health Plan Comparison**

Active Duty Family Members

| | TRICARE Prime | TRICARE Extra | TRICARE Standard |
|---|--------------------------|--|--|
| Annual Deductible | None | \$150/individual or \$300/family for E-5 & above; \$50/\$100 for E-4 & below | \$150/individual or \$300/family for E-5 & above; \$50/100 E-4 below |
| Annual Enrollment Fee | None | None | None |
| Civilian Outpatient Visit | No cost | 15% of negotiated fee | 20% of allowed charges for covered service |
| Civilian Inpatient Admission | No cost | Greater of \$25 or \$13.32/day | Greater of \$25 or \$13.32/day |
| Civilian Inpatient Mental Health | No cost | \$20/day | \$20/day |

ATTACHMENT 2
TRICARE Health Plan Comparison

Retired Service Members, Their Families, and Survivors

| | TRICARE Prime | TRICARE Extra | TRICARE Standard |
|---|--|--|---|
| Annual Enrollment Fee | \$230/individual \$460/family | None | None |
| Annual Deductible | \$0/individual \$0/family Unless point-of-service option is used | \$150/individual or \$300/family | \$150/individual or \$300/family |
| Civilian Outpatient Visit Copayment | \$12 copayment per visit | 20% of negotiated rate after the deductible is met | 25% of allowed charges for covered service after the deductible is met |
| Clinical Preventive Services | \$0 copayment/service | Applicable deductible and cost-shares apply per service | Applicable deductible and cost-shares apply per service |
| Civilian Inpatient Cost-Shares | \$11 per day (\$25 minimum charge per admission) | \$250 per day or 25% of the negotiated rate for institutional services, whichever is less, plus 20% of separately allowed professional charges | \$459 per day or 25% of the negotiated rate for institutional services, whichever is less, plus 25% of separately allowed professional charges |
| Emergency Services | \$30 copayment per visit | 20% of negotiated rate | 25% of allowed charges |
| Civilian Outpatient Behavioral Health | \$25 (individual visit) \$17 (group visit) | 20% of negotiated rate after the deductible is met | 25% of allowed charges after the deductible is met |
| Civilian Inpatient Behavioral Health | \$40 per day | 20% of the negotiated rate for institutional services, plus 20% of separately allowed professional charges | Low-volume hospitals: The lesser of \$164 per day or 25% of hospital-specific per diem High-volume hospitals: 25% of hospital-specific per diem |
| Civilian Inpatient Skilled Nursing Facility Care | \$11 per day (\$25 minimum charge per admission) (No separate copayment for separately billed professional charges, catastrophic cap protection limits apply.) | Lesser of \$250 per day or 20% of the negotiated fee for institutional services, plus 20% of the negotiated professional fee | 25% of allowed charges for institutional services, plus 25% of separately allowed professional charges |

ATTACHMENT 3

TRICARE For Life Health Plan Comparison

| | Medicare ¹ Pays | | TRICARE ² Pays | What You Pay ³ |
|--|----------------------------|---|--|--|
| Inpatient Services (Medicare Part A) - Outside a Military Treatment Facility (MTF) | | | | |
| Inpatient Hospitalization (Medical, Surgical, and hospital-based psychiatric care) <i>A new benefit period⁴ must begin before Medicare will cover additional days.</i> | Days 1-60 | 100% (after \$912 deductible ⁴) | \$912 deductible ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 61-90 | All but \$228/day ⁴ | \$228/day ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 91-150 ⁵ | All but \$456/day ⁴ | \$456/day ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 151+ | Not Covered | The DRG-allowed ⁷ amount minus patient's copayment/cost share | \$250/day or 25% of institutional charges, whichever is less plus 20% of professional charges if care is delivered in a TRICARE network hospital ⁸ . \$512/day ⁹ or 25% of billed charges for institutional services, whichever is less, plus 25% of allowable for professional charges if care is delivered in a Non-network hospital. |
| Inpatient Mental Health (Psychiatric Facility) ¹⁰ Inpatient mental healthcare requires preauthorization. Care in excess of 30 days requires a waiver for secondary TRICARE coverage. If authorized, TRICARE pays cost share or deductible. <i>A new benefit period⁸ must begin before Medicare will cover additional days.</i> | Days 1-60 | 100% (after \$912 deductible ⁴) | \$912 deductible ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 61 - 90 | All but \$228/day ⁴ | \$228/day ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 91-150 | All but \$456/day ⁴ | \$456/day ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days ¹¹ 151+ | Not Covered | 80% if network hospital ⁸ 75% if Non-network hospital | 20% of institutional charges plus 20% of professional charges for services received in a network hospital ⁸ . For services received in a Non-network hospital see TRICARE Reimbursement Manual Chap 2, Addendum A, page 10 for beneficiary payment information. The manual is available on the TRICARE Web site www.tricare.osd.mil/tricaremanuals/ |
| | Days 1-20 | 100% | Remaining Beneficiary Liability (if any) | Nothing for services payable by Medicare and TRICARE |
| | Days 21-100 | All but \$114/day ⁴ | \$114/day ⁴ | Nothing for services payable by Medicare and TRICARE |
| | Days 101+ | Not Covered | 80% if network hospital ⁸ 75% if Non-network hospital | 20% of TRICARE allowable charges if care delivered in a TRICARE network hospital 25% of TRICARE allowable charges if care delivered in a Non-network hospital |
| | | 95% | Remaining Beneficiary Liability 5% | Nothing for services payable by Medicare and TRICARE |

| Outpatient Services (Medicare Part B) - Outside an MTF | | | |
|--|--|---|--|
| | Medicare¹ Pays | TRICARE² Pays | What You Pay³ |
| Doctors Visits (Outside an MTF) | 80% | 20% | Nothing for services payable by Medicare and TRICARE |
| Emergency Room Visit | 80% | 20% | Nothing for services payable by Medicare and TRICARE |
| Mental Health Visit | 50% | 50% | Nothing for services payable by Medicare and TRICARE |
| Laboratory Services | 100% | Remaining Beneficiary Liability (if any) | Nothing for services payable by Medicare and TRICARE |
| Radiology (X-Rays) | 80% | 20% | Nothing for services payable by Medicare and TRICARE |
| Home Health Care | 100% for approved services | Remaining Beneficiary Liability (if any) | Nothing for services payable by Medicare and TRICARE |
| Durable Medical Equipment | 80% | 20% | Nothing for services payable by Medicare and TRICARE |
| Outpatient Hospital Services | 80% | 20% | Nothing for services payable by Medicare and TRICARE |
| Blood | Nothing for the first three pints 80% for additional pints (beyond the first three) | 100% of the cost of the first three pints of blood 20% for additional pints (beyond the first three) | Nothing for services payable by Medicare and TRICARE |
| Chiropractic Services | 80% | Not Covered | 20% Medicare cost-share |
| Healthcare Outside of the United States and Its Territories (US&T) - Outside an MTF | | | |
| | Medicare¹ Pays | TRICARE² Pays | What You Pay³ |
| Inpatient Services | Not covered Outside US&T ¹² | 75% | 25% of TRICARE allowable charges; plus 25% of professional fees |
| Outpatient Services | Not covered Outside US&T ¹² | 75% | 25% of TRICARE allowable charges after the TRICARE fiscal year deductible has been met (\$150 per person \$300 per family) |

¹All percentages paid by Medicare are for the Medicare approved amounts for services received from Medicare providers who accept Medicare assignment.

²TRICARE will pay the difference between Medicare's paid amount and Medicare's limiting charge (up to 115 percent of the allowable amount) for non-participating provider claims.

³TRICARE has a \$3,000.00 per fiscal year (Oct 1- Sept 30) catastrophic cap (your maximum out of pocket expense).

⁴Medicare amount that will change every calendar year.

⁵Lifetime Reserve days (91-150) are sixty additional days that Medicare will pay for, minus \$456/day (in 2005) deductible, when you are in a hospital for more than 90 consecutive days. These 60 reserve days can be used only once.

⁶A benefit period begins when a beneficiary is admitted to a hospital or skilled nursing facility and continues until the beneficiary has been out the facility for at least 60 consecutive days.

⁷A reimbursement system using Diagnosis Related Groups (DRGs) that assigns payment levels to each DRG based on the average cost of treating all patients in a given DRG.

⁸A network hospital is one that has a contractual agreement with TRICARE.

⁹DRG per diem rate that will change every fiscal year.

¹⁰190 days in a lifetime are available within a psychiatric facility.

¹¹Medicare ceases to pay after day 150, unless a new benefit period begins. TRICARE will pay 75% or 80% and the beneficiary pays up to 25% depending on whether a network or non-network facility is used.

¹²The Original Medicare Plan does not cover health care when you travel outside the United States and its territories, except for some emergency situations in Mexico and Canada.

PRESCRIPTION DRUG COVERAGE: WHO PAYS?

| | Medicare Pays | TRICARE Pays | What You Pay ² |
|---|---------------|---|--|
| Prescription Drugs (Not Covered by Medicare) | | | |
| MTF Pharmacy | Not Covered | 100% (up to a 90-day supply) | Nothing |
| TRICARE Mail Order Pharmacy | Not Covered | All costs except for the generic or brand name prescription drug co-payment (up to a 90-day supply) | Co-pay for generic prescription is \$3 (up to a 90-day supply) Co-pay for brand-name prescription is \$9 (up to a 90-day supply) |
| TRICARE Retail Network Pharmacy | Not Covered | All costs except for the generic or brand name prescription drug co-payment (up to a 30-day supply) | Co-pay for generic prescription is \$3 (up to a 30-day supply) Co-pay for brand-name prescription is \$9 (up to a 30-day supply) |
| Non-network Retail Pharmacy | Not Covered | All costs except for the generic or brand name prescription drug co-payment (up to a 30-day supply) | Co-pay for all drugs (up to a 30-day supply) is \$9 or 20% whichever is greater (in most cases full cost of prescription must be paid in advance). A yearly deductible of \$150/individual or \$300/family will apply. |

The **TRICARE Pharmacy** benefit is available to all eligible uniformed service members and their family members, and all eligible retirees and their family members, including their survivors 65 years of age and older. Eligible beneficiaries who turned 65 before April 1, 2001, are not required to enroll in Medicare Part B. Those who turned 65 on or after April 1, 2001, are required to enroll in Medicare Part B. However, to participate in **TRICARE For Life**, Medicare Part A and Part B are required.

For more information about your benefits please call
 TRICARE For Life: 1-888-DoD-LIFE (1-888-363-5433)
 TRICARE Senior Pharmacy: 1-877-DoD-MEDS (1-877-363-6337)
 For the hearing impaired (TTY/TDD): 1-877-535-6778

ATTACHMENT 4
Deployed Specialties

OFFICERS:

041A3 - Health Services Administrator
042B3 - Physical Therapists
042E3 - Optometrist
042G1 - Physician Assistant
042G3 - Physician Assistant
042P3 - Clinical Psychologist
042S3 - Clinical Social Worker
043E3A - Bioenvironmental Engineer, General
043H3 - Public Health
043P3 - Pharmacist
043T3A - Biomedical Lab, Biomedical Lab Science
044E3A - Emergency Services Physician
044F3 - Family Physician
044K3 - Pediatrician
044M3 - Internist
044M3H - Internist, Infectious Disease
044R3 - Diagnostic Radiologist
044S3A - Dermatologist, Dermatologist Surgeon
044Y3 - Critical Care Medicine
045A3 - Anesthesiologist
045B3 - Orthopedic Surgeon
045G3 - OB/GYN
045N3 - Otorhinolaryngologist
045S3 - Surgeon
45S3A - Surgeon,
45S3C - Surgeon, Cardiac
45S3E - Surgeon, Peripheral
45S3F - Surgeon, Neurological
45S3G - Surgeon, Plastic
046A3 - Nursing Administrator
046M3 - Nurse Anesthetist
046N3 - Clinical Nurse
046N3E - Clinical Nurse, Critical Care
046N3G - Clinical Nurse, Obstetrical
046P3 - Mental Health Nurse
046S3 - Operating Room Nurse
047G3 - Dentist
047G3A - Dentist, Comprehensive
047S3 - Oral/Maxillofacial Surgeon
048A3 - Aerospace Medical Specialist
048R3 - Aerospace Medical, Res Training Flight Surgeon

ENLISTED Personnel:

- 4A0X1 - Health Services Management
- 4A1X1 - Medical Materiel
- 4A2X1 - Biomedical Equipment
- 4B0X1 - Bioenvironmental Engineering
- 4C0X1 - Mental Health
- 4E0X1 - Public Health
- 4H0X1 - Cardiopulmonary Laboratory
- 4N0X1 - Aerospace Medical Services
- 4N1X1 - Surgical Services
- 4N1X1C - Surgical Services, Orthopedics
- 4P0X1 - Pharmacy
- 4R0X1 - Diagnostic Imaging
- 4T0X1 - Medical Laboratory
- 4V0X1 - Optometry
- 4Y0X1 - Dental
- 9U100 - (TCN Escort Duty – filled by various enlisted AFSC's)



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

July 1, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: HQ USAF/SGE
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Response to BRAC 2005 Question #0052 - VA - Rep. Scott: Naval Medical Center
Portsmouth

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.


MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query

Query:

From: Waldman, Mitch (Lott)

Subject: Re: Tri-Care Request

Did the BRAC analysis only reflect the availability of network providers when assessing medical capacity of the Gulf Coast, or was an estimate also included of non network providers that would accept Tricare? If an estimate of non-network providers that accept Tricare was included, what was that estimate? What are the quantities of network providers, by major specialty, that existed on the Mississippi Gulf Coast - Jackson, Harrison, and Hancock County - for 1999, 2001, 2002, 2003, and 2004, respectively?

Response to Query:

The BRAC analysis considered the number of primary care, specialty care, dentists, and inpatient beds available within a 40-mile radius of the medical treatment facility. This includes both network and non-network participants. These data points were utilized to compute the military value score and to assess the impact of the recommendation on the local community.

The Medical Joint Cross Service Group analysis noted, Keesler's catchment area is underserved in Primary Care, Specialty Care, and Dental providers when compared to the national averages. The same analysis showed the Keesler area to be over-served in inpatient bed availability.

The MJCSG chose only to close the inpatient infrastructure at Keesler, while retaining Primary Care, Specialty Care, and Dental capabilities. Creating an opportunity to leverage the available inpatient infrastructure in the local community by enabling military providers to continue primary and specialty healthcare delivery within the Keesler medical facility, while performing surgeries and attendant inpatient care at local facilities.

The Medical JCSG used publicly available, licensed databases or BRAC data calls to collect the data requested. What can be provided to the public has been posted and given to the Commission.



Memorandum

June 20, 2005

TO: Honorable Gene Taylor
Attention: Brian Martin

FROM: Jim Hahn
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT: Health Care Resources in the Biloxi-Gulfport-Pascagoula Metropolitan Area

You requested a comparison of health care resources in the Biloxi-Gulfport-Pascagoula metropolitan area of Mississippi against national averages. Specifically, you asked for per capita measures of the number of civilian and VA hospital beds, primary and specialty care providers and dentists. The memo summarizes an analysis based on data from the Area Resource File (ARF).¹

The Biloxi-Gulfport-Pascagoula metropolitan area has fewer physicians and dentists but more hospital beds per capita than the national average. The area has roughly three-quarters the number of physician specialists (60 vs. 83 per 100,000 population) and dentists (36 vs. 48 per 100,000 population) compared to the national average, and almost two-thirds the number of family and general practice physicians (34 vs 53 per 100,000 population).² (see Table 1). However, the Biloxi-Gulfport-Pascagoula metropolitan area has 66% more short-term community and VA hospital beds than the national average (510 vs. 307 per 100,000).

The Biloxi-Gulfport-Pascagoula area is similar to other areas in the state on most measures of health care resources. When compared against the rest of the state of Mississippi, the Biloxi-Gulfport-Pascagoula area has almost the same number of hospital beds per 100,000 (510 vs. 513) but fewer family/general practice physicians (34 vs. 47) and more specialty physicians (60 vs. 48) and dentists (36 vs. 31). When compared to other

¹ The Area Resource File is a county-specific health resources database compiled by the National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services. The ARF contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics for each county.

² Data for physicians and hospitals reflect 2001 experience, while the numbers for dentists reflect 1998. In each case, the population used in the denominator in calculating per capita rates matches the year for the numerator.

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metropolitan areas in the state, the Biloxi-Gulfport-Pascagoula area has fewer hospital beds (510 vs. 605) and proportionately fewer physicians and dentists, as these figures are higher in other Mississippi metropolitan areas than in the rest of the state including Biloxi-Gulfport-Pascagoula.³

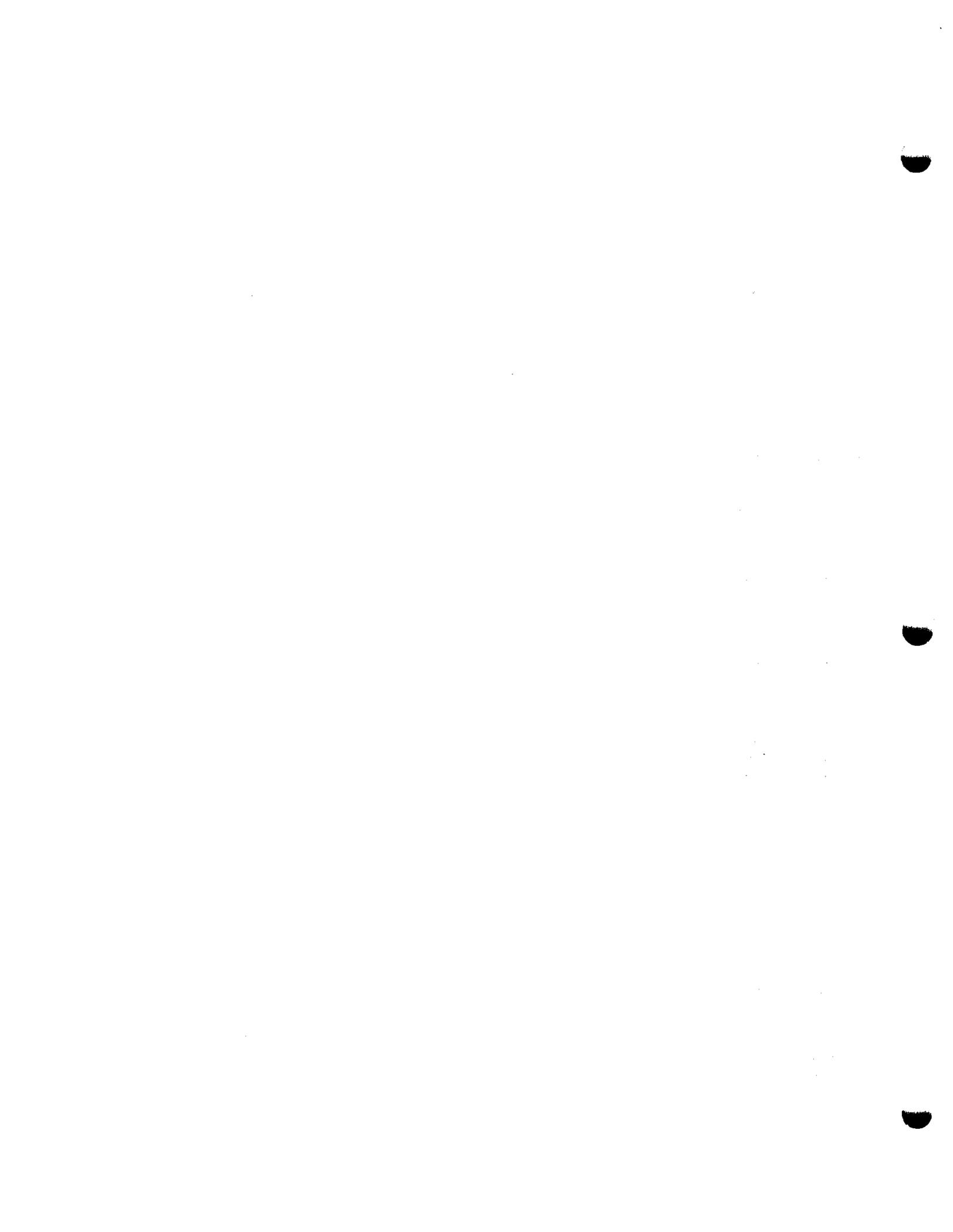
Table 1. Selected Health Care Resources per 100,000 Population, United States, Mississippi, Mississippi Metropolitan Areas, and the Biloxi-Gulfport-Pascagoula Metropolitan Area

| Health care resource | U.S. | MS | MS metropolitan areas | Biloxi-Gulfport-Pascagoula |
|---|------|-----|-----------------------|----------------------------|
| Short-term community and VA hospital beds | 307 | 513 | 605 | 510 |
| Family and general practice physicians | 53 | 47 | 51 | 34 |
| Specialty care physicians | 83 | 48 | 79 | 60 |
| Dentists | 48 | 31 | 40 | 36 |

Source: Area Resource File, Feb. 2003 Release. National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services.

Please contact me at 707-4914 if you have additional questions.

³ In addition to the three counties that make up the Biloxi-Gulfport-Pascagoula metropolitan area, six additional counties in Mississippi are parts of Metropolitan Statistical Areas. This includes three counties that make up the Jackson, MS MSA, two counties that comprise the Hattiesburg, MS MSA, and one county that is part of the Memphis, TN-AR-MS MSA.





DEPARTMENT OF THE AIR FORCE
AIR EDUCATION AND TRAINING COMMAND

14 Jun 05

MEMORANDUM FOR SAF/LLI

FROM: 81 TRW/CC

SUBJECT: Congressional Inquiry - Keesler AFB Medical, BRAC

Attached is information requested by Senator Lott's office regarding current BRAC information with reference to the Keesler Medical Center.

A handwritten signature in black ink, reading "W. T. Lord", is positioned above the typed name.

WILLIAM T. LORD
Brigadier General, USAF
Commander

cc: AETC/CCX
Senator Lott's Office

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1959



SUB-SPECIALTIES OF THE MEDICAL CENTER

Pediatrics (13)

General
Adolescent Medicine
Allergy
Cardiology
Clinical Genetics
Clinical Genetics and Clinical
Cytogenetics
Developmental/Behavioral
Endocrinology
Gastroenterology
Hematology-Oncology
Infectious Diseases
Neonatology
Neurology

Internal Medicine (14)

General
Allergy
Cardiology
Dermatology, General
Dermatology, Mohs Surgery
Endocrinology
Gastroenterology
Hematology-Oncology
Infectious Diseases
Intensive Care
Nephrology
Neurology
Pulmonology
Rheumatology

Surgery (15)

General
Cardiothoracic
Colorectal
Laparoscopic
Neurosurgery
Ophthalmology
Optometry
Orthopedics, General
Orthopedics, Hand
Orthopedics, Pediatric
Otolaryngology
Plastics
Trauma/Critical Care

Surgery (cont)

Urology
Vascular

Obstetrics-Gynecology (7)

General
Reproductive Endocrinology
and Infertility
Maternal Fetal Medicine
Molecular Genetics
Gynecologic Oncology
Gynecologic Pathology
Urogynecology and Pelvic
Reconstructive Surgery

Emergency Medicine

Emergency Medicine

Family Practice

Family Practice

Flight Medicine (2)

Aerospace Medicine
Occupational Medicine

Life Skills (2)

Psychiatry
Child Psychiatry

Radiology (5)

General
Chest/Cardiac
Neuroradiology
Nuclear Medicine
Radiation-Oncology

Pathology (4)

General
Cytopathology
Dermatopathology
Transfusion
Medicine/Bloodbanking

Dental (11)

General
Dental Materials
Endodontics
Hospital Dentistry
Maxillo-facial Prosthodontics
Oral Pathology
Oral Surgery
Orthodontics
Pedodontics (Pediatric
Dentistry)
Periodontics
Prosthodontics

**75 specialties or
subspecialties represented in
all**

(Chiropractic)
(Clinical Pharmacy)
(Clinical Psychology)
(Occupational Therapy)
(Optometry)
(Physical Therapy)
(Podiatry)
(Public Health)



Answers to Senator Lott's Inquires:

1. How many Graduate Medical Education programs does the medical center have? **10**
 - General Dentistry
 - General Practice Residency (Dental)
 - Endodontics
 - Internal Medicine
 - Obstetrics and Gynecology
 - Nurse Anesthetists
 - Pediatrics
 - General Surgery
 - General Thoracic Fellowship (VA)
 - Orthopedic Physician Assistant

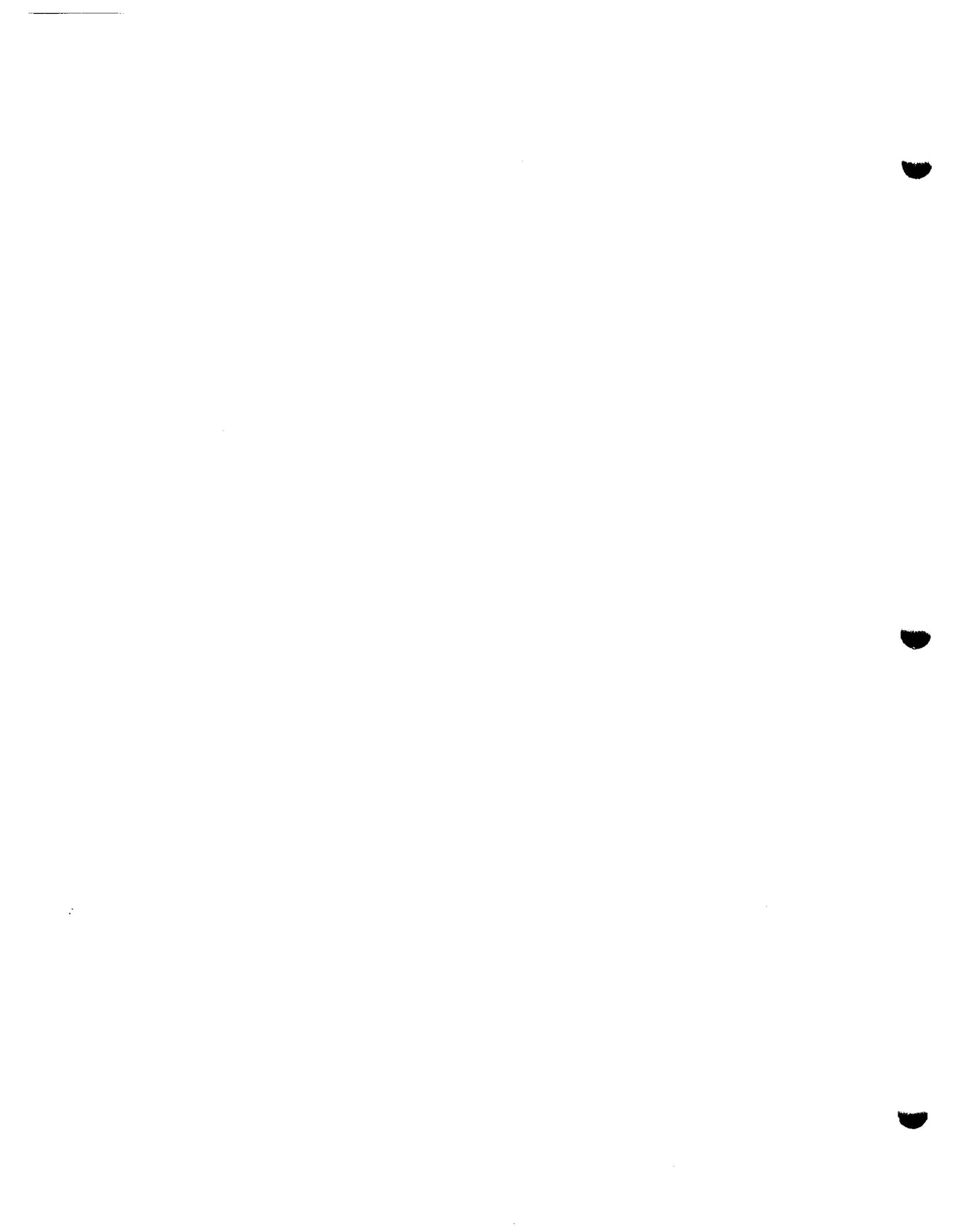
2. How many graduates per year? **69**

3. How many sub-specialties does the medical center provide? **75**
See attached listing

4. How many physicians are assigned at the medical center? **We have 338 credentialed providers assigned to KMC as of 06/05. Of this total:**
 - 204 physicians (MD/DO)**
 - 39 dentists (including oral surgeons and hospital dentists)**
 - 24 nurse practitioners**
 - 71 allied health professionals with active clinical privileges (ie: optometrists)****Additionally, there are 77 physicians assigned, who are involved in obtaining their specialty training (GME).**

5. How many Active Duty, veterans and retirees does the medical center treat on an annual basis?
 - Active Duty: 94,054**
 - Retirees: 52,023**
 - Veterans: 3,031**
 - AD Admission: 545**
 - Retiree Admissions: 1,129**
 - Veteran Admissions: 111**

6. How many appointments are seen per year? **319,687**





DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

June 14, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: AF/SGE
1420 Air Force Pentagon
Washington, DC 20330-1420

SUBJECT: OSD BRAC Clearinghouse Tasker # 0299/ Rep. Taylor Request for Source of Data

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.

A handwritten signature in black ink, reading "Mark A. Hamilton", is positioned above the typed name.

MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query



Query:

Cindy,

The Medical Joint Cross-Service Group recommended disestablishing hospital inpatient services at nine military hospitals.

In the COBRA Report of estimated costs and savings of the recommendation, the estimates of the increased costs to TRICARE are based on something called the "inpatient admission cost factor." The COBRA model assumes that TRICARE will pay \$4,314.25 per inpatient admission for the military personnel, family members, and retirees who are forced out of the Keesler hospital. That is a much lower estimate per admission than the other eight hospitals in the recommendation, and well below the \$6,000 per admission average in the TRICARE *Chartbook of Statistics* for Fiscal Year 2003. The estimated cost per inpatient admission that is used to estimate active military and family admissions is also used to estimate the cost of admissions of retirees under 65 and the TRICARE share of admissions of retirees 65 and older.

Please help me find the source of the \$4,314.25 estimate per admission in civilian hospitals near Keesler. Did this figure come from TMA? What is the source and the sample from which it was determined? Is it based on current TRICARE claims data? If so, is this data on the active duty and family population or does it include the retiree populations? Is this data for the Keesler catchment area or for the Gulfport-Biloxi MSA or for some other geographic entity?

Thank you for your assistance. This information is very important to any analysis of the DOD recommendation since the inpatient admission cost factor is the basis for the estimate of the recurring costs of the proposed action.

Brian Martin

Office of Rep. Gene Taylor

202-225-5772

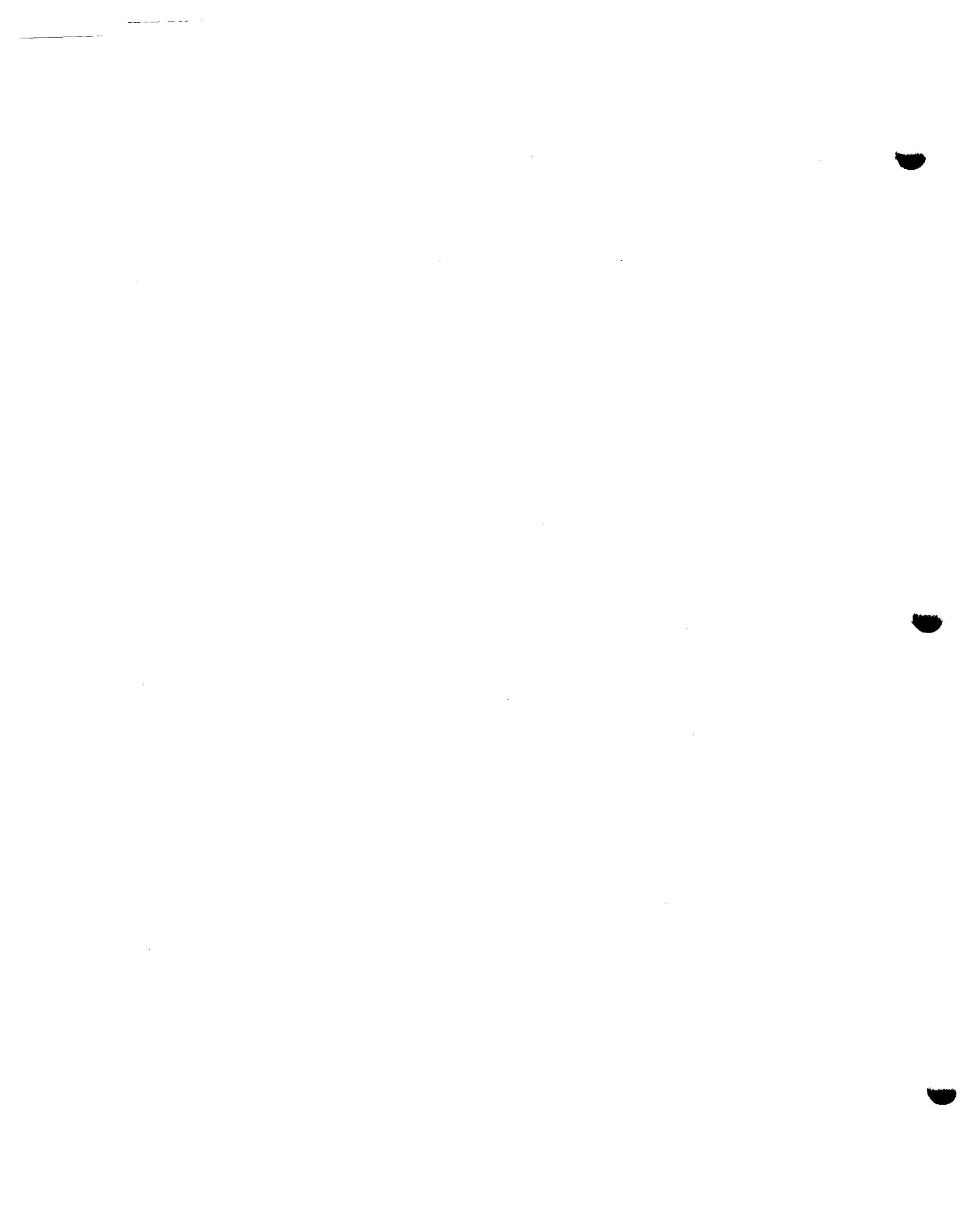
Response to Query:

The MJCSG used the average of the FY02-FY03 paid cost per admission recorded in the TRICARE claims database to estimate the costs of providing inpatient care in the Keesler local community. This is the source of the \$4314.25 cost used for the Keesler analysis. This figure includes all beneficiaries and is adjusted for TRICARE FOR LIFE beneficiaries where the DoD is a second payer to MEDICARE.

The nation-wide average per admission cost for the AF Medical Service for the FY02-FY04 time period was determined to be \$6790 from the same TRICARE Claims databases.



Applying this cost to the data for the Keesler recommendation reduces the annual savings by \$10 million from \$30M to \$20M.





DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

June 27, 2005

MEMORANDUM FOR OSD BRAC CLEARINGHOUSE

FROM: AF/SGE
1780 Air Force Pentagon
Washington, DC 20330-1420

SUBJECT: Response to CM Taylor Questions

Attached is the Medical Joint Cross Service Group response to the referenced query.

If you have any questions, please contact me at (703) 692-6990 or
mark.hamilton@pentagon.af.mil.

A handwritten signature in black ink that reads "Mark A. Hamilton".

MARK A. HAMILTON, COL, USAF, BSC
Secretary
Medical Joint Cross Service Group

Attachments:

1. Response to Query

Query:

What is the number of military personnel on the Mississippi Gulf Coast enrolled in the separate Tricare programs; Tricare Prime, Tricare Standard, and Tricare Extra?

Answer:

| <i>Beneficiary Category</i> | <i>FY 2004 Enrollment</i> |
|-----------------------------|---------------------------|
| AD | 11,346 |
| ADFM | |
| Prime | 12,077 |
| Standard/Extra | 4,927 |

What would be the costs for a service member to have a family member treated at a civilian hospital on Tricare Standard? Using the pregnant wife having a baby and a child with cancer as examples?

Answer: The attached Chart provides details of the benefits.

For Active Duty family members who enroll in Prime (no premium), there again are no out-of-pocket expenses provided they are seen with a referral. (If they choose to get care without a referral, Point of Service (POS) charges apply (50%)). For Active Duty family members who enroll in Prime (no premium), there again are no out-of-pocket expenses provided they are seen with a referral. (If they choose to get care without a referral, Point of Service (POS) charges apply (50%).

For those Active Duty Family members who choose not to enroll in Prime (presumably because they want the flexibility to access the civilian healthcare market) a civilian hospital admission will cost the greater of \$25 or \$13.32/day. Note that there is an annual deductible amount of \$300 per family meaning that the family will pay the first \$300 of claims and then the cost shares to the annual catastrophic cap of \$1000. For a normal OB delivery, assuming a 48 hrs stay time, the maximum charge would be \$350. For a significant medical care event (cancer treatment), the maximum annual charge would be \$1,000, which includes the deductible amount.

Contrasted with the TRICARE Prime benefit, an Active Duty or Active Duty Family Member referred to the civilian healthcare system to deliver their baby would have no charge—the same if the baby was delivered in the military hospital.

To successfully implement your scenarios, the USAF has stated that the cooperation of local hospitals is essential. Which local hospitals has the USAF been in contact with to discuss the feasibility of the USAF plan regarding Keesler doctors and residents using local hospitals for inpatient services, including services connected to GME? Has any potential agreements been discussed with any local hospitals? If so, which ones?

Answer: No conversations between local hospitals and Air Force Headquarters have occurred on this matter. We understand that the leadership at Keesler AFB and as well as the Tricare Regional Office and local hospitals is ongoing.

What is the impact of local hospitals not accepting inpatients whose doctors are based at Keesler?

Answer: Ultimately, the Air Force will determine if the workload opportunities in at Keesler AFB provide enough scope of care to maintain the currency of our providers there. Likewise, the certifying bodies for Graduate Medical Education will determine if the workload opportunities at Keesler AFB will meet their standards.

What are the actual reimbursement rates/fees paid to providers in the Gulf Port, Biloxi, Pascagoula area? How do they compare to actual reimbursement rates paid in other locations or similar population/income/etc.?

Answer: Our information, averaged for all beneficiaries over the FY02-FY04 time, shows that inpatient claims in the Keesler area, average \$5,627 per admission. The national average for inpatient TRICARE claims over the same timeframe was \$6,479 per admission. Both costs include professional as well as hospital fees.

Active Duty Family Members:

| | TRICARE Prime | TRICARE Extra | TRICARE Standard |
|--|--|--|--|
| Annual Deductible | None | \$150/individual or \$300/family for E-5 & above; \$50/\$100 for E-4 & below | \$150/individual or \$300/family for E-5 & above; \$50/100 E-4 below |
| Annual Enrollment Fee | None | None | None |
| Civilian Outpatient Visit | No cost | 15% of negotiated fee | 20% of negotiated fee |
| Civilian Inpatient Admission | No cost | Greater of \$25 or \$13.32/day | Greater of \$25 or \$13.32/day |
| Civilian Inpatient Mental Health | No cost | \$20/day | \$20/day |
| Civilian Inpatient Skilled Nursing Facility Care | \$0 per diem charge per admission No separate co-payments/cost share for separately billed professional charges | | |

Retirees, Their Family Members, and Others

| | TRICARE Prime | TRICARE Extra | TRICARE Standard |
|-------------------------------|--|---|--|
| Annual Deductible | None | \$150/individual or \$300/family | \$150/individual or \$300/family |
| Annual Enrollment Fee | \$230/individual \$460/family | None | None |
| Civilian Copays | \$12 \$30 \$25 \$17 for group visit | 20% of negotiated fee | 25% of allowed charges for covered service |
| Civilian Inpatient Cost Share | \$11/day (\$25 minimum) Charge per admission | Lesser of \$250/day or 25% of negotiated charges plus 20% of negotiated professional fees | Lesser of \$441/day or 25% of billed charges plus 25% of allowed professional fees |

Martin, Brian

From: Martin, Brian
Sent: Wednesday, June 29, 2005 10:14 AM
To: 'linda.richardson@pentagon.af.mil'
Cc: Peranich, Stephen; Edwards, Randy
Subject: Medical capacity request

Linda L. Richardson, Lt Col, USAF
SAF/LLP
Legislative Liaison
Linda,

Thank you for obtaining responses to Congressman Taylor's previous requests regarding the data used in the Medical Joint Cross-Service Group's BRAC process. Please help us clarify another data question.

In my attempt to verify the data used by the Medical Joint Cross-Service Group, I asked the Congressional Research Service of the Library of Congress for the hospital and physician capacity data for the Gulfport-Biloxi-Pascagoula MSA. I specifically requested data from the Area Resource File compiled by the Health Resources and Services Administration of HHS, the source specified in the Military Value Framework Report. Attached please find the response from the Congressional Research Service.

Despite the specification to use the ARF, the MJCSG deliberative documents use different figures that yield a different result in the military value formula.

Area Resource File bed ratios:
Gulfport-Biloxi-Pascagoula MSA: 510 beds per 100,000 population or 1:196 ratio;
USA: 307 beds per 100,000 population or 1:326 ratio.

MJCSG-reported bed ratios:
G-B-P MSA: 1 bed per 264 people;
USA: 1 bed per 373.7 people.

Using either source, the MSA has a better ratio than the national average, so Keesler would receive 0 points of the 7.2 points available for beds/population in the military value model.

Area Resource File physician ratios:
MSA: 60 specialists per 100,000 population or 1:1,667;
34 family/general physicians per 100,000 or 1:2,941;
36 dentists per 100,000 people or 1:2,778.

USA: 83 specialists per 100,000 or 1:1,205
53 family/general physicians per 100,000 or 1:1,887
48 dentists per 100,000 or 1:2,083

MSA has 72% of the US average of specialty care physicians per population. Anything less than 82% receives full credit of 2.25 points in military value model.

7/7/05

MSA has 64% of the US average of family & general practice physicians per population. Anything less than 82% receives full credit of 5.4 points in military value model.

MSA has 75% of the US average of dentists per population. Anything less than 82% receives full credit of 1.35 points in military value model.

Thus, Keesler should have received all 9 points available in the measurement of civilian provider capacity. Instead, it appears that Keesler receive only 5.4 points of the 9 available.

MJCSG-reported physician ratios:

MSA: 1 physician per 476 people or 210 per 100,000.

USA: 1 physician per 421.2 people or 237 per 100,000.

No separate accounting of primary, specialty, and dentists, despite the formula.

MJCSG's data would have MSA with 88.6% of the national average of physicians per population. Ratio between 88.0 and 89.9 is worth 0.6 credit of the 9 possible points or 5.4 points.

Therefore, Keesler should have received 3.6 additional points in military value had the correct numbers been used. Also, the severe shortage of civilian physicians compared to the national averages should have raised a red flag had it not been understated by the MJCSG data.

Can you please identify the source of the MJCSG's figures for the number of hospitals beds and physicians, and explain why the number of primary care physicians, specialty care physicians, and dentists are not listed separately as required by the Military Value Framework?

Finally, I have unzipped and searched through dozens of files in search of data that should be readily available. Is there any one source that would simply show Keesler's score on each component of the military value formula? The attached document is my attempt to determine how Keesler scored on various components of the formula. If this data is available in one of the DOD files, could someone please point me to it? Since the military value scoring is the primary basis for the recommendation, can you supply an itemization of Keesler's score?

Brian Martin

Office of Rep. Gene Taylor

Analysis of Keesler COBRA Report

DOD Cost and Savings Estimates for Eliminating Inpatient Services at Keesler Medical Center

| | |
|-------------------------------|---------------------|
| One-Time Costs: | \$2,620,289 |
| Recurring Savings: | \$49,388,000 |
| Recurring Costs: | \$18,977,000 |
| Net Recurring Savings: | \$30,411,000 |

Total Net Savings Through 2011: \$139,437,000

Year In Which Total Savings Exceed Total Costs: 2007

One-time Costs

| | |
|-----------------------------------|-------------|
| Civilian RIF | \$688,779 |
| Civilian Early Retirement | \$35,967 |
| Eliminated Military PCS | \$1,183,745 |
| Unemployment | \$53,412 |
| Program Overhead | \$273,703 |
| Mothball/Shutdown | \$21,600 |
| Civilian Priority Placement (PPP) | \$212,976 |
| HAP / RSE | \$150,106 |

DOD estimates that disestablishing inpatient services at Keesler in FY 2007 will eliminate the positions of 71 officers, 110 enlisted, and 31 civilians. None of the 212 are slated for realignment elsewhere. The cost estimates come from the DOD COBRA formulas. The COBRA model plugs in standard figures based on the average salaries of officers, enlisted, and civilians, the average rates of retirement and priority placement, the average moving costs, and the average homeowner reimbursement rates. (HAP is the Homeowner Assistance Program.) These are nation-wide DOD averages, not figures based on Keesler or on medical personnel or on specific positions that would be eliminated. In fact, the 212 total is almost certainly understated. It comes from a formula that uses something called the Medical Expense Performance Reporting System (MEPRS) to estimate the number of full-time equivalents (FTEs) in inpatient services and inpatient admissions. The formula also made prorated adjustments to command administration, support services, materiel services, housekeeping, equipment repair, and laundry services, also using MEPRS figures. The gaping hole in the estimates is the highly questionable assumption that eliminating inpatient services would have no impact on outpatient services or graduate medical education. If only 212 positions are lost at Keesler, it will be a very overstaffed clinic.

Recurring Costs

| | |
|------------------|--------------|
| TRICARE | \$6,976,000 |
| Mission Activity | \$12,001,000 |

These figures are grossly underestimated. No one who know anything about medical care could possibly believe these numbers. DOD appears to selectively jump from using national average figures for estimating the savings and lower local figures for estimating the costs as a way to artificially inflate the net savings estimates. Here is the flawed process by which DOD produced the low cost estimates:

First, TRICARE delivered an "inpatient admission cost factor" for Keesler of \$4,314.25 for 2005. That is what TMA claims is the average TRICARE cost per inpatient admission at civilian hospitals in the Biloxi-Gulfport MSA. That is a ridiculously low number and is much lower than the other hospitals in the BRAC recommendation and much lower than the national average for TRICARE. The "inpatient admission cost factor" for the other 8 hospitals whose inpatient services would be eliminated range from \$5,141 to \$7,663. The median cost factor for the nine hospitals in the BRAC recommendation is \$5,994 per admission. According to the TRICARE *Chartbook of Statistics*, the nationwide average cost per TRICARE admission in FY 2003 was \$6,003. The accuracy of the inpatient admission cost factor is important because it is the basis for estimating the costs of inpatient care at civilian facilities for active military, their family members, and military retirees.

The average number of inpatient admissions at Keesler for fiscal years 2001 through 2003 is used as the baseline for estimates for future years.

| | |
|---|-------|
| Active duty & family member admissions @ MTF | 2,782 |
| Active & family admissions @ civilian hospitals | 161 |
| Retirees under 65 admissions @ MTF | 1,365 |
| Retirees 65 and older @ MTF | 1,260 |

The \$12 million Active Mission estimate of the cost of paying for inpatient care provided to active duty military and their family members at civilian hospitals was determined simply by multiplying 2,782 admissions times \$4,314.25 per admission. If, in fact, TRICARE is paying only \$4,314.25 per admission in civilian hospitals in the region, which is highly questionable, it would almost certainly be because Keesler is currently treating a much more complex and expensive caseload. If the cost factor is based on the claims from just the 161 admissions per year from active military and family members, it represents a pitifully small sample that is not representative of the full pool of patients. There was no attempt to match the actual mix of cases and procedures currently treated at Keesler with the amount that TRICARE would have to pay for them in civilian hospitals.

In a display of even worse judgment, DOD made the incredible assumption that inpatient care for retirees is no more expensive per admission than is inpatient care for active duty personnel and their family members. The cost of TRICARE for retirees under age 65 was estimated by multiplying 1,365 admissions times \$4,314.25 per admission for a total of \$5,888,951. The cost of TRICARE for retirees aged 65 and older was estimated by multiplying 1,260 admissions times \$4,314.25 per admission for a total cost of \$5,435,955. However, since Medicare pays 80% and TRICARE pays 20%, the TRICARE cost is only \$1,087,191. The estimate of \$6,976,000 was created by adding

the \$5,889,000 estimate for retirees under 65 and the \$1,087,000 estimate for retirees over 65. Both numbers and the total are ridiculously below any reasonable expectation of the actual cost to TRICARE for the expected volume of inpatient admissions at civilian hospitals following the closure of Keesler.

Of course, inpatient care for active military and their families will be more expensive than \$4,314.25 and inpatient care for retirees will be much more expensive than that. According to American Hospital Association statistics, community hospitals had average expenses of \$7,355 per day in 2002. The National Center for Health Statistics reported that the average inpatient length of stay in 2002 was 3.3 days for patients between ages 18 and 44, 4.6 days for patients 45-64 years old, and 5.9 days for patients 65 and older.

In addition, these cost estimates also assume that the elimination of inpatient services at Keesler would have no effect on the number and specialties of physicians who provide outpatient care and would have no effect on availability of medical residents. The DOD data reported an average of 188,659 outpatient visits at Keesler by active-duty military and their families, 85,710 Keesler outpatient visits by retirees under 65, and 69,708 Keesler outpatient visits by retirees 65 and older.

Finally, the projection of future savings assumes that TRICARE costs per inpatient admission will keep pace with inflation. For several decades, medical inflation has been consistently higher than general inflation. If TRICARE costs per stay increase at a rate higher than general inflation, then the real savings will decline over time.

Recurring Savings

| | |
|------------------------------|--------------|
| Sustainment | \$169,000 |
| Recapitalization | \$150,000 |
| Base Operating Support (BOS) | \$576,000 |
| Civilian Salary | \$2,061,000 |
| Officer Salary | \$8,873,000 |
| Enlisted Salary | \$9,064,000 |
| Housing Allowance | \$1,110,000 |
| Mission Activity | \$27,384,000 |

The DOD COBRA model simply applies its service-wide, nation-wide standard figures for the savings estimated for each officer, enlisted, or civilian position eliminated. Each officer position is counted as \$124,971.93 salary in 2005 dollars. Each enlisted position is counted as a salary of \$82,399.09. Each civilian is counted as a \$59,959.18 salary. The COBRA team multiplies the number of positions eliminated times the salary standard to estimate the future savings. Thus, the COBRA estimates that eliminating 71 officers, 110 enlisted, and 31 civilians would save \$21 million per year in salaries and housing allowance. Here again, DOD used national averages to inflate savings while using local figures to underestimate the costs of the action. The civilian positions at Keesler that would be eliminated by the recommendation certainly do not pay an average of \$60,000.

The sustainment, recapitalization, and BOS costs also are determined by formulas according to the number and type of positions that are being eliminated at the base.

The Mission Activity savings is an exaggerated projection of the savings from closing the inpatient function, apart from the savings from eliminating personnel. Using FY2003 MEPRS cost data, the Medical Joint Cross-Service Group estimated the following:

| | |
|-------------------------|--------------|
| Free Receipts | \$722,612 |
| Supplies | \$370,972 |
| Equipment | \$2,016,101 |
| Contractual Services | \$9,189,504 |
| Other Funded | \$698,097 |
| Other Unfunded | \$40 |
| Medical/Dental Supplies | \$13,232,260 |

They then multiplied by 1.044 to adjust the FY 2003 estimates to FY 2005 dollars.

Surely, Keesler is not spending \$13 million on medical and dental supplies dedicated solely to inpatient care. Keesler had a reported average of 5,407 inpatient admissions, so the formula suggests that Keesler spends \$2,447.25 on medical supplies per patient. The contractual services amount also is much more than seems reasonable. The fact that these huge numbers were produced by a formula rather than from the data call or the actual budget of the facility, and that the Air Force "validated" or "concurred" with them, confirms our suspicions about the gross mismanagement of the entire BRAC process.

The COBRA Report is a work of fiction. Very few of the DOD estimates can pass the most basic scrutiny. The estimates of increased TRICARE costs probably are about half of what should be expected. The estimates of the savings in personnel, supplies, and other costs from the elimination of inpatient services may be double what should be expected. If corrected to reflect reasonable expectations of savings and costs, any savings probably would be confined to the effects of the overall reduction in military medical personnel.

Military Value Formula Biases

The Military Value formula and the other devices used by the Medical Joint Cross-Service Group are as flawed as the COBRA model. The formula for determining military value of hospitals is heavily biased against older facilities, does not adequately consider the value of medical education programs or of the importance of treating the retiree population in order to provide the complexity to train and retain clinical skills, and worst of all, is only marginally interested in the quantity, quality, and efficiency of the actual services provided at a facility. In fact, the actual inpatient care services provided by a hospital account for only 6.4 % of the Military Value formula for health care services. The military retiree population accounts for only 4.05%. The age and condition of the building account for 25% of the formula.

The Health Care Services Military Value Formula, 100 points possible

| | |
|--|-------|
| Active Duty Eligibles | 16.20 |
| Active Duty Family Eligibles | 1.35 |
| Other Eligibles | 1.35 |
| AD Family Members Enrolled in Prime | 5.40 |
| Other non-AD Enrolled in Prime | 2.70 |
| Civilian/VA hospitals | 1.80 |
| Civilian/VA beds per population | 7.20 |
| Civilian primary care providers per population | 5.40 |
| Civilian specialty providers per population | 2.25 |
| Civilian dentists per population | 1.35 |
| | |
| Facility Condition Index | 12.50 |
| Weighted Age | 12.50 |
| | |
| On-site FDA blood testing | 4.00 |
| Proximity of warehouse storage | 2.00 |
| Contingency beds | 4.00 |
| | |
| Inpatient cost per RWP | 2.80 |
| Outpatient costs per RVU | 4.00 |
| Dental costs per DWV | 1.20 |
| Inpatient total RWP | 3.60 |
| Outpatient total RVU | 4.80 |
| Dental total DWV | 1.20 |
| Pharmacy total scripts | 1.20 |
| Total weighted radiology procedures | 0.92 |
| Total weighted lab procedures | 0.28 |

Source: Military Value Framework Report, page 15.

Keesler reported 145,123 hours per week in clinical education and training in FY 2002, 2nd most in the Air Force and 9th most in the DOD.

Keesler reported 281,655 RVUs in outpatient specialty care for FY 2002, 2nd most in Air Force. RVUs are Relative Value Units, a measure that attempts to account for the complexity of different medical services and procedures.

Keesler's reported 6,190 inpatient RWPs, 2nd highest in the Air Force, 12th highest in the DOD. Inpatient care is measured in RWPs – Relative Weighted Product, which combines the RVU measure of complexity for physicians and the resource requirements of the hospital for an inpatient procedure.

Despite the relatively high usage of inpatient care and ambulatory specialty care, Keesler received a very low military value score for health care services. The military value score of 39.40 is ridiculously low and suggests some serious flaws in the formula.

The Combined Military Value Score, combining the health care services score with the education and training services score is 96.82, ranked 20th among all DOD facilities. Yet, the Composite Military Value Score of 35.12 ranked 41st among DOD facilities.

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MINUTES OF THE JULY 6, 2004 MEETING OF THE MJCSG PRINCIPALS

LOCATION: BUMED, Bldg. 3, 3rd Floor CR

Attending: Lt Gen Taylor - AF/SG; RADM Hufstader - USMC SG; Col Hamilton - Secretary; CAPT Shimkus - BUMED; Mr. Curry - USA OTSG; Dr. Opsut - OSD/HA; Mr. Yaglom - USA SG; Mr. Christensen - Cna; CDR Hight - BUMED; Lt Col Stultz-Lalk - AF/SG; Lt Col Jones - AF/SG; Maj Guerrero - AF/SG; Maj Fristoe - HA/TMA; Maj Harper - AF/SGSE; Ms. Sanfleben - TMA; Ms. Zamora - SAF/IEBJ; Mr. Porth - OSD/BRAC.

Decisions:

- Original transformation options would not be forwarded

Action Items:

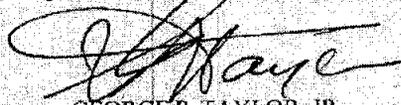
- Review and comment on Imperatives NLT COB 8 Jul 04 to Col Hamilton
- Lt Gen Taylor will prepare response for ISG concerning Transformational Options NLT 8 Jan 04

Meeting Overview:

- Lt Gen Taylor opened the meeting by discussing the progress of the group and that soon the working groups would be very busy after the return of the military value data. AF representative reviewed the MJCSG Transformational Options Briefing. The task for this meeting is to provide transformational options by 8 Jul 04 to be forwarded to SECDEF for approval. This is a requirement for scenario analysis. A Navy representative cautioned the group on the recommendations put forward. The group was reminded that the options must adhere to the criteria established in Mr. Wynne's Memo dated 21 Jun 04. In addition, options must be actionable under BRAC 2005 process, Title 10 changes not part of BRAC law. The original transformation options were reviewed and the group felt most of these options did not adhere to the criteria or violated BRAC law (Title 10). Each option was reviewed and discussed briefly. Title 10 issues were addressed during the discussion of Joint staffing of MTFs. Each of the working groups reviewed their respective transformational suggestions with the group. (Healthcare Services had 8 options, Education and Training had two options; Infrastructure had 8 options, RDA had 10 options, and 2 options presented by other members.) At the conclusion of review of the original Transformational Options, none were deemed appropriate to forward at this time. Lt Gen Taylor remarked he would sculpt a response to the ISG based on the discussion that took place today.
- Mr. Wynne's Memo concerning imperatives was reviewed. The group must prepare a document addressing each imperative and how that imperative would constrain or affect the medical mission. All members were encouraged to review memo and send comments to Col Hamilton NLT COB 8 Jul 04. Lt Gen Taylor will forward the document to the principals for their input before forwarding to the ISG.
- Mr. Porth commented that the Military Value data due date is 16 Aug 04.

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NEXT MEETING: MJCSG 0-6 Lead Meeting, 8 Jul 2004, 1500/1700, Pentagon, 2C554.



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

Attachments:

1. Agenda
2. MJCSG Transformation Options, 6 Jul 04
3. Memo for Chair, JCSG, dated 2 Jul 04
4. Memo for Chair, JCSG, dated 21 Jul 04

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MJCSG Principals Meeting

7/6/2004
3:00 PM to 4:20 PM
BUMED Bldg 3, 3rd Floor

Meeting called by: Chair Type of meeting: Decision
Note taker: Lt Col Stultz-Lalk

Agenda

| | | |
|--|---------------|----|
| Chair Comments | Lt Gen Taylor | 5 |
| Review of Transformational Options - <i>Decision</i> | All | 60 |
| Imperatives Review - Information | Col Hamilton | 10 |
| Closing | Chair | 5 |

Additional Information



"Wynne to JCSG



"MJCSG



"Wynne Memo to

Chairs requesting Tr? Transformational Opt? JCSG Chairs requesti



MJCSG Transformational Options

Col Hamilton

6 Jul 2004



Task

- Provide Transformational Options by 8 Jul 2004
 - Forwarded to SECDEF for Approval
 - Required in Scenario Analysis
- Criteria
 1. Overarching and notional – no installations identified
 2. General/Identifiable effect on infrastructure
 3. Actionable under BRAC 2005 process – Title 10 changes not part of BRAC law



MJCSG Transformational Options

- DoD will maintain effective and affordable Force Health Protection across the full spectrum of *Joint* military operations, and provide cost efficient access to healthcare from fixed treatment facilities as Service components of the Military Healthcare System.
 - **Status quo**
 - **Operational Change**
 - ❑ **Interoperable/interchangeable in-garrison**
 - ❑ **Interoperable/interchangeable deployed**
 - ❑ **Joint Military Medical Contracting Activity**
 - **Organizational change**
 - ❑ **Joint Manning of Military Treatment Facilities**
 - ❑ **Joint Functional Commands**
 - **Joint Education and Training Facilities**
 - **Joint Medical Contracting Activity**
 - **Joint RDA Facilities**
 - ❑ **Defense Health Agency**
 - ❑ **Joint Medical Command**
 - ❑ **Federal Healthcare System (DoD/VA)**



Assessment versus Criteria

| | Overarching | Infrastructure | BRAC Law |
|--|-------------|----------------|----------|
| Interoperable/interchangeable in-garrison | ✓ | ✓ | ✓ |
| Interoperable/interchangeable deployed | ✓ | ? | ✓ |
| Joint Manning of Military Treatment Facilities | ✓ | ? | ✓ |
| Joint Education and Training Facilities | ✓ | ✓ | ✓ |
| Joint Medical Contracting Activity | ✗ | ? | ✓ |
| Joint RDA Facilities | ✗ | ? | ✓ |
| Defense Health Agency | ✓ | ? | ✗ |
| Joint Medical Command | ✓ | ? | ✗ |
| Federal Healthcare System (DoD/VA) | ✓ | ? | ? |



Healthcare Services

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|--|-------------|----------------|----------|
| Close all ADPL of less than 20 | ✓ | ✓ | ✓ |
| Close all hospitals/retain clinics/outsource GME | ✓ | ✓ | ✓ |
| Outsource outpatient pharmacy | ✓ | ✓ | ✓ |
| Size facilities based upon AD & ADD FM | ✓ | ✓ | ✓ |
| Close hospital where beneficiary population is < 50,000 | ✓ | ✓ | ✓ |
| Decentralize clinics lease space near beneficiary population centers | ✓ | ✓ | ✓ |



Education and Training

| Transformational Option | Overarching Law | Infrastructure | BRAC Law |
|--|-----------------|----------------|----------|
| Military/Civilian Educational Partnerships | ✓ | ✓ | ✓ |
| Consolidate Like Functions - GME/Training | ✓ | ✓ | ✓ |



Infrastructure

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|--|-------------|----------------|----------|
| Consolidate Medical Infrastructure in Multi-Service Market Areas | ✓ | ✓ | ✓ |
| Consolidate Class VIII Storage/Acquisition | ✓ | ✓ | ✓ |
| Consolidate like Functions – single Contracting Agency | ✓ | ✓ | |
| Outsource Outpatient Pharmacy | ✓ | ✓ | ✓ |
| Pharmacy Refills – Mail Order Only | ✓ | ✓ | ✓ |



Infrastructure

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|---|-------------|----------------|----------|
| Consolidate Medical Infrastructure – Maintain limited Medical on USMC bases | ✓ | ✓ | ✓ |
| Explore additional City-Base Opportunities | ✓ | ✓ | ✓ |
| Consolidate Medical Infrastructure based on – BCA, CCA, ECA | ✓ | ✓ | ✓ |



RDA

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|---|--------------------|-----------------------|-----------------|
| Consolidate Like Functions – Military Unique Research | ✓ | ✓ | ✓ |
| Collocate military aerospace medicine research | ✓ | ✓ | ✓ |
| Increase efficiencies of Navy Medical R&D through consolidation and realignment | ✓ | ✓ | ✓ |
| Explore realignment of Army and Air Force dental research labs | ✓ | ✓ | ✓ |
| Consolidate medical R&D HQ management activities and establish a tri-service staffed organization, i.e., AFMRDA | ✓ | ✓ | ✓ |



RDA

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|---|--------------------|-----------------------|-----------------|
| Consolidate research laboratories/activities involved in military infectious disease | ✓ | ✓ | ✓ |
| Consolidate research laboratories/activities involved in combat casualty care | ✓ | ✓ | ✓ |
| Consolidate research laboratories/activities involved in medical chemical and biological defense | ✓ | ✓ | ✓ |
| Consolidate research laboratories/activities involved in medical operational medicine research | ✓ | ✓ | ✓ |
| Consolidate research laboratories/activities involved in military infectious disease | ✓ | ✓ | ✓ |



Misc

| Transformational Option | Overarching | Infrastructure | BRAC Law |
|---|-------------|----------------|----------|
| Joint Medical Command | ✓ | ✓ | |
| Medical Centers built with “state of the art” Anti-terrorism systems (air and skin precautions) | ✓ | ✓ | ✓ |



ACQUISITION,
TECHNOLOGY
AND LOGISTICS

THE UNDER SECRETARY OF DEFENSE

3010 DEFENSE PENTAGON
WASHINGTON, DC 20301-3010

JUL 2 2004

MEMORANDUM FOR CHAIRMEN, JOINT CROSS-SERVICE GROUPS

SUBJECT: Review of Draft Base Realignment and Closure (BRAC) Imperatives

The Infrastructure Steering Group (ISG) has agreed that the most appropriate way to ensure that military value is the primary consideration in making closure and realignment recommendations is to determine military value through the exercise of military judgment built upon a quantitative analytical foundation. The military value analysis that your groups will undertake is the quantitative analytical foundation. The exercise of military judgment occurs through the development and application of principles and imperatives. Limited in number and written broadly, principles enumerate the essential elements of military judgment to be applied to the BRAC process. Imperatives are specific, detailed statements that flow from the principles and act as safety valves on the quantitative military value analysis, ensuring that it does not produce results that would adversely affect essential military capabilities.

As constraints on potential recommendations, the attached draft imperatives will, upon their approval by the Infrastructure Executive Council, significantly affect the BRAC analytical process.

The July 16, 2004, Infrastructure Steering Group meeting will consider imperatives and their affect on the BRAC analysis. To inform the deliberations at that meeting, I would appreciate your comments on these draft imperatives, focusing particularly on the affect they may have on your military value analysis.

Please provide your comments to the OSD BRAC office by July 9, 2004, so they can be considered in the preparation of imperatives for ISG consideration. Additionally, please plan to attend the July 16th ISG meeting and be prepared to answer any questions about how the imperatives may affect your military value analysis. If you have any questions regarding these comments, please contact Peter Potochney, Director, Base Realignment and Closure, at 614-5356.

A handwritten signature in black ink, appearing to read "Michael W. Wynne".

Michael W. Wynne

Acting USD (Acquisition, Technology & Logistics)
Chairman, Infrastructure Steering Group

cc: Infrastructure Steering Group Members

Attachment: As stated



Principles and Corresponding Imperatives

Recruit and Train: The Department must attract, develop, and retain active, reserve, civilian, and contractor personnel that are highly skilled and educated and that have access to effective, diverse, and sustainable training space in order to ensure current and future readiness, to support advances in technology, and to respond to anticipated developments in joint and service doctrine and tactics.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to support the Army's Leader Development and Assessment Course and Leader's Training Course.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to meet both peacetime and wartime aviation training requirements, including undergraduate and graduate pilot training.
- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that fails to preserve additional training areas in CONUS where operational units can conduct company or higher-level training when home station training areas are not available due to the training load or environmental concerns.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the only remaining training environments designed to support airborne, air assault, urban operations, cold weather training, Joint Logistics Over The Shore (JLOTS) training in the United States, combat formations for full spectrum operations to include obscurant training and electro-magnetic operations, MAGTFs, live fire and combined arms training, and chemical live agent training.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to conduct graduate medical/dental education (GME/GDE) and clinical training for uniformed medics.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that locates Navy or Marine Corps Fleet Replacement Squadrons and Operational Squadrons outside operationally efficient proximity (e.g., for the Department of the Navy, farther than one un-refueled sortie) from DoD-scheduled airspace, ranges, targets, low-level routes, outlying fields and over-water training airspace with access to aircraft carrier support.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the organic capability for Service specific Strategic Thought and Joint and Coalition Security Policy Innovation.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that locates undergraduate flight training with operational squadrons or within high air traffic areas.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the organizational independence of training units from combat units.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that locates undergraduate Navy or Marine Corps flight training without access to DoD-scheduled airspace over open water and land with access to aircraft carrier support.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that locates major CSG / ESG level exercises, ranges / OPAREAs more than 3 underway days from air, sea and over the shore maneuver space or that locates individual operational ships and aircraft more than 6 underway hours for ships, 12 underway hours for submarines, and 1 un-refueled sortie for aircraft, from unimpeded access to ranges and operating areas.
- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that eliminates a Service's ability to provide timely responses to military contingencies or support RC mobilization, institutional training, and collective training because of insufficient infrastructure, maneuver space, and ranges.
- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that fails to retain access to sufficient training area (air, land, and sea) and facilities across a wide variety of topography and climatic conditions (e.g., cold weather, swamps, mountains, desert, etc.) with operationally efficient access and proximity to meet current and future Service and Joint training requirements for both Active and Reserve Component forces and weapons systems.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates access to educational programs which include specific focus on those areas which are uniquely related to distinctive Service capabilities (e.g., maritime, land warfare).
- Fleet concentration areas will provide Navy skills progression training and functional skills training relevant to homeported platforms whenever possible.
- Navy initial skills training will be located with accessions training to minimize student moves or with skills progression training to allow cross-utilization of instructors, facilities and equipment, and support future training and efficiency improvements.

Quality of Life: The Department must provide a quality of life, to include quality of work place, that supports recruitment, learning, and training, and enhances retention.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates access to housing, medical, career progression services, child development services, spousal employment services, MWR services, or education.
- Maintain sufficient capacity to provide operational-non-operational (sea-shore) rotation.

Organize: The Department needs force structure sized, composed, and located to match the demands of the National Military Strategy, effectively and efficiently supported by properly aligned headquarters and other DoD organizations, and that take advantage of opportunities for joint basing.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that removes the Headquarters of the Department of Defense, the Department of the Army, the Department of the Navy (including the Commandant of the Marine Corps), or the Department of the Air Force from the National Capital Region.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to station existing Continental United States Army (CONUSA) headquarters, Major Army Command (MACOM) headquarters, and United States Army Reserve Command (USARC) headquarters in the United States.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the last remaining Navy presence (excluding recruiters) in a state.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment that prohibits fulfilling the air sovereignty protection site and response criteria requirements stipulated by COMNORTHCOM and COMPACOM.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates START Treaty land-based strategic deterrent.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to support the Army's modular force initiative, the Navy's Global Concept of Operations force initiative, the USMC's expeditionary maneuver warfare initiatives, and the USAF's 10 fully- and equally-capable AEFs.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to support surge, mobilization, continuity of operations, evacuations for natural disasters, or conduct core roles and missions (e.g., sea-based operations, combined arms, etc.).
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment involving joint basing unless it increases average military value or decreases the cost for the same military value, when compared to the status quo.

Equip: The Department needs research, development, acquisition, test, and evaluation capabilities that efficiently and effectively place superior technology in the hands of the warfighter to meet current and future threats and facilitate knowledge-enabled and net-centric warfare.

- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that eliminates the Army's single headquarters organizational structure that combines responsibility for developmental and operational test and evaluation.
- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that does not provide RDT&E infrastructure and laboratory capabilities to attract, train, and retain talent in emerging science and engineering fields.
- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that eliminates the Army, Navy, and Air Force RDT&E capability necessary to support technologies and systems integral to the conduct of Land, Maritime, and Air warfare, respectively.

Supply, Service, and Maintain: The Department needs access to logistical and industrial infrastructure capabilities optimally integrated into a skilled and cost efficient national industrial base that provides agile and responsive global support to operational forces.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates ship maintenance capabilities to:
 - ? Dry dock CVNs and submarines on both coasts and in the central Pacific.
 - ? Refuel/de-fuel/inactivate nuclear-powered ships.
 - ? Dispose of inactivated nuclear-powered ship reactor compartments.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the Department of the Navy lead for engineering, producing, maintaining, and handling ordnance and energetic materials designed specifically for the maritime environment.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability of a Service to define its requirements (all classes of supply), integrate its logistics support, and acquire appropriate support for its unique material.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates inherent Service capabilities where concepts of operations differ from other Services (e.g. MALS support to the FRSSs, deployable intermediate maintenance support for MPS equipment, Navy IMAs, reach back support for sea-based logistics, etc).
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that creates a single point of failure in logistics operations.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the last remaining strategic distribution platforms on the east and west coast.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates distribution support services at Component depot maintenance activities.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates logistics information management and oversight capabilities:
 - ? Data standardization
 - ? Information routing
 - ? Supply chain efficiency information capture
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates

needed organic industrial capabilities to produce, sustain, surge, and reconstitute if those capabilities are not commercially available or capable of being privatized.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates access to ammunition storage facilities which will not complete planned chemical demilitarization before 2011.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the Army lead for life cycle materiel management of systems integral to the conduct of Joint expeditionary land warfare.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to move hazardous and/or sensitive cargos (e.g., ammunition).
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates critical production capabilities that cannot be readily rebuilt or expanded during mobilization and reconstitution or commercially duplicated, as well as capabilities to replenish stockpiles.
- DON requires a depot maintenance industrial complex that delivers best value cradle-to-grave results in cost-efficiency (total unit cost), responsiveness (schedule compliance and flexibility), and quality (compliance with specifications).

Deploy & Employ (Operational): The Department needs secure installations that are optimally located for mission accomplishment (including homeland defense), that support power projection, rapid deployable capabilities, and expeditionary force needs for reach-back capability, that sustain the capability to mobilize and surge, and that ensure strategic redundancy.

- The Military Departments and JCSGs will not recommend to the Secretary any closure or realignment recommendation that eliminates the Army's ability to simultaneously deploy, support, and rotate forces from the Atlantic, Pacific, and Gulf coasts in support of operational plans due to reduced quantities of, or reduced access to port facilities, local/national transportation assets (highways and railroad), and airfields or lack of information infrastructure reach back capabilities.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to absorb overseas forces within the United States.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to surge in support of mobilization requirements (e.g., National Defense contingency situations, national disasters, and other emergency requirements).
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that prohibits:
 - ? Fleet basing that supports the Fleet Response Plan.
 - ? CVN capability: 2 East Coast ports, 2 West Coast ports, and 2 forward-based in the Pacific.
 - ? SSBN basing: 1 East Coast port, 1 West Coast port.
 - ? MPA and rotary wings located within one un-refueled sortie from over water training areas.
 - ? OLF capability to permit unrestricted fleet operations, including flight training, if home base does not allow.
 - ? CLF capability: 1 East Coast and 1 West Coast base that minimize explosive safety risks and eliminate waiver requirements.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates unimpeded access to space (polar, equatorial, and inclined launch).
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that does not preserve:
 - ? two air mobility bases and one wide-body capable base on each coast to ensure mobility flow without adverse weather, capacity, or airfield incapacitation impacts; and
 - ? sufficient OCONUS mobility bases along the deployment routes to potential crisis areas to afford deployment of mobility aircraft.
- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the

capability to respond to reach back requests from forward deployed forces and forces at overseas main operating bases engaged in or in support of combatant commander contingency operations.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates the capability to provide missile warning and defense in the 2025 force.
- Align Naval Medicine's Military Treatment Facilities with Navy and Marine Corps force concentration for maximum efficiency and effectiveness, and to maximize operational medical support to the Fleet and Marine Corps.
- Maintain sufficient medical capacity (manning, logistics, training and facilities) integral to the MAGTF as well as reach back infrastructure to ensure the continuum of care for the operating forces and additional organic capacity for the supporting establishment and Service member families.



- **34.1 Functional Military Value**
- **Average Functional Military Value for all inpatient facilities**
 - **With MacDill AFB – 42.58**
 - **Without MacDill AFB – 42.74**



Payback

| Military as Civilians | |
|------------------------------|-------------------|
| One-Time Costs | \$630K |
| MILCON | 0 |
| NPV | -\$14,185K |
| Recurring Savings | \$1,103K |
| Payback Years | 1 Yr |
| Break Even Years | 2008 |
| Mil/Civ Reductions | 18/1 |



Justification

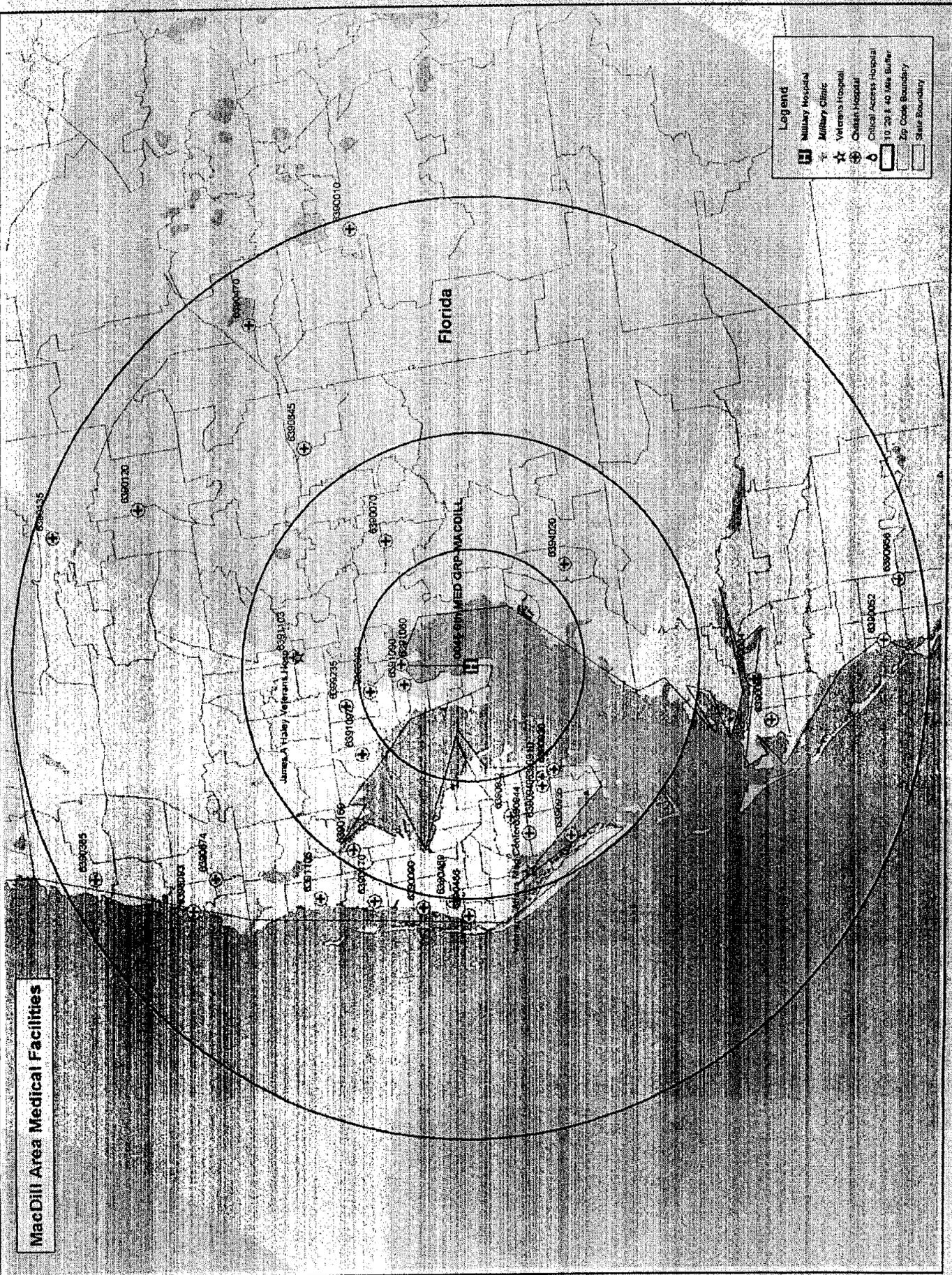
- **Reduces excess capacity**
- **Redistributes military providers to areas with more eligible population**
- **Reduces inefficient inpatient operations**
- **Civilian capacity exists in area**



Background – MacDill AFB

- **ADPL – 3.8**
 - **MHS Avg - 40.8**
- **Beds – 16**
 - **Certified - 32**
- **RWPs – 502**
- **Population**
 - **Eligible (AD/ADFM/Other) 9,165 / 18,176 / 45,258**
 - **Enrolled (ADFM/Other) 9,086 / 14,810**
- **Civilian/VA Hospitals within 40 Miles – 34**
 - **10,585 Beds/ 6,843 Avg Daily Census**
 - **Existing Partnership: Tampa General (877 Beds / 502 ADC)**
- **Auth O/E/C (176/407/84)**
- **Military Value**
 - **Total - 26.1**
 - **Functional - 34.1**

MacDill Area Medical Facilities



Medical Joint Cross Service Group



MED 049 MacDill AFB

Disestablish Inpatient



Medical Manpower Realignment
As of 4 Jan 05

| | Officer | Enlisted |
|-------------------|----------------|-----------------|
| Cherry Point | 5 | 11 |
| Great Lakes | 25 | 45 |
| Navy Total | 30 | 56 |

| | Officer | Enlisted |
|-------------------|----------------|-----------------|
| Knox | 9 | 25 |
| Eustis | 2 | 8 |
| West Point | 6 | 19 |
| Army Total | 17 | 52 |

| | Officer | Enlisted |
|-----------------|----------------|-----------------|
| USAFA to Carson | 9 | 17 |
| USAFA Other | 1 | 3 |
| AF Total | 10 | 20 |



MJCSG Scenario Data Call/COBRA
As of 4 Jan 05

■ **Scenarios in tracker: 43**

Briefed to MJCSG: 9 (21%)

Briefed to ISG: 0

■ **Total Scenario Data Calls: 92**

■ **Total Fielded to Services/4th Estate: 92 (100%)**

Army: 35

Air Force: 29

Navy: 26

4th Estate: 2

■ **Total Received from Services/4th Estate: 66 (71%)**

Army: 15 (43%)

Air Force: 26 (90%)

Navy: 23 (88%)

4th Estate: 2 (100%)

Medical Joint Cross Service Group



MJCSG Principles Meeting Combined Briefings

4 Jan 05

MJCSG Principals Meeting

01/04/2005
15:30 PM to 17:30 PM
Pentagon, Room 2C554, Rm 6

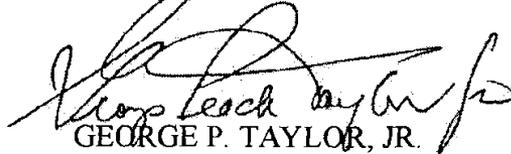
Meeting called by: Chair Type of meeting: Deliberative
Note taker: Maj Coltman

Agenda

| | | |
|---------------------------|---------------|----|
| Chair Comments | Lt Gen Taylor | 5 |
| Data Call Status | Maj Fristoe | 10 |
| Candidate Recommendations | | |
| McDill AFB | Mr. Chan | 10 |
| Scott AFB | Mr. Chan | 10 |
| Keesler AFB | Mr. Chan | 10 |
| Fort Polk | Mr. Chan | 10 |
| Scenario Cleanup | | |
| Beaufort NH | CAPT Shimkus | 10 |
| West Point | Maj Cook | 10 |
| Around the Table | All | 10 |
| Schedule | Col Hamilton | 5 |
| Closing | Chair | 5 |

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- NEXT PRINCIPAL MEETING: 7 Jan 05, Pentagon Room 4E1084, 1300-1500.



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

Attachments:

1. Agenda with attachments (Data Status Updates Slide; Candidate Recommendations Slides)

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ADFM/8,877 Other enrolled. There are 41 Joint Accreditation of Hospital Organizations (JCAHO) or Medicare accredited hospitals with inpatient services located within a 40 miles radius. Total civilian capacity for inpatient services was identified as 12,868 beds with an average daily census of 9,600 (as reported by AHA). There are two civilian community hospitals located within a ten miles radius with 371 beds/average daily census of 269. The Army rep voiced concern of the civilian community's ability to absorb the additional inpatient workload. Another previous concern included weather-related hazardous road conditions to/from this facility which could impede traveling to the local area civilian hospitals. Payback cost/savings were discussed. There is a one-time implementation cost of \$2,875 with an annual reoccurring cost after implementation of \$1,915K with no expected payback. The NPV over 20 years is a cost of \$31,584. With the disestablishment of this function, the average functional military value for all inpatient facilities increases from 42.58 to 42.86. The Army rep voiced concern of allowing training cadets to obtain inpatient treatment off base, stating it was Army policy to maintain positive military control of cadets. The Army rep also raised the question of available external partnerships related to specialty services (specifically Internal Medicine) within the local civilian medical community. The Marine rep voiced concern over the impact to the Sports Medicine Fellowship program, stating, "If the program is at risk, I would vote to maintain the inpatient mission." E&T reported that the orthopedic/sports medicine fellowship could be supported elsewhere but may not be the same configuration. The group focused discussion on the fact that there was no savings and the payback years were never with significant implementation and reoccurring for disestablishing. The chair emphasized the focus should be to reduce capacity based on low ADPLs/MILVAL to provide the right platform to support clinical competence. The Chair recommended running COBRA and to hold decision pending follow up on the below issues.

- **HCS-1 (MED-004): Disestablish Inpatient Mission at West Point.** Hold on decision pending additional information on the Sports Medicine Fellowship (E&T), TRICARE network/partnerships (HCS), and Military Judgment (Army rep) (**MJCSG voted 5/0 to hold; Action item, follow up**)
- Candidate Recommendation Overview/Schedule: At the next MJCSG the following candidate proposals will be presented: 1) Langley/Tidewater Area (HSC), 2) Enlisted Training (E&T), 3) USHUS (E&T), and 4) West Point Follow-up.
- Closing Comments: The Chair review the ISG candidate submission and scheduling process emphasizing the need to submit the candidate proposal packages by Wednesday to be able to present to the ISG a week from the following Friday. Need to remember that there is another lag time with the legal review so be proactive having all the information ready to include the environmental surveys approved by the Services. Continue to work the large San Antonio and National Capital Region scenarios and push for/follow up on the scenario data calls. The Chair voiced that he believes we are underestimating personnel reductions and overall savings and encouraged the sub-groups to scrutinize/validate the personnel reduction numbers for all scenarios. Follow up with action items identified.

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1,148 (as reported by AHA) but the capacity is small and may not be able to absorb the additional workload (see attached map). Payback cost/savings were discussed. There is a one-time implementation cost of \$2,575K with an annual reoccurring cost after implementation of \$1,637K with no expected payback. The NPV over 20 years is a cost of \$27,343K. With the disestablishment of this function, the average functional military value for all inpatient facilities decreases from 42.58 to 42.54. The civilian cost per admission lies in the 4th deciles for inpatient services which is a relatively low. The Army rep informed the group that the facility is located in a fairly isolated area and that Fort Polk has visibility in the Army proposals and the Joint Readiness Training Center (JTRC) is firmly in place. The Chair emphasized that although the ADPL is low, there is a question on whether the local capacity can absorb the additional workload, there are no savings or benefit to the MILVAL and the with the Army's additional input this proposal may not be a good candidate. This scenario disestablishes the inpatient capabilities, converting the hospital into a clinic with an ambulatory care center. Recommend MJCSG approve the following Candidate selection based on optimization model runs, excess capacity, and low ADPL:

- **HCS-1D (MED-043): Disestablish the Inpatient Mission at Fort Polk (MJCSG Disapproved, voted 5/0 to Retain the Inpatient Mission)**

□ Scenario Clean-up:

- Reassessment of HCS-1 (MED-004): Disestablish the Inpatient Mission at NH Beaufort
 - Previous discussion noted that this facility was located in a fairly isolated region with four Joint Accreditation of Hospital Organizations (JCAHO) or Medicare accredited hospitals with inpatient services located within a 40 miles radius. However, the closest most accessible facility has limited capacity and has a somewhat difficult TRICARE relationship. The Navy rep previously noted that they were working on developing a more amenable relationship but have not reached that point yet. The NDA group did validate that the associated civilian hospitals were not on the list of those declining TRICARE enrollees. The Marine rep identified that the MCRA system and associated basic recruit training center are elements of the Beaufort and voiced concern over allowing the new training recruits to obtain inpatient treatment off base, stating it was imperative to maintain military control while in the training environment. HCS rep follow up reported 250 out of 824 non-enrolled AD annual admissions (approximately 30 percent) were coded for trainees which is based on M2 non-certified data. Based on Navy/Marine input related to MILVAL (MSRA operational mission and issue of basic training center location), limited civilian inpatient capacity and current TRICARE relationship with local civilian community hospital, Navy rep recommends the MJCSG approve the following:
 - **HCS-1 (MED-004): Maintain inpatient facilities at NH Beaufort. (MJCSG voted 5/0 to approve)**
- Reassessment of HCS-1 (MED-004): Disestablish the Inpatient Mission at West Point
 - Previous discussion noted that this facility was identified from optimization model runs because of low ADPL (8) and functional MILVAL (27.1). In FY02, the AD eligible population was 8,833(which include the 400 cadets) with 4,000

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- HCS-1M (MED-052): Disestablish the Inpatient Mission at Scott AFB
 - HCS rep presented and lead discussion on HCS-1M (MED-052) to disestablish the inpatient mission at Scott AFB, converting the hospital to a clinic with an ambulatory care center (see attached slides). Again, the Chair voiced concern over the validity of reducing only 77 positions from a total of 1,110 billets when closing the inpatient function and challenged the 0-6 Leads to scrutinize the numbers for personnel reductions in this and future scenarios. The Chair also emphasized that the number one issue today is the following: “Is it rational to maintain the inpatient function at Scott, given the facts and numbers? The Army rep questioned whether there would be reverberations given the fact that two combatant commanders are positioned at Scott AFB. The Chair’s response was that they would have available expanded hospital services/specialties in the surrounding community rather than a small hospital with limited specialties/service lines such as currently exists at Scott. Also highlighted was that the family practice residency, according to the E&T rep, could be absorbed into the resulting Military Healthcare System (MHS). This scenario disestablishes the inpatient capabilities, converting the hospital into a clinic with an ambulatory care center. Recommend MJCSG approve the following Candidate selection based on optimization model runs, excess capacity, low MILVAL, ADPL and other supporting data analysis:
 - **HCS-1M (MED-052): Disestablish the inpatient mission at Scott AFB (MJCSG Approved with 5/0 vote)**
- HCS-1K (MED-050): Disestablish the Inpatient Mission at Keesler AFB
 - HCS rep presented and lead discussion on HCS-1K (MED-050) to disestablish the inpatient mission at Keesler AFB, converting the hospital to a clinic with an ambulatory care center (see attached slides). The NPV of the costs/savings over 20 years is a savings of \$307,081K. The Secretary noted that the Services/ISG may challenge the redistribution of 181 military billets identified because of potential impact to the gaining facilities. The Chair responded that from a military perspective there may only be a need to retain a portion based on mission requirements. The current residency programs, according to the E&T rep, could be absorbed into the remaining MHS. This scenario disestablishes the inpatient capabilities, converting the hospital into a clinic with an ambulatory care center. Recommend MJCSG approve the following Candidate selection based on optimization model runs, excess capacity, low MILVAL, ADPL and other supporting data analysis:
 - **HCS-1K (MED-050): Disestablish the Inpatient Mission at Keesler AFB (MJCSG Approved with 5/0 vote)**
- HCS-1D (MED-043): Disestablish the Inpatient Mission at Fort Polk
 - HCS rep presented and lead discussion on HCS-1D (MED-043) to disestablish the inpatient mission at Fort Polk, converting the hospital to a clinic with an ambulatory care center (see attached slides). This facility was identified because of a low ADPL (7.3), and its functional MILVAL is ranked at 44.7. In FY02, the AD eligible population was 8,876 with 10,254 ADFMs/4,127 Other enrolled. There are four JCAHO or Medicare accredited/VA hospitals with inpatient services within 40 miles with a total of 276 beds/average daily census of

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Army rep emphasized that the data return percentages may not reflect completeness/quality and that data received is still requiring additional work/clarification. The Army rep also voiced concern over identified problems with the current data processing system. Secretary expressed that the COBRA analysis is being delayed waiting for certified data but will push forward with available data. Chair stressed the limited time when considering the upcoming Services candidate submission suspense of 20 Jan 05. Outstanding scenarios after 20 Jan 05 will have to deal with the impact of the Services' major force movements and the ensuing changes they present. Chair is scheduled to update ISG this Friday on the MJCSG's progress. OSD/BRAC rep informed the group that HSA will brief ISG this week but recommended submitting a projected schedule of MJCSG candidate submissions/briefs.

- Total Medical Manpower Realignment (Base X) for officer, enlisted, and civilian for each Service were reviewed/discussed (see slide). These numbers will be accumulative and reported with each candidate recommendation reflecting total manpower reductions and realignments. It was noted that the civilian numbers are true reductions while the military positions will be re-distributed by the Services to replace civilian/contract medical personnel elsewhere in the MHS activities with higher military value. This will allow identification of immediate cost savings when realigning the military slots into the empty civilian billets. Continue to provide data call status and manpower realignment updates to MCJSG. **(Action Item – 0-6 Leads Ongoing Follow Up)**
- HCS rep presented the following Candidate Recommendations for MJCSG decision/vote specifically to close the inpatient mission at non-isolated facilities that do not meet the established ADPL and/or MILVAL requirement(s). The workload would be realigned to the civilian networks and/or other military hospitals. Optimization Model runs were performed using the above criteria identifying the following sites: MacDill AFB, Scott AFB, Keesler AFB and Fort Polk.
 - HCS-1J (MED-049): Disestablish the Inpatient Mission at MacDill AFB
 - HCS rep presented and lead discussion on HCS-1J (MED-049) to disestablish the inpatient mission at MacDill AFB and convert the hospital to a clinic with an ambulatory care center (see attached slides). In FY02, the AD eligible population was 9,165 with 9,086 ADFMs/14,810 Other enrolled. There are 34 Joint Accreditation of Hospital Organizations (JCAHO) or Medicare accredited/VA hospitals with available inpatient services within 40 miles with a total of 10,585 beds/average daily census of 6,843 [as reported by American Hospital Association (AHA)] and the capability to absorb the additional workload (see attached map). The Chair voiced concern over the validity of the identified 19 positions lost with closing the inpatient function, stating that if the facility no longer has to maintain 24 hour operations (to include the inpatient units, laboratory, pharmacy, radiology, ER, etc); the number of reductions should be higher. The OSD/BRAC rep stated that the numbers could be challenged. The Chair encouraged the 0-6 Lead group to review the numbers and validate their accuracy for this and all scenario recommendations. Recommend MJCSG approve the following Candidate selection based on optimization model runs, excess capacity, low MILVAL, ADPL and other supporting data analysis:
 - **HCS-1J (MED-049): Disestablish the inpatient mission at MacDill AFB (MJCSG Approved with 5/0 vote)**

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MINUTES OF THE JANUARY 4, 2004 MEETING OF THE MJCSG PRINCIPALS

LOCATION: Pentagon, Room 4E1084, 1500 -1700

Attending: LtGen Taylor – Chair; MGen Webb USA/SG; Mr. Chan – ASD (HA)/CP&P; CAPT Shimkus - Representing USN/SG; CAPT Cullison – USMC/SG; Col Hamilton – Secretary; Mr. Yaglom – USA/SG; Mr. Porth – OSD/BRAC; Mr. Curry – USA/OTSG; CAPT Hight – BUMED; Mr. Sherman – OTSE; Maj Fristoe – HA/TMA; Maj Guerrero – AF/SG; Maj Harper – AF/SGSF; Dr. Christensen - CNA; Maj Cook – HA Analyst; CDR Bradley – Navy Analyst; Maj Coltman – Recorder.

Decisions:

- **Approved** the following Candidate Recommendation [**MJCSG Approved; vote (5/0)**]:
 - HCS-1J (MED-049): Disestablish the Inpatient Mission at MacDill AFB
 - HCS-1M (MED-052): Disestablish the Inpatient Mission at Scott AFB
 - HCS-1K (MED-050): Disestablish the Inpatient Mission at Keesler AFB
- **Disapproved** the following Candidate Recommendations for disestablishing inpatient missions (**MJCSG Disapproved; vote (5/0) to maintain the inpatient missions**):
 - HCS-1D (MED-043): Maintain the Inpatient Mission at Fort Polk
 - HCS-1 (MED-): Maintain inpatient facilities at NH Beaufort
- **Hold** on decision for the following Candidate Recommendation pending additional information on the Sports Medicine Fellowship (E&T), TRICARE network/partnerships (HCS), and military judgment (Army rep) (**MJCSG voted 5/0 to hold**):
 - HCS-1 (MED-004): Disestablish Inpatient Mission at West Point

Action Items:

- Legal Reviews:
 - Can Medical/line services occupy/share the same building?
 - USHUS closure prohibited by Title 10, can BRAC supercede?
- 0-6 Lead Follow-up:
 - HCS-1K (MED-050): Disestablish the Inpatient Mission at Keesler AFB: Validate that the VA hospital located near Keesler will remain open and has available capacity
 - HCS-1 (MED-004): Disestablish the Inpatient Mission at West Point: Research/provide additional information on the Sports Medicine Fellowship (E&T), TRICARE network/partnerships (HCS), and military judgment issues (Army Rep)
 - Sub-groups continue working criteria 5-8 questions for candidate development
 - Continuous follow up/report on outstanding COBRA data calls
 - Complete Summary of Scenario Environmental Impacts for Candidate Recommendations
 - Scrutinize personnel reduction numbers for all scenarios

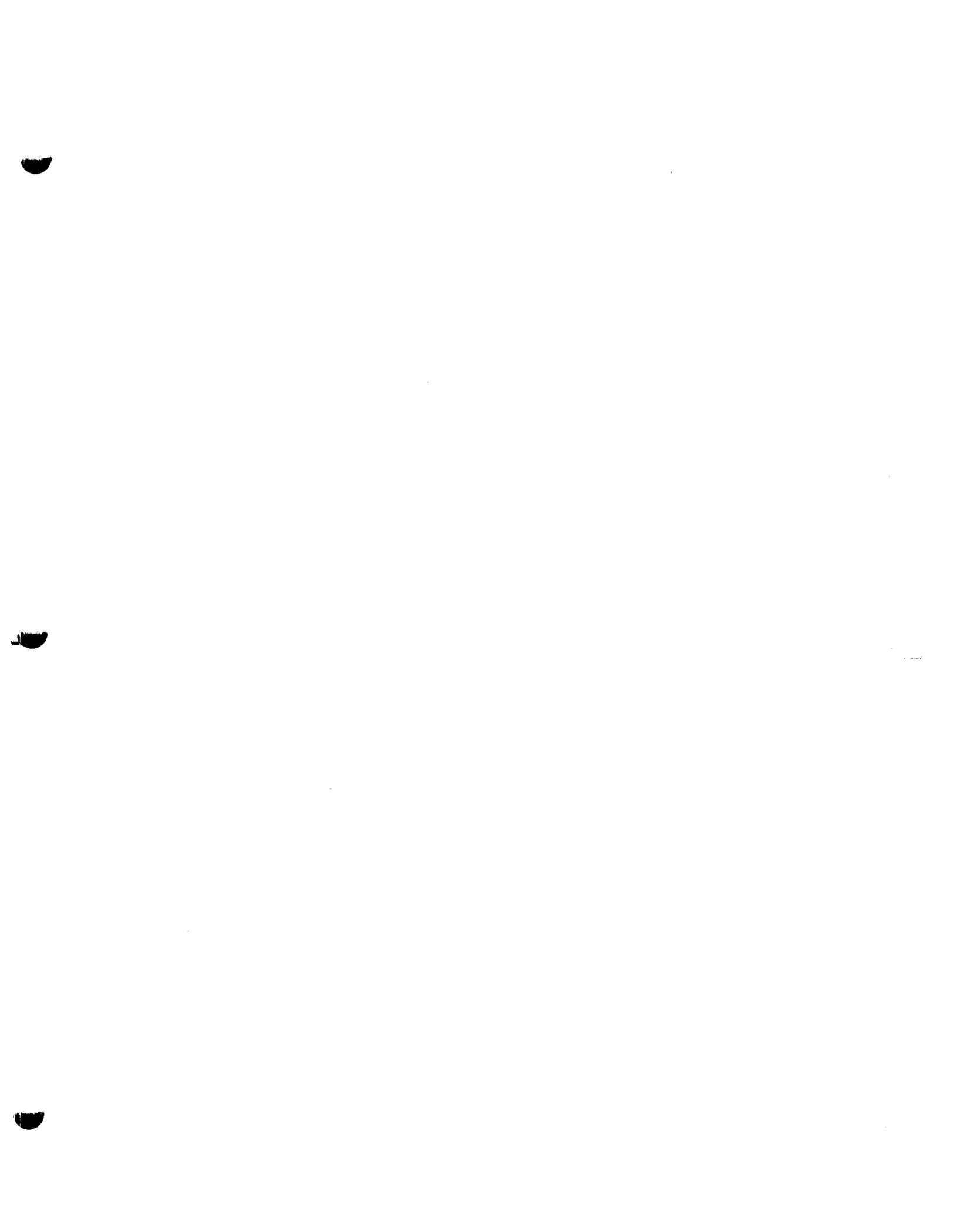
Meeting Overview:

Members: Present: 4, represented: 1, absent: 1

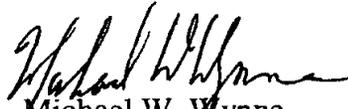
- Chair opened the meeting with review/discussion on the Scenario Data Calls/COBRA & Manpower Reductions slides (See attachments): There are 43 MJCSG scenarios in the tracker with total of 92 (100%) data calls currently fielded out to the Services. Total returned 66 (71%). Of the data received it was noted that the Army return rate is lower than the other Services.

01/04/2005

1



Your timely support is requested. I look forward to your contribution to shaping our BRAC 2005 effort. Should you have any questions regarding this request, please contact Mr. Peter Potochney, Director, Base Realignment and Closure, at (703) 614-5356.



Michael W. Wynne
Acting USD (Acquisition, Technology & Logistics)
Chairman, Infrastructure Steering Group



ACQUISITION,
TECHNOLOGY
AND LOGISTICS

THE UNDER SECRETARY OF DEFENSE

3010 DEFENSE PENTAGON
WASHINGTON, DC 20301-3010

JUN 21 2004

MEMORANDUM FOR CHAIRMEN, JOINT CROSS-SERVICE GROUPS

Subject: Transformational Options for BRAC 2005

The Secretary of Defense, in his November 15, 2002 memorandum initiating the BRAC process, asked for a broad series of options for stationing and supporting forces and functions to increase efficiency and effectiveness. As the Secretary indicated in that memorandum, the enduring value of our BRAC effort rests largely on our ability to conduct an analysis that reaches beyond a mere capacity reduction in the status-quo configuration to one that "reconfigure[s] our current infrastructure into one in which operational capacity maximizes both warfighting capability and efficiency."

The Infrastructure Steering Group needs your assistance in putting together the very best suggestions to stimulate critical analysis by the Military Departments and the Joint Cross-Service Groups in support of the most comprehensive and transformational analysis possible. You may recall that my predecessor, Mr. Pete Aldridge, asked each of you to provide recommendations for transformational options over a year ago. The suggestions received are helpful, but given your experiences to date in the BRAC 2005 process, it is appropriate to provide each of you an additional opportunity to submit revised or new transformational options. Please forward your responses to the OSD Base Realignment and Closure Directorate by July 8, 2004.

Once your responses and suggestions are received, they will be arrayed for review by the Infrastructure Steering Group and the Infrastructure Executive Council before being forwarded to the Secretary for approval. Once approved, these options will constitute minimum analytical frameworks upon which the Military Departments and Joint Cross-Service Groups will conduct their respective BRAC analyses.

As a guideline for drafting your additional transformational options, please ensure that each option:

1. Is overarching and notional, without identifying specific installations for analysis;
2. Has a general and identifiable effect on infrastructure; and
3. Is actionable within the BRAC 2005 process.



Intelligence: The Department needs intelligence capabilities to support the National Military Strategy by delivering predictive analysis, warning of impending crises, providing persistent surveillance of our most critical targets, and achieving horizontal integration of networks and databases.

- The Military Departments and the Joint Cross Service Groups will not recommend to the Secretary any closure or realignment recommendation that eliminates sufficient organic ISR/analytic capability to meet warfighting and acquisition requirements while effectively leveraging Joint and National intelligence capabilities.



Impacts

- **Criteria 6 (Economic) – Minimal**
- **Criteria 7 (Community) – None**
- **Criteria 8 (Environmental) – None**
- **Other Medical impacts**
 - **Civilian cost per admission - \$5,944**
 - **6th decile**



Recommendation

- **Recommend disestablishment of inpatient mission at MacDill AFB**

Medical Joint Cross Service Group



MED 052 Scott AFB

Disestablish Inpatient

Scott Area Medical Facilities





Background – Scott AFB

- **ADPL – 11.8**
 - **MHS Avg - 40.8**
- **Beds – 69**
 - **Certified - 138**
- **RWPs – 1,547**
- **Population**
 - **Eligible (AD/ADFM/Other) 9.660 / 17,347 / 25,848**
 - **Enrolled (ADFM/Other) 12,031 / 13,114**
- **Civilian Hospitals within 40 Miles – 38**
 - **9,465 Beds/ 6,124 Avg Daily Census**
 - **2 VA Hospitals within 30 miles**
- **Auth O/E/C (321/610/179)**
- **Military Value**
 - **Total - 24.1**
 - **Functional - 28.9**



Justification

- **Reduces excess capacity**
- **Redistributes military providers to areas with more eligible population**
- **Reduces inefficient inpatient operations**
- **Civilian capacity exists in area**



Payback

| Military as Civilians | |
|------------------------------|------------------|
| One-Time Costs | \$2,770K |
| MILCON | 0 |
| NPV | -\$8,555K |
| Recurring Savings | \$981K |
| Payback Years | 5 Yrs |
| Break Even Years | 2012 |
| Mil/Civ Reductions | 62/15 |



Military Value

- **28.9 Functional Military Value**
- **Average Functional Military Value for all inpatient facilities**
 - **With Scott AFB – 42.58**
 - **Without Scott AFB – 42.83**



- **Criteria 6 (Economic) – Minimal**
- **Criteria 7 (Community) – None**
- **Criteria 8 (Environmental) – None**
- **Other Medical impacts**
 - **Civilian cost per admission - \$7,663**
 - **8th decile**



Recommendation

- **Recommend disestablishment of inpatient mission at Scott AFB**

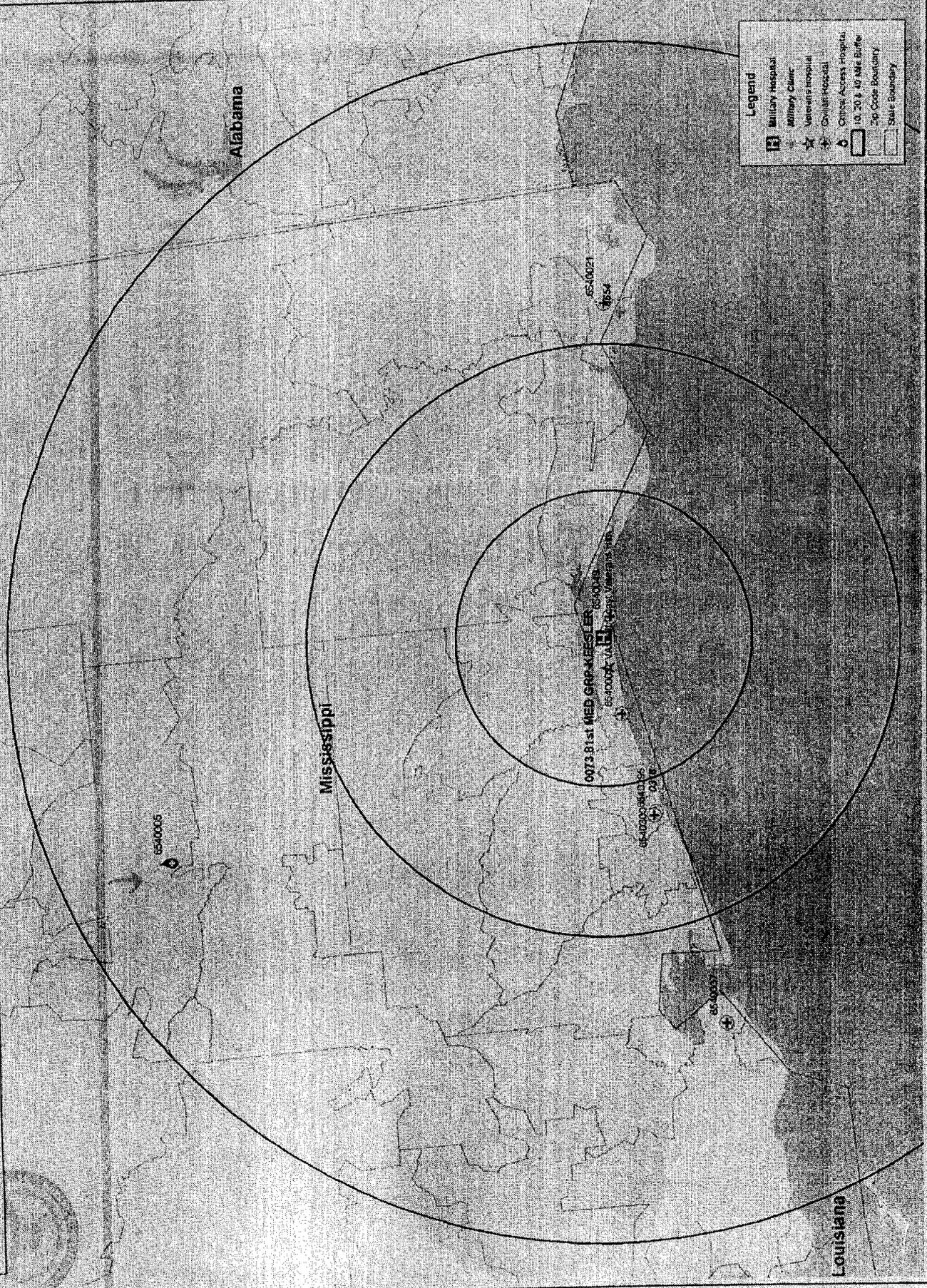
Medical Joint Cross Service Group



MED 050 Keesler AFB

Disestablish Inpatient

Keesler Area Medical Facilities



Legend

- Military Hospital
- Military Clinic
- Veterans Hospital
- Civilian Hospital
- Critical Access Hospital
- 10, 20 & 40 Mile Buffer
- Zip Code Boundary
- State Boundary



- **ADPL – 60**
 - **MHS Avg - 40.8**
- **Beds – 154**
- **RWPs – 6,190**
- **Population**
 - **Eligible (AD/ADFM/Other) 15,781 / 16,616 / 23,286**
 - **Enrolled (ADFM/Other) 12,991 / 13,194**
- **Civilian Hospitals within 40 Miles – 8**
 - **1,957 Beds/ 1,148 Avg Daily Census**
 - **VA within 5 Miles (552 Beds / 394 ADC)**
- **Auth O/E/C (609/1,080/202)**
- **Military Value**
 - **Total – 32.7**
 - **Functional - 35.3**



Justification

- **Reduces excess capacity**
- **Redistributes military providers to areas with more eligible population**
- **Reduces inefficient inpatient operations**
- **Civilian/VA capacity exists in area**



Payback

| Military as Civilians | |
|------------------------------|--------------------|
| One-Time Costs | \$7,825K |
| MILCON | 0 |
| NPV | -\$307,018K |
| Recurring Savings | \$23,080K |
| Payback Years | Immediate |
| Break Even Years | 2007 |
| Mil/Civ Reductions | 181/31 |



Military Value

- **35.3 Functional Military Value**
- **Average Functional Military Value for all inpatient facilities**
 - **With Keesler AFB – 42.58**
 - **Without Keesler AFB – 42.71**



Impacts

- **Criteria 6 (Economic) – Minimal**
- **Criteria 7 (Community) – None**
- **Criteria 8 (Environmental) – None**
- **Other Medical impacts**
 - **Civilian cost per admission - \$4,314**
 - **4th decile**



Recommendation

- **Recommend disestablishment of inpatient mission at Keesler AFB**

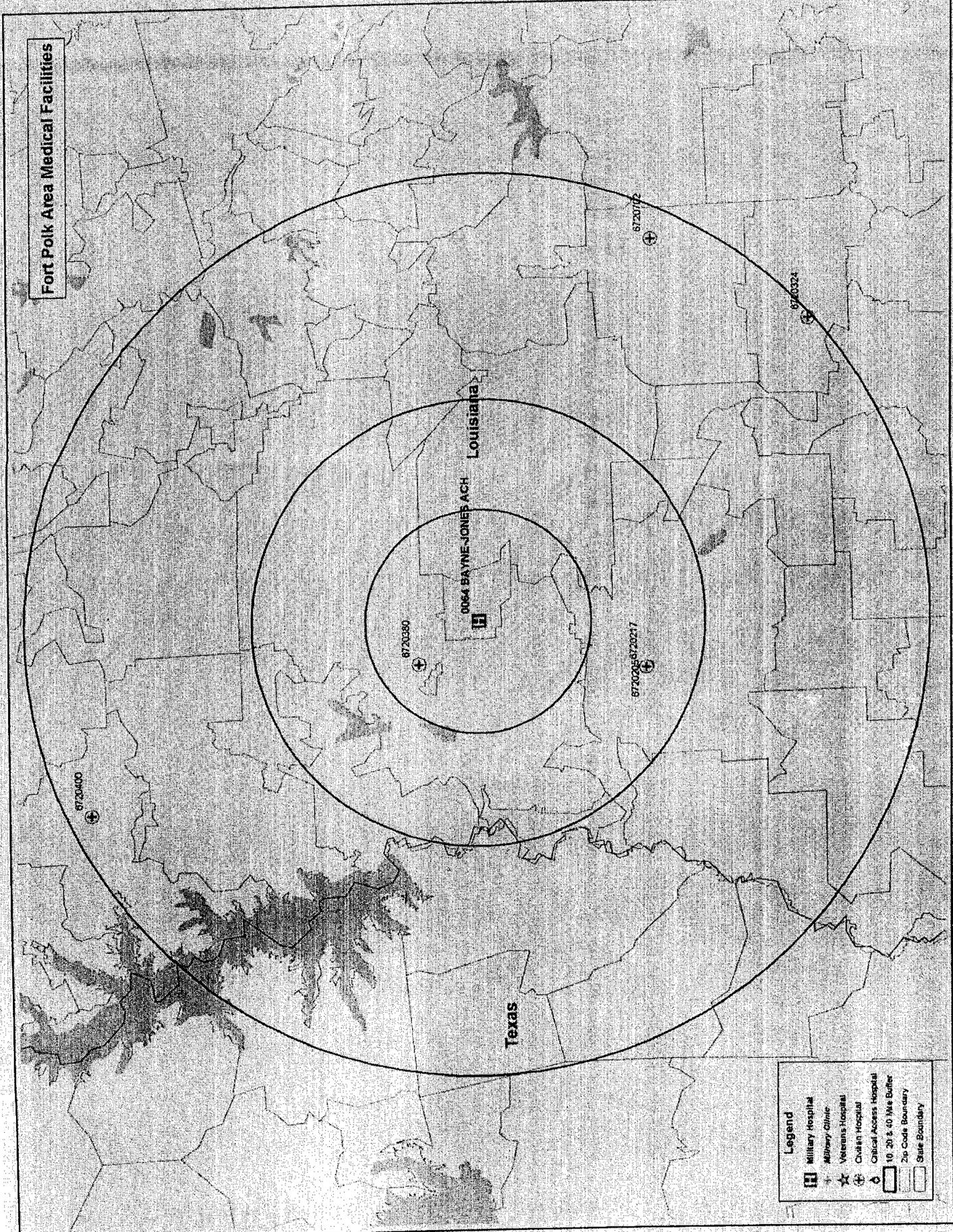
Medical Joint Cross Service Group



MED 043 Fort Poik

Disestablish Inpatient

Fort Polk Area Medical Facilities



Legend

- Military Hospital
- Military Clinic
- Veterans' Hospital
- Civilian Hospital
- Critical Access Hospital
- 10, 20 & 40 Mile Buffer
- Zip Code Boundary
- State Boundary



Background - Fort Polk

-
- **ADPL – 7.3**
 - **MHS Avg - 40.8**
 - **Beds – 35**
 - **Certified - 70**
 - **RWPs – 965**
 - **Population**
 - **Eligible (AD/ADFM/Other) 8,876 / 11,060 / 8,193**
 - **Enrolled (ADFM/Other) 10,254 / 4,127**
 - **Civilian Hospitals within 40 Miles – 4**
 - **276 Beds/117Avg Daily Census**
 - **Auth O/E/C (117/149/433)**
 - **Military Value**
 - **Total - 31.1**
 - **Functional - 44.7**



Justification

- **Reduces excess capacity**
- **Redistributes military providers to areas with more eligible population**
- **Reduces inefficient inpatient operations**
- **Civilian capacity exists in area**



Payback

| Military as Civilians | |
|------------------------------|------------------|
| One-Time Costs | \$2,575K |
| MILCON | 0 |
| NPV | \$27,343K |
| Recurring Costs | \$1,637K |
| Payback Years | Never |
| Break Even Years | N/A |
| Mil/Civ Reductions | 28/38 |



Military Value

- **44.7 Functional Military Value**
- **Average Functional Military Value for all inpatient facilities**
 - **With Ft Polk – 42.58**
 - **Without Ft Polk– 42.54**



-
- **Criteria 6 (Economic) – Minimal**
 - **Criteria 7 (Community) – None**
 - **Criteria 8 (Environmental) – None**
 - **Other Medical impacts**
 - **Civilian cost per admission - \$4,997**
 - **4th decile**



Recommendation

- **Recommend disestablishment of inpatient mission at Fort Polk**

Medical Joint Cross Service Group



**MED 004 MCAS
NH Beaufort Re-visit**

Disestablish Inpatient

Medical Joint Cross Service Group



**MED 004 West Point
Re-visit**

Disestablish Inpatient



Payback - West Point

| | Realign Military to Base X | Eliminate Military to Scenario | Military to Civilian |
|----------------------------|-------------------------------|-----------------------------------|----------------------|
| One-Time Costs | \$2,020K | \$2,024K | \$2,875K |
| MILCON | 0 | 0 | 0 |
| NPV | \$52,661K | \$19,347K | \$31,584K |
| Recurring Costs | \$3,553K | \$1,076K | \$1,915 |
| Payback Years | Never | Never | Never |
| Break Even Years | N/A | N/A | N/A |
| Mil/Civ Reductions | 0/39 | 25/39 | 25/39 |
| Mil/Civ Relocations | 25/0 | 0/0 | 0/0 |



**CARES COMMISSION
SITE VISIT REPORT**

**VISN 16's VA Gulf Coast Veterans Health Care System
Biloxi and Gulfport, Mississippi**

Date of Visit: July 2, 2003

Site(s) Visited:

Biloxi VA Medical Center, Mississippi
Gulfport VA Medical Center, Mississippi
Keesler Air Force Base, Biloxi, Mississippi

CARES Commissioners/Staff in Attendance:

Commission Vice Chairman R. John Vogel
Commissioner Joseph Binard
Commission Staff Team Leader Kathy Collier

Overview of Visit to Biloxi and Gulfport VA Medical Centers (VAMCs) and Keesler Air Force Base:

The Biloxi and Gulfport VAMCs are the only two medical centers along the Mississippi, Alabama and panhandle Florida Gulf Coast. The Biloxi and Gulfport VAMCs are eight miles apart and have been consolidated for greater than 30 years.

The Biloxi VAMC employs approximately 1,088 employees and is a 48 bed acute medical and surgical inpatient unit including intensive care. Biloxi VAMC provides health care for 124-nursing home and intermediate care beds, 171 domiciliary beds, and outpatient mental health. Located on the Biloxi campus is a VA National Cemetery. All of the buildings on the Biloxi campus are utilized either for administrative services or health care delivery. There is ample vacant land to accommodate expansion through new construction. A corporate office for the Gulf Coast Health Care System is located at Biloxi (as well as a second, smaller corporate office located in Pensacola, Florida.)

The Gulfport VAMC employs approximately 430 employees. This facility serves as an inpatient psychiatric care unit with 144 operating beds (with a 30% average daily census.) Through collaborative agreement with the Keesler Air Force Base in Biloxi, this inpatient unit also houses active duty military personnel with acute mental health needs, although some patients are there for an extended period of time. On July 2, one Air Force member had a 75-day stay. At the time of our visit, approximately eight of the psychiatric inpatients were active duty military personnel. The Gulfport VAMC has a 56-bed nursing home and dementia unit, and the primary outpatient mental health care facility. The Gulfport VAMC also has a very large laundry facility, which provides laundry services for VAMCs in New Orleans, Louisiana and Gulf Coast regions.

The Gulfport facility was built in 1917 to commemorate the 100th anniversary of Mississippi's statehood. Initially this facility was by the Navy as a training facility until

1919, when it became a public health facility. In 1922, VA acquired the facility for \$125,000. All of the buildings except those constructed in recent years are on the historic registry. In Gulfport many of these historic buildings are vacant or used only for storage.

The Biloxi and Gulfport VAMCs appear to be well organized with appropriate staffing to provide patient care. The facilities have consolidated administrative services. Due to recent renovations, the Biloxi VAMC is well equipped to provide health care services. Additional renovations are planned to maximize health care delivery. Renovations that included administrative offices were also planned in such a way as to be converted to medical wards in the event that is needed.

Keesler Air Force Base is only a few miles from Gulfport VAMC and abuts the Biloxi VAMC. Keesler's primary goal through collaboration with VA is to support VA infrastructure by meeting veterans' acute hospitalization, surgery and rehabilitation needs and in return Keesler Medical Center's graduate and medical education training programs expand. Keesler would also like to engage in joint clinical research with VA as well as joint psychiatric services. Keesler's model involves the Department of Defense (DOD), in this case the Air Force, taking care of inpatient services while VA takes care of outpatient services. Access to the military base is considered by the Air Force leadership to be a technical obstacle and one that can be overcome. Additionally, as it relates to access to the military base, the Air Force, the Director of the VA Gulf Coast Veterans Health Care System (VAGCVHCS), and state and local government officials are discussing the possibility of constructing a connector road between the Biloxi VAMC and Keesler Air Force Base.

Two primary issues must be considered relating to the collaborative model with Keesler Air Force Base. First, according to Brigadier General David Young, Keesler's short runway makes it vulnerable to closure under DOD's Base Realignment and Closure initiative, which will not be known until approximately 2005. An enhanced relationship with VA may make retaining Keesler Air Force Base more viable. Second, the veterans receiving inpatient care in military facilities must abide by DOD rules. Of particular note is the rule of no smoking in DOD facilities.

Summary of Meeting with VISN Leadership:

Names and Titles of Attendees:

Mr. Lynn Ryan, Acting Deputy Network Director, VISN 16

Ms. Julie Catellier, Director, VAGCVHCS

Gregg Parker, MD, Chief of Staff, VAGCVHCS

Ms. Chris Jones, Associate Director, VAGCVHCS

Mr. Andy Welch, Associate Director for Outpatient Clinic Management,
VAGCVHCS

Ms. Evelyn Wingard, PhD, RN, Associate Chief of Staff for Nursing, VAGCVHCS

Ms. Cindy Jwainat, VISN 16 Business Manger

Mr. Mario Rossilli, VISN 16, Public Affairs Officer

Ms. Tina Cassell, Administrative Assistant to the Director, VAGCVHCS

Meeting and Tour of Facilities:

Ms. Julie Catellier lead the informal meeting giving an overview of the VAGCVHCS, which includes sites visited as well as major other locations in Mobile, Alabama, Pensacola, Florida, and Panama City, Florida. Following this meeting, visiting Commissioners and Commission Staff were escorted on a walking tour of the Biloxi VAMC. A driving tour of the Gulfport VAMC followed. Also, Commissioners and Commission Staff met Brigadier General David Young, Medical Officer from Keesler Air Force Base. As mentioned earlier, General Young provided a brief overview of the sharing opportunities under discussion with the VAGCVHCS and directed everyone on a driving tour of the base.

What did we learn?

The VAGCVHCS has two VAMCs in the Biloxi and Gulfport. The Alabama and panhandle Florida gulf coasts are primarily served through 100% VA-staffed community outpatient clinics (CBOCs). The greatest need in VISN 16 is present in the panhandle of Florida, partially due to the growing aged veteran population and the fact there is no medical center in that area. At this time, inpatient care to veterans from Florida and southern Alabama are provided in Biloxi and Gulfport, unless community-based services can be arranged. This requires some veterans to drive up to eight hours (average) to receive VA health care.

Throughout the VAGCVHCS, there are tremendous opportunities to partner with the DOD. Generally, DOD medical response is good with adequate medical resources available unless these resources are deployed in support of military defense efforts. Thirteen VA/DOD sharing agreements are in place between VAGCVHCS and six military facilities and more are in the planning stages. Agreements include selling, buying and sharing of staff, space, and clinical and non-clinical resources. Among the VA/DOD sharing arrangements:

- Gulfport VAMC provides inpatient psychiatric health care to Keesler's active duty military personnel with non-adjustment/stress-type mental health illnesses.
 - NOTE: The Gulfport VAMC presently has 32 high intensity (acute) beds, 32 general intermediate psychiatry beds (chronic), 29 geropsychiatry beds (more long term beds), and a 54 bed Dementia Unit under the Extended Care Service.
- Shared inpatient and specialty care with Keesler Air Force Base with Keesler providing cardiovascular surgery, VA providing critical care nurses, and both sharing radiation oncology physician.
 - NOTE: Keesler Air Force Base Hospital has 90 operating beds and the capacity for 200-300, if needed. At the time of our visit, 75 beds were occupied.
- Joint ambulatory care center in Pensacola, Florida on Corry Station.
 - NOTE: The Naval Hospital in Pensacola has 60 beds with a 42 percent occupancy rate and an average daily census of 25. In addition to overnight stays, this facility has a large volume of same day surgery and other procedures that occupy these beds.

- Expanded primary care services at Tyndall Air Force Base, Florida.
- Shared use of urology physician assistant at Pensacola Navy Hospital.
 - NOTE: In April 2003, the Congress passed Veterans' Health Care Facilities Capital Improvement Act, H.R. 1720, which authorized the Secretary of VA to carry out construction projects for the purpose of improving, renovating, establishing, and updating patient care facilities at VAMCs. It was mentioned that under this authority, up to \$45 million was authorized for a joint VA/DOD clinic in Pensacola.

Under the CARES market planning process, VISN 16 has proposed a new medical center in the Pensacola, Florida area. However, several pre-CARES strategies have been implemented in the Mobile, Alabama and Florida panhandle to respond to the rapid growth in demand in those areas. Coupled with the VA/DOD sharing arrangements under development, these pre-CARES strategies include:

- New CBOC in Panama City, Florida in June 1998, with expansion in April 2002
- Relocated and expanded the Mobile, Alabama CBOC in March 2001, with a second expansion to begin in July 2003
- Because Pensacola, Florida is the fastest growing area in the VAGCVHCS, Pensacola North Clinic in September 2002, and plans include expanding primary care
- Establishment of VA CBOC on Eglin Air Force Base, Florida
- Additional expansion of primary care at Tyndall Air Force Base

Significant Issues to consider:

The DOD plays a dominant role in the VAGCVHCS's ability to meet health care demand. First there is the issue of potential closure of Keesler Air Force Base under DOD's Base Realignment and Closure initiative in as early as 2005. If Keesler Air Force Base is closed, VA could utilize that hospital complex to satisfy much of VA's present and future needs. Second, other military facilities in this market area have the capacity to accommodate VA workload.

The CARES market plan calls for closure of the Gulfport VAMC in 2009. The biggest question with this potential closure is where to place the inpatient psychiatric patients, the Alzheimer's unit, as well as the administrative support staff presently located in the operating buildings at that facility. Again, DOD plays a heavy role in this decision. Absent an agreement with Keesler Air Force Base, patients could be moved from Gulfport to the Biloxi campus but only if new construction is approved. This new construction, as we learned, may be in the form of new administrative offices because as mention earlier, administrative office renovations in recent years at the Biloxi campus may be reverted to medical wards with minor alterations.

Both the Biloxi and Gulfport VAMCs have many buildings on the Mississippi historic register. However, the CARES market plan for Gulfport includes long-term enhanced

use lease agreements that would preserve these buildings but provide for appropriate re-use of the grounds. (NOTE: There is strong opposition to closure of Gulfport from Congressman Gene Taylor, primarily due to an economic development opportunity for a retirement community in the Gulfport area that promotes federal health care availability.)

Summary of Stakeholder Meeting(s)

Ms. Catellier provided welcoming remarks to all stakeholders and introduced the Commissioners and Commission Staff. Ms. Catellier gave an overview of the purpose of the meetings and asked each attendee to introduce him/herself. Stakeholders present represented veteran service organizations, state and county veteran service organizations, State Directors of Veterans Affairs, Congressional staff, and DOD representatives from TriCare.

Vice Chairman Vogel thanked everyone for taking time to be at the meeting. Vice Chairman Vogel gave a brief background description of the CARES experience. He gave an overview of the Commission, its role and responsibilities as chartered by Secretary Principi, the role of the stakeholders meetings, and the purpose of the Commission's future hearings.

Commissioner (Dr.) Binard provided a brief discussion of the need to focus on the "enhanced services" part of CARES. Commissioner Binard also emphasized the importance of the stakeholders input not only in terms of what is, but what the stakeholders perceive the needs of veterans to be.

Topics of Discussion:

As a group, the stakeholders felt they were well versed in the issues surrounding CARES and how the market plans may impact their constituents. They were keenly interested in the next steps of CARES particularly the Commission's role in those next steps.

The group's discussions fell into the following general categories:

- **Interrelationships/Joint ventures with DOD:** There was generally universal support for VA/DOD sharing in VISN 16. They felt the VA leadership is taking advantage of the current connectivity with DOD and the future plans sound promising. There was, however, expressed concern over the potential closure of Keesler Air Force and the lost opportunity for inpatient surgery. Stakeholders also expressed some concern regarding the ability of DOD to absorb the growing workload capacity. A small number of stakeholders expressed some concern regarding the ability to obtain specialty care from the DOD. For example, in the case of neurosurgeons in the Gulf Coast area, there were five neurosurgeons in the area. Now, there are only two on the Air Force's staff because the malpractice crisis caused the other three to leave the area.
- **Access to Inpatient and Outpatient Care:** Many stakeholders, particularly Florida's Congressman Jeff Miller's staff member, shared their concerns regarding the lack of inpatient health care services in the Florida panhandle and southern Alabama. Driving times are on the average from six to eight hours to the nearest VAMC. It was stated that the outpatient resources are inadequate for the

Florida panhandle especially in light of migration of veterans to the south, advances in health care, and the fact that the CBOCs in that area were build to handle a much smaller workload. Congressman Miller's staff member expressed on behalf of the Congressman support for the Secretary and the CARES process.

- **Optimization of Resources/Potential closure of Gulfport VAMC:**
Stakeholders understood the logic of closing the Gulfport VAMC but were deeply concerned over status of the inpatients at that facility should it close. There is heavy reliance on the ability to establish a sharing arrangement with Keesler but the uncertainty of Keesler's future added to their concerns.
- **Concerns for the Families:** Stakeholders asked the Commissioners to consider the families of veterans before asking veterans to up-root in order to receive care, especially if the veteran requires nursing home care. Stakeholders expressed an interest in alternative VA nursing home care with the use of home-based nursing/assisted living caregivers and more state veterans homes. There is a state nursing home in Panama City, Florida, which will start admitting veterans in August 2003. Another state nursing home is being added to the Florida panhandle. There are three state nursing homes in Mississippi. In the Biloxi/Gulfport area, there is an Armed Services Retirement Home providing assisted living to veterans and military retirees.
- **Communications/Stakeholder Involvement:** Stakeholders were positive about local VA management and most felt they have been included in the CARES process thus far. They look forward to being included in the formal hearing process on August 26, 2003.

Exit Briefing with VISN/VAGCVHCS Leadership:

The following key issues were highlighted:

- Closure of Gulfport by 2009:
 - Provides an opportunity for VA to divest of the property under long-term enhanced use lease agreements.
 - Heavily contingent on future of Keesler Air Force Base under the DOD's Base Realignment and Closure initiative. Expected decision to be made by 2005.
 - Contingent on VA funding to construct new buildings at Biloxi. These new buildings will support administrative services personnel and the buildings now housing these personnel would be converted to medical wards.
 - Congressional opposition by Mississippi Congressman Gene Taylor.
- Large, vocal veteran population in the Florida panhandle
- Network Director, Dr. Robert Lynch, has committed to no loss of services to veterans and their families and no loss of employment for VA staff

Commissioners Vogel and Binard and Commission Staff Member Collier expressed gratitude for the hospitality extended them during this learning experience. Additionally, Commissioners and Staff expressed special thanks and appreciation to all the behind the scenes staff who helped make this visit a valuable experience.

Outstanding Items/Questions/Follow-up:

As a result of the stakeholder meeting, Florida's Congressman Jeff Miller's staff member requested information regarding how much of VA's national budget is appropriated for long-term care services.

Attachments:

1. H.R. 1720, Veterans health Care Facilities Capital Improve Act, dated April 10, 2003
2. PowerPoint Presentation Director, VAGCVHCS, dated Jul 6 2, 2003

Approved by: R. John Vogel, Vice Chairman and Commissioner (Dr.) Joseph Binard
July 14, 2003

Prepared by: Kathy Collier, CARES Commission Staff Team Leader
July 14, 2003



**CARES COMMISSION
POST HEARING SUMMARY**

VISN 16 Biloxi Hearing
August 26, 2003

- I. Commissioners in Attendance:
- a. Charles Battaglia, Hearing Chairman
 - b. Joseph Binard, MD
 - c. Chad Colley
 - d. Layton McCurdy, MD
 - e. Al Zamberlan

- II. Market Areas Addressed in Hearing
- a. Central Southern (MS, LA)
 - b. Eastern Southern (FL, AL)

III. Market Area Summary

| Market Area (Facility) | Planning Initiative (met criteria) | Market Plan Recommendation | DNCP Recommendation |
|---------------------------|--|---|---|
| CS/ES | Inpatient Care - Medicine | CS – Increase number of beds by reopening existing wards to meet 2022 demand. Increase contracting w/ community. ES - Increase sharing agreement w/ DoD – Pensacola and establish agreement w/ Eglin. Contract for 10 beds in Panama City, FL. Possibly build a 100-bed hospital in Pensacola to service Eastern and Southern markets. | Biloxi will undergo renovation to increase beds. ES will provide care through joint venture, sharing, and community contracts |
| CS/ES | Outpatient Care - Primary - Specialty | ES – Joint VA/DoD ambulatory care center in Pensacola FL. New CBOC in Okaloosa County FL in collaboration w/ Eglin AFB. Provide additional specialists at Pensacola CBOC in collaboration w/ DoD CS – Open 8 CBOCs. Expand specialty care at expanded CBOCs – to accept referrals from primary care CBOCs. Increase community contracts. | 11 CBOCs in ES/CL markets. CBOCs for CS market are not in high priority category. Joint venture and contracts in ES market. |
| CS | Inpatient Psychiatry <i>(did not meet standard for this market)</i> | Expand beds at Biloxi to serve as a resource for New Orleans, Jackson and parts of Alabama and Florida | Renovation and new construction in Biloxi to accommodate Gulf Port workload. |

| | | | |
|-------|---------------------------|---|---|
| CS/ES | Access - Primary Care | ES – Joint VA/DoD ambulatory care center in Pensacola FL. New CBOC in Okaloosa County FL in collaboration w/ Eglin AFB CS – Open 8 CBOCs | 11 CBOCs in ES/CL markets. CBOCs for CS market are not in high priority category. |
| ES | Access - Hospital Care | 4% access in ES. Increase sharing agreement w/ DoD – Pensacola and establish agreement w/ Eglin. Contract for 10 beds in Panama City, FL. Possibly build a 100 bed hospital in Pensacola to service Eastern and Southern markets. | Biloxi will undergo renovation to increase beds. ES will provide care through joint venture, sharing, and community contracts |

IV. Brief Description of Hearing Testimony

Panel 1 – Network Leadership – Dr. Robert Lynch

Dr. Lynch outlined the DNP for VISN 16 Central Southern and Eastern Southern Markets, including areas in Mississippi, Louisiana, Florida, and Alabama. According to the CARES model, these market areas will see an increase in enrollment over the next 20 years, with peak enrollment in 2012. Patients generally travel long distances to receive care in these large and geographically diverse markets and there is an absence of inpatient capacity, particularly in the Florida panhandle area.

Important components of the DNP for these markets include DoD/VA sharing for hospital and outpatient care at Biloxi with Keesler AFB; and in the Florida panhandle with Eglin AFB and Pensacola Naval Base. Additionally, the DNP includes the transfer of workload from Gulfport campus to the nearby Biloxi facility.

In the question and answer session, Dr. Lynch noted that he agrees with the DNP for his network overall, but has some concerns about the CBOC priorities and feels that some markets in the network are in greater need of CBOCs than some included in first priority group.

Dr. Lynch also discussed the consolidation of the Gulfport and Biloxi facilities and the need for capital improvements at Biloxi to accommodate the additional workload. He also noted the importance of consolidation to ensure a single standard of patient care within this market. He outlined the savings achieved by consolidating these facilities would result in a near term (7 year) pay back for the necessary capital investment. He also mentioned that consolidation would not have an adverse impact on employees. Dr. Lynch discussed working with Keesler AFB as a potential solution to accommodating the increased inpatient workload at Biloxi and mentioned that active discussions are underway with local DoD leadership on this issue. Additionally, Dr. Lynch briefly described plans for an enhanced use project at the Gulfport site.

In reference to the proposed SCI unit at the North Little Rock campus, Commissioners asked why New Orleans was not selected for this unit. Dr. Lynch

responded that New Orleans generally met the requirements for such a unit; however, the campus did not have available land for new construction.

When asked about inpatient care in the Eastern Southern market, which does not currently have an inpatient facility, Dr. Lynch outlined plans to develop a sharing agreement with the DoD at the Pensacola naval base to accommodate inpatient workload. When asked to describe any potential obstacles to working with the DoD, Dr. Lynch outlined the importance of local support for these initiatives, and to ensure equal sharing of resources.

a. Panel 2 – Elected Officials

Representative for Congressman Gene Taylor
Representative for Congressman Jeff Miller
Representative for Congressman David Vidder
Representative for Senator Bill Nelson

Elected officials expressed some concern about the consolidation of Gulfport and Biloxi, discussed the absence of inpatient facilities in the Florida panhandle and the need for additional outpatient care on the North Shore in Louisiana.

b. Panel 3 – Veteran Service Organizations

Timothy Hicks, Paralyzed Veterans of America
Dennis Moody, Disabled American Veterans
Rocky McPherson, Executive Director, Department of Veterans Affairs, Florida
Adrian Grice, Veterans of Foreign Wars, Deputy Director, MS State Veterans Affairs

The PVA expressed concern about proposed location of the SCI unit at the Little Rock campus and the absence of necessary tertiary care services at this location. PVA feels that a more southern location, such as New Orleans would be a better choice for unit.

Other VSOs discussed the proposed collaboration with Keesler AFB for inpatient care, and expressed concern about relying on DoD to serve healthcare needs of veterans. Dr. McPherson underscored the importance of implementing standardization for all DoD/VA sharing activities.

c. Panel 4 – Collaboration

Brig General David Young, Hospital Commander, Keesler AFB
Capt Richard Buck, Commanding Officer, Pensacola Naval Hospital

DoD representatives expressed general support for collaborative activities with VA. Gen Young noted the need for a centralized DoD/VA “sharing office” to coordinate all sharing activities between the two agencies. Gen Young also noted that the current Air Force Surgeon General was supportive of collaboration and encouraged continued discussions on the Biloxi/Keesler initiative. Gen. Young outlined that proposed sharing at the Keesler Medical Center would require new construction to accommodate additional workload.

V. Commissioner Views

| Market Area (Facility) | Planning Initiative (met criteria) | DNCP Recommendation | Commissioner Views |
|---------------------------|---|---|--|
| CS/ES | Inpatient Care - Medicine | Biloxi will undergo renovation to increase beds. ES will provide care through joint venture, sharing, and community contracts | Commissioners believe that additional study needs to be undertaken to assess the cost/benefit of the options available at Biloxi including partnership with Keesler AFB. In the ES market, Commissioners agree that further developing relationships w/ the DoD at Pensacola and Eglin will provide a solid solution for inpatient in this underserved region. |
| CS/ES | Outpatient Care - Primary - Specialty | 11 CBOCs in ES/CL markets. CBOCs for CS market are not in high priority category. Joint venture and contracts in ES market. | Commissioners agree that the CBOCs in the ES/CL region are necessary and agree that sharing agreements in ES market are essential to ensuring care for the veteran population in this market. |
| CS | Inpatient Psychiatry (did not meet standard for this market) | Renovation and new construction in Biloxi to accommodate Gulf Port workload. | Commissioners believe that additional study needs to be undertaken to assess the cost/benefit of the options available at Biloxi. However, they agree that inpatient psychiatry should be housed at the Biloxi facility. |
| CS/ES | Access - Primary Care | 11 CBOCs in ES/CL markets. CBOCs for CS market are not in high priority category. | Same as Outpatient Care |
| ES | Access - Hospital Care | Biloxi will undergo renovation to increase beds. ES will provide care through joint venture, sharing, and community contracts | Same as Inpatient Care |

VI. Other Comments

Commissioners agree that a centralized DoD/VA sharing oversight board would be effective in facilitating joint initiatives.

VII. Follow-up questions for VHA/VISN

N/A

**STATEMENT OF
ROBERT LYNCH, M.D.,
NETWORK DIRECTOR
OF THE SOUTH CENTRAL VA HEALTH CARE NETWORK (VISN 16)
BEFORE THE CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
August 26, 2003
VA Gulf Coast Veterans Health Care System
Biloxi, Mississippi**

Good morning, Commissioners. On behalf of the South Central VA Health Care Network, let me welcome you to the VA Gulf Coast Veterans Health Care System. We're honored to have you here today.

Thank you for the opportunity to appear before your commission today and testify about Capital Asset Realignment for Enhanced Services, the national VA initiative known as CARES. Joining me on the panel are: Mr. John Church, director of the New Orleans VA Medical Center, Mr. Richard Baltz, director of the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Miss., and our host for today's hearing Ms. Julie Catellier, director of the VA Gulf Coast Veterans Health Care System. After my opening statement, we will all be available for questions.

My name is Robert Lynch. I am the director of the South Central VA Health Care Network, Veterans Integrated Service Network 16. Prior to my current position, I served as chief of staff at the G.V. (Sonny) Montgomery VA Medical Center. Prior to that, I served as associate chief of staff for what used to be the VA Southern Region. As a veteran, it has been my great privilege to serve veterans as a VA employee for more than 20 years.

Network 16 consists of 10 medical centers, 30 community-based clinics, and two domiciliaries and includes all or part of the following states – Florida, Alabama, Mississippi, Louisiana, Texas, Arkansas, Oklahoma, and Missouri. By geography, it is the second largest of VHA's 21 Veterans Integrated Service Networks. More than 400,000 veterans will receive treatment from one of our network facilities. We are currently the second largest network. Approximately 16,000 employees work for the network.

Over the last eight years, our network, like all of VA, has transformed itself as a health care delivery system. We have shifted our services away from an out-dated inpatient model of care to an outpatient model that brings health care closer to the veteran as well as emphasizes prevention and education. VA is now recognized as a model of excellence in the health care community. Our accreditation scores and veterans surveys consistently reflect the high level of care veterans receive from VA.

I believe it is important to view CARES through the prism of VA's transformation. I firmly believe that CARES offers our network, as well as all of VA, a road map to build on successes made over nearly a decade of hard work. We are proud of the changes we've made and the services we provide veterans. However, we cannot stand still. We cannot – excuse the cliché – rest on our laurels. We must look forward to ensure veterans find a health care system that is prepared to provide them the same level – if not greater – of services in 5 years, in 10 years, and in 20 years.

CARES provides such a strategic road map. Our network is defined by its largely rural population coupled with a consistently growing veteran population. For years, improving access and enhancing services for veterans have been great challenges for our network. Prior to CARES, we identified these challenges. Through our strategic planning process, we developed short, medium and long term tactics to address these challenges.

We have integrated our strategic goals with CARES. Ultimately, I believe CARES brings greater focus to our network's strategic goals.

VA's CARES National Draft Plan adopts market plans that our network developed and recommended as part of this process to realign and enhance veterans' health care services for the decades to come.

To address CARES, our network defined four geographic markets – the Central Lower, which includes 84 counties and parishes in Texas and Louisiana and five border counties in Arkansas, Upper Western, which includes 132 counties in Oklahoma, Texas, Arkansas, and Missouri, the Central Southern, which includes 80 counties and parishes in Mississippi and Louisiana, and the Eastern Southern, which includes gulf coast areas of Alabama and Florida.

Today, of course, we are meeting about the Central Southern Market and Eastern Southern Market. The network's Central Southern Market includes the VA Gulf Coast Veterans Health Care System with divisions in Biloxi and Gulfport, Miss., the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Miss., the New Orleans VA Medical Center, and community-based outpatient clinics in Greenville, Miss., Kosciusko, Miss., Meridian, Miss., Hattiesburg, Miss., Natchez, Miss., Baton Rouge, La., with new clinics scheduled to open in Columbus, Miss., and Houma, La. The Eastern Southern Market does not include a VA Medical Center. It consists of community-based outpatient clinics in Pensacola, Fla., Panama City, Fla., and Mobile, Ala.

Our market plan, adopted in the Draft National Plan, includes collaboration with Keesler Air Force Base in Biloxi to meet VA and Department of Defense needs in the area, the conversion of Gulfport to a long term lease through enhanced use authority that would generate recurring revenue for the medical center, the establishment of a blind rehabilitation center at the Biloxi division of the VA Gulf

Coast Veteran's Health Care System and joint VA/DoD ventures with Eglin Air Force Base and Pensacola Naval Hospital.

The Florida panhandle area remains a critically underserved area. Prior to CARES, our network was actively working with DoD to provide health care services to veterans in this area. We will continue to do so. Again, CARES brings a national perspective to our ongoing collaborative efforts with DoD.

For the record, I also want to address the possible shift of services from the Gulfport Division of the VA Gulf Coast Veterans Health Care System. There has been a great deal of media attention about CARES leading to the possible closure of VA hospitals, including our Gulfport facility. I must note that the Gulfport facility is one division within a larger health care system that spans three states. The Gulfport Division is eight miles away from the Biloxi Division, the main campus for the VA Gulf Coast Veterans Health Care System. If services are shifted from Gulfport, veterans would be able to receive the same services at the Biloxi Division or from nearby Keesler Air Force Base.

What follows is a list of our network's recommendations to address project gaps in services, or planning initiatives, that were identified by VA Central Office.

1. **GAP:** Access to hospital care. In the Eastern Southern Market, four percent of veterans were within a driving distance established by VA Central Office. The target is 65 percent. CARES criteria calls for veterans to be able to drive to a VA hospital in 60 minutes in urban areas, 90 minutes in rural areas, and 120 minutes in highly rural areas.

RECOMMENDATION: We can increase our VA/DoD sharing agreement with Navy Air Station Hospital in Pensacola and establish a VA/DoD sharing agreement with Eglin Air Force Base Medical Center in Florida. We recommend contracting for 10 beds in Panama City, Fla., through community resources and continued contracting with the University of South Alabama in Mobile, Ala. Another option would be to build a new 100 bed VA Hospital in Pensacola
2. **GAP:** Access to primary care. In the Central Southern Market, 57 percent of veterans were within a driving distance established by VA Central Office while that number was 62 percent in the Eastern Southern Market. CARES set 70 percent as the target. As an optimal standard, CARES establishes the following guidelines: in urban and rural areas, veterans should be within a 30 minute drive of a VA health care provider. In highly rural areas, veterans should be within a 60 minute drive of a VA health care provider.

RECOMMENDATION: In the Central Southern Market, we recommend opening eight community-based outpatient clinics areas in Slidell, La., Hammond, La., Franklin, La., Bogalusa, La., LaPlace, La., McComb,

Miss., including clinics scheduled to open in Columbus, Miss., and Houma, La. FY 04. In the Eastern Southern Market, we recommend building a joint VA/DoD state-of-the-art ambulatory care center in Pensacola, Fla. that would replace the Pensacola community-based outpatient clinic. In addition, we recommend a new community-based outpatient clinic in Okaloosa County, Fla. in collaboration with Eglin Air Force Base.

NOTE: The Draft National Plan adopts this recommendation for the Eastern Southern Market only. All recommended clinics for the Central Southern Market are included in the plan's second priority group.

3. **GAP:** Inpatient medicine beds. In the Central Southern Market, a 42 percent gap is projected in 2022 in demand for inpatient medicine beds. **RECOMMENDATION:** We recommend increasing the number of medicine beds by reopening wards to meet 2022 bed projections within existing facilities. We will also provide service through contracts with local providers to meet peak capacity requirements in peak demand years.
4. **GAP:** Outpatient primary care. In the Central Southern Market, a 35 percent gap is projected in 2022 in demand for outpatient primary care services. That gap is 97 percent in the Eastern Southern Market. **RECOMMENDATION:** We recommend establishing community-based outpatient clinics in areas with large populations of veterans as noted previously in my statements regarding primary care access.
5. **GAP:** Outpatient specialty care. In the Central Southern Market, a 76 percent gap is projected in 2022 in demand for outpatient specialty care services. In the Eastern Southern Market, there is a 154 percent gap projected in 2022 in demand for outpatient specialty care services. **RECOMMENDATION:** We recommend providing additional specialists at existing medical center clinics. In the Central Southern Market, we would establish specialty care at expanded community-based outpatient clinics which accept referrals from other primary care community-based outpatient clinics. This is another area where we can benefit from contracting with local providers. For the Eastern Southern Market, we recommend providing additional specialists – audiology, cardiology, neurology, GI, urology, optometry/ophthalmology and women's health at the Pensacola community-based outpatient clinic in collaboration with Department of Defense facilities in the market area.
6. **GAP:** Inpatient psychiatry services. In the Central Southern Market, a 23 percent gap is projected in 2022 in demand for inpatient psychiatry services. **RECOMMENDATION:** We recommend expanding beds at the Biloxi facility in order to serve as a resource for New Orleans, Jackson, and

parts of Alabama and Florida. New Orleans and Jackson should maintain current beds.

7. **GAP:** Proximity issue. VA Gulf Coast Veterans Health Care System includes divisions in Biloxi and Gulfport that are eight miles apart. CARES criteria calls for consideration of the role of acute care facilities within a 60-mile distance.

RECOMMENDATION: We recommend collaborating with Keesler Air Force Base to meet VA and DoD health care demands in the area and converting Gulfport to a long-term lease through enhanced use authority. An enhanced use lease would provide recurring revenues for the local VA medical center. Specific clinical services to be shared with Keesler Air Force Base have not been determined at this time. Based on the outcome of these decisions, renovation and additional construction to accommodate the transfer of services from Gulfport may be required.

8. **GAP:** Special populations. VA Central Office identified a gap in blind rehabilitation in the network.

RECOMMENDATION: We recommend establishing a blind rehabilitation center in Biloxi at the VA Gulf Coast Health Care System which would require construction of additional space.

Finally, I'll mention that CARES encourages VA to think outside the box, to look for opportunities to work with other organizations and institutions to ensure veterans continue to receive quality health care well in to the future. I applaud such efforts. I'm pleased to say in these markets we currently are participating in collaborative relationships with the National Cemetery Administration and the Department of Defense. We will continue to seek opportunities to further enhance such collaborations.

That concludes my testimony. Again, thank you for this opportunity to appear before your commission. My colleagues and I will be pleased to answer any questions.



The following is a summary of the CARES Commission meeting and is not intended to be a complete transcript of the meeting. The information in this summary is believed, but not guaranteed, to be accurate. All information will be verified prior to issuance of the Commission's report.

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Full Commission Meeting
October 14, 15 and 16, 2003
Washington, D.C.

Review of Draft National Plan

Commissioners in Attendance:

The Honorable Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard, MD
Chad Colley
Vernice Ferguson, RN, M.A.
John Kendall, MD
Richard McCormick, PhD
Layton McCurdy, MD
Richard Pell, Jr.
Robert A. Ray
The Honorable Raymond John Vogel, Vice Chairman
The Honorable Jo Ann Webb, RN
Michael K. Wyrick, Major General, USAF (Ret.)
Al Zamberlan

ADMINISTRATIVE and PREPARATORY SESSION

October 14, 2003

Chairman Alvarez opened the meeting at 8:00 A.M. He announced the Commission's schedule for completing the remaining hearings. Next week he and Commissioner McCurdy will hold a hearing in Cheyenne, Wyoming and Commissioner Battaglia will lead hearings in Canandaigua, New York and Montrose, New York. He also indicated that the individual who was going to brief the Commission on the VISN 12 experience is unable to come to the meeting this week, but will be invited to next month's meeting.

Chairman Alvarez reported on his meeting with Secretary Principi last week when he and other Commissioners brought the Secretary up to date on where things stand with the Commission's review of the Draft National CARES plan. The Chairman said the Secretary accepts the reality of how things were looking. The Chairman also informed the Secretary that the Commission may not have its full report by the target date.



In the *small facilities* category, the Draft National Plan proposes to continue operations at Poplar Bluff as a critical access hospital (CAH). Poplar Bluff is authorized 40 beds but is operating only 18. The occupancy rate of those beds is 80 percent, with 95 percent of the long-term care beds occupied. Poplar Bluff is an old facility that treats about 55 patients. It appears to be a matter of time before the facility will go away. In the meantime, there is a problem with contracting out to the community because the local hospital is experiencing difficulty. The briefing Commissioner believes that the CAH designation is appropriate for Poplar Bluff but the Commission should look at the proposal the same as the others.

Special Disabilities

The VISN 15 Director is proposing to move acute spinal cord injury beds downtown. This move came as a surprise to stakeholders. In response to a question about stakeholder reactions, the Paralyzed Veterans Association indicated it is adamantly opposed to moving the SCI beds.

Other VISN 15 Proposals

There is a substantial and growing collaboration between VA and DoD at Fort Leavenworth with great potential for this collaboration to expand in the future.

The VISN also requested three new CBOCs in the East Market that seem justified but were not included on the tier one list.

VISN 16 – Oklahoma, Mississippi, Louisiana, Arkansas

Presentation of Data and Issues

VISN 16 has four markets and seven hospitals.

Gulfport-Biloxi Discussion and Sense of the Commission

The biggest issue is the campus realignment at Gulfport-Biloxi; the proposal is to vacate Gulfport by 2009. The target market is the Florida Panhandle. The VISN is trying to collaborate with Florida to improve service to this market. The Plan also proposes to increase collaboration on inpatient surgery with Keesler Air Force Base.

One Commissioner said the next base realignment and closing (BRAC) may affect Keesler. The base commander at Keesler is concerned about BRAC and thinks that if he can hook up with VA, Keesler might not be on the BRAC list. A Commissioner commented that TRICARE is actually drawing patients away from the Keesler facility. Another Commissioner said he did not get the impression that the collaboration discussions between VA and Keesler were headed in a 'go' direction.

The VISN had said Keesler had the capacity to absorb the excess workload, but the base commander said Keesler had no capacity. If the VA wants to share the Keesler facility, the Commander said it would have to build there. One Commissioner noted that his understanding was that Keesler has the beds but not the staff to accommodate the additional workload. Another Commissioner agreed, observing that Keesler has over 200 beds – plenty of space but no staff.

A Commissioner commented that the Gulfport-Biloxi realignment proposal is very well documented.

The Chairman said the Commission would defer its recommendation on the proposed realignment pending the receipt of additional data.

Discussion of Muskogee Proposal

The briefing Commissioner introduced a discussion of the Muskogee small facility proposal. The Draft National Plan calls for Muskogee to keep its inpatient program but study its other programs. The Commissioner said the biggest potential population at Muskogee comes from Oklahoma City and the VISN would like them to go there for care instead of to Tulsa.

One Commissioner said he agrees with the idea, but indicated it will be a challenge. A second Commissioner said the cost of the proposal, \$543 million, is too high. Another Commissioner said the facility at Muskogee is a relatively new building, two floors of which have never had a patient. He said the VISN has not tried to attract new patients.

Asked if the VA could seek collaboration with the Indian Health Service in Muskogee under which the Service would buy services from VA, the reply was that it would be a good idea but that there would likely be bureaucratic problems.

One Commissioner suggested the best solution might be to expand Oklahoma City and phase out Muskogee. It was suggested that the Commission will want to mention that Muskogee should not stay open in the long term. It was suggested that the recommendation be worded differently: i.e., "there is such a large veteran population in Tulsa that VA should consider increasing capacity in that market area."

In the area of *outpatient care*, the VISN is scheduled to receive 11 of the 48 high priority new CBOCs. Only two of the CBOCs are actually new; the VISN would be expanding others. The VISN claims the new CBOCs would provide access to 31,000 new enrollees but this does not meet the standard of 7,000-enrollee per CBOC.

With regard to *special disabilities*, the Draft National Plan proposes to build a new 20-bed Blind Rehabilitation unit at Biloxi. The briefing Commissioner observed that this unit might be more appropriately located in Gulfport, saying he is not sure about space availability in Biloxi. Another Commissioner indicated that there is room at Biloxi. The Commission agreed to recommend the establishment of a new Blind Rehabilitation Unit at Biloxi provide that space is available.

One Commissioner suggested that the Commission's report should also note that there is a documented need for outpatient mental health services in several markets in this VISN. There is only four percent access in the Southern Market now.

The Commission also agreed to strongly recommend the need for improved inter-VISN cooperation between VISN 16 and VISN 8. This would address the need for better access to care in the Florida Panhandle.

The following is a summary of the CARES Commission meeting and is not intended to be a complete transcript of the meeting. The information in this summary is believed, but not guaranteed, to be accurate. All information will be verified before it is used in the Commission's report.

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Full Commission Meeting
November 19, 20 and 21, 2003
Washington, D.C.

Decisions on Draft National Plan and Commission Report

Commissioners in Attendance:

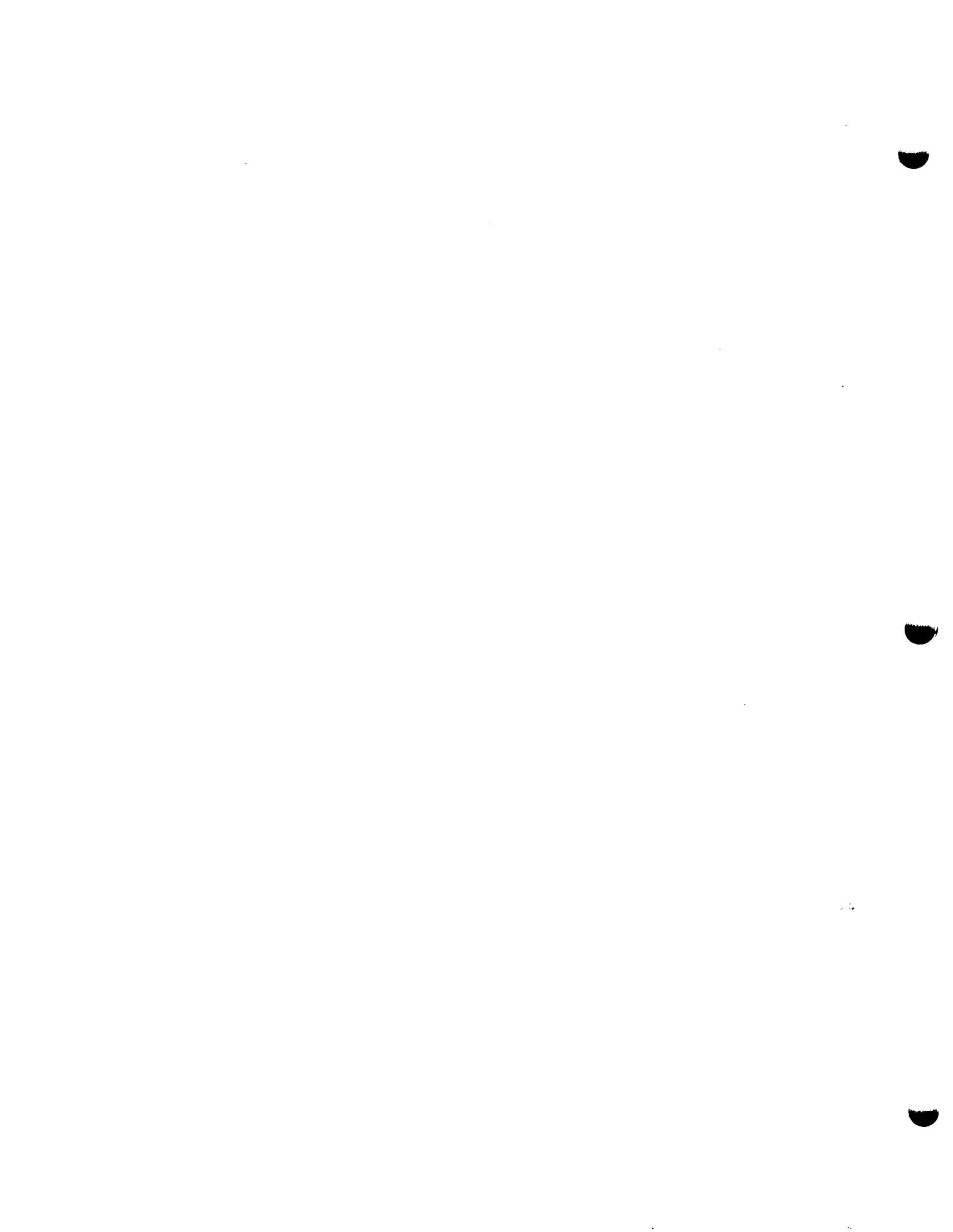
The Honorable Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard, MD
Raymond Boland
Chad Colley
Vernice Ferguson, RN, M.A.
John Kendall, MD
Richard McCormick, PhD
Layton McCurdy, MD
Richard Pell, Jr.
Robert A. Ray
Sister Patricia Vandenberg, CSC
The Honorable Raymond John Vogel, Vice Chairman
The Honorable Jo Ann Webb, RN
Michael K. Wyrick, Major General, USAF (Ret.)
Al Zamberlan

Wednesday, November 19 2003

ADMINISTRATIVE and PREPARATORY SESSION

Vice Chairman Vogel opened the meeting at 8:00 A.M. He indicated that the Commission would be spending most of the day on crosscutting issues, including proposed realignments and consolidations. Since the last meeting, the Commission has received a lot of data. Staff will be going over that data with the Commissioners. He noted, however, that the data doesn't provide the Commission with a full understanding for how empty facilities really are now. He said the demographic figures don't always back up the VISN plans and the things the Commission heard during the hearings. He noted that there may be information available that would be helpful to the Commission that isn't purely factual.

The Executive Director indicated that the Commission still has a lot of work to do. Staff prepared a draft report based on what the Commission said at its last meeting about



Commission Discussion of Issue

A Commissioner said this proposal came up during the course of Commission hearings. He said St. Louis is an undesirable location and environment for an SCI Center.

When asked why the Commission was proposing to address the issue if it is not included in the Draft National Plan, the first Commissioner replied that the proposal was included in the original Network plan. It is “out there” and will have a life of its own. Additionally, the Draft National Plan mentions that there will be “some shifting of care between facilities.” He believes the Commission should comment on the proposal because it is ill advised. He offered to provide substitute language to use in redrafting the recommendation.

Commission Decision

The Commission agreed that its report will explicitly state that it does not concur with proposed changes involving an SCI Center at St. Louis and, as discussed, to redraft the language in the recommendation.

Issue: Outpatient care

Alternatives: Not discussed.

Draft National Plan Recommendation: This VISN has no new CBOCs on the VA proposed priority list. Outpatient specialty care will be met through expansion of in-house services.

Commission Recommendation: Use the standard Commission recommendation for CBOCs (Recommendations Five and Six)

Commission Decision

The Commission made no substantive changes to the draft recommendation. Proposals will be handled in accordance with the Commission’s standard recommendation for CBOCs.

Consideration of VISN 16

Issue: Consolidation/realignment – Gulfport, MS

Alternatives:

1. Status Quo
2. Dispose of the property and/or seek an enhanced use lease
3. Obtain a sharing agreement with Keesler Air Force Base; transfer services to Keesler or Biloxi; close Gulfport; evaluate enhanced use lease potential.

Draft National Plan Recommendation: Alternative 3. Transfer current services from Gulfport to Biloxi or Keesler; close Gulfport; evaluate enhanced use lease potential.

Commission Recommendation: Concur with relocating services and closing Gulfport. Concur with proposed collaboration with Keesler AFB. Concur with evaluating enhanced use lease potential. (Recommendations one, two and part of three).

Commission Discussion of Issue

One Commissioner said the Director of the Medical Center told the Commission that this is the right thing to do in terms of providing veterans with the medical care they need. He said the current wording of the recommendation in the report needs to be changed to make it clear that the Commission is concurring with relocating the services, not just closing the facility.

He said Gulfport is a good example of the difficulty of VA-DoD collaboration. It is difficult to get any commitment from DoD regarding the number of beds DoD will provide at Keesler. The Commissioner noted that there is a problem with access to the base but that it could easily be solved with a small road.

He said the local commander is interested in protecting Keesler from what might happen in the next BRAC (base realignment and closing) process. Under BRAC, other federal agencies would have first choice on acquiring facilities. Consequently, it is possible that VA could just take over the hospital at Keesler if BRAC proposes to close it.

The Commissioner said the Keesler base hospital is a tremendous capital asset. VA will need to have access to it in order to accomplish the proposed transfer of services from Gulfport to Biloxi. He is afraid that the current situation might inhibit the process. He was not satisfied with the progress of the discussions to date. Both sides need to resolve their issues and move ahead.

Commission Decision

No substantive changes were made to the draft report recommendation, but revised wording will be used as noted above.

Issue: Small facilities – Muskogee, OK

Alternatives: Not available.

Draft National Plan Recommendation: Maintain the inpatient program; evaluate ICU bed needs and review the surgical program for scope of practice.

Commission Recommendation: The Commission does not concur with maintaining inpatient services at Muskogee. The Commission recommends that VA construct a new facility in Tulsa, OK, then close Muskogee. (Recommendations number four and five).

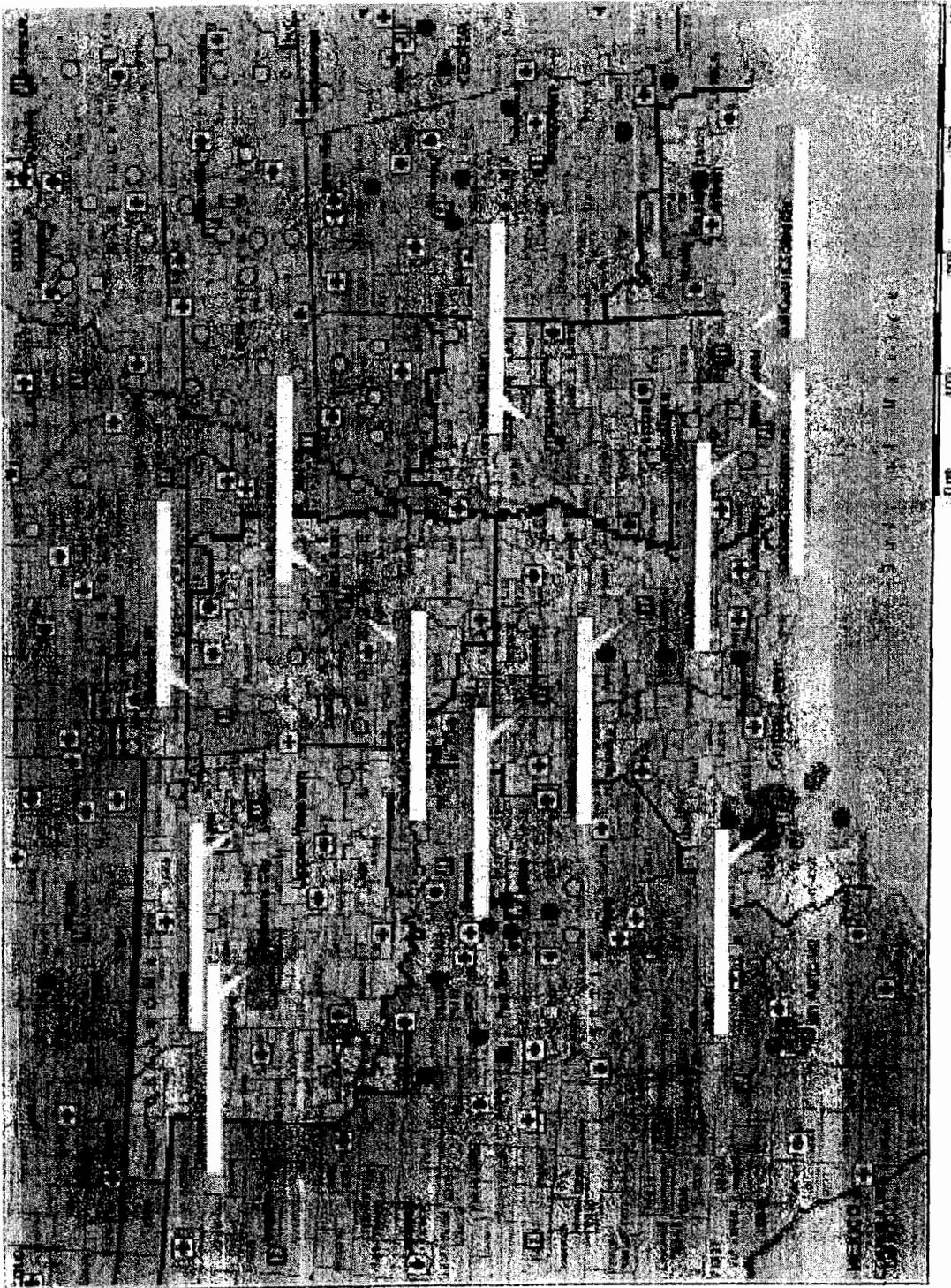
Commission Discussion of Issue

One Commissioner objected that he had never heard of anyone recommending to build a hospital in Tulsa. He asked where the recommendation came from. A second Commissioner said the earlier discussions had identified Tulsa as a key market. The first Commissioner said the problem is that Muskogee has not developed the programs that would attract the Tulsa market. The facility at Muskogee is in good repair. He believes VA should make a much better effort to utilize what is has in Muskogee. It is not appropriate to recommend a new hospital in Tulsa until VA makes an effort to utilize Muskogee.

It was noted that the Commission was unable to get information and answers to questions from Muskogee.

One Commissioner said he does not want to see veterans tied to a particular facility. He does not believe VA should try to entice people to use Muskogee. Another Commissioner said it is difficult to recruit specialists in Muskogee now, but it wouldn't be if the facility had enough

WISN 15 - South Central VA Health Care Network



- New EDIC's
- Priority 1
- Priority 2
- Priority 3
- 2013 ESTIMATED
- Population by County
- 75,000 to 100,000
- 100,000 to 150,000
- 150,000 to 200,000
- 200,000 to 250,000
- 250,000 to 300,000
- 300,000 to 350,000
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VISN 16, South Central VA Health Care Network

VISN Overview

VISN 16, South Central VA Health Care Network, is an integrated, comprehensive health care system that provided health care services to 382,000 of the 574,000 veterans enrolled in VA's health care system in FY 2003.³³⁸ Geographically, this VISN spans nearly 170,000 square miles.

With a VA staff of 14,869 FTEs,³³⁹ VISN 16 delivers health care services through ten medical centers, 30 CBOCs, seven nursing homes, and two domiciliary units. Additionally, VA operates 11 Vet Centers in VISN 16's catchment area. The VISN includes all or part of Florida, Alabama, Mississippi, Louisiana, Arkansas, Missouri, Oklahoma, and Texas.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for the veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify levels of need for services in VISN 16.

| VISN 16 | FY 2001 | FY 2012 | FY 2022 |
|--------------------|-----------|-----------|-----------|
| Enrollees | 382,000 | 543,624 | 510,867 |
| Veteran Population | 1,977,280 | 1,670,716 | 1,459,861 |
| Market Penetration | 19.35% | 32.54% | 34.99% |

For the CARES process, VISN 16 was divided into four markets: Central Lower Market (*facilities*: Houston, TX, and Alexandria and Shreveport, LA); Central Southern Market (*facilities*: New Orleans, LA, and Jackson, Gulfport, and Biloxi, MS); Upper Western Market (*facilities*: Oklahoma City and Muskogee, OK, and Fayetteville, Little Rock, and North Little Rock, AR); Eastern Southern Market (*facilities*: none).

³³⁸ VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.

³³⁹ VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The CARES Commission visited five sites and conducted three public hearings in VISN 16.

The Commission received 3,090 comments regarding VISN 16.

- ▶ *Site Visits:* Biloxi and Gulfport on July 2; Muskogee on July 22; and Little Rock and North Little Rock on September 3.
- ▶ *Hearings:* Muskogee on August 22; Biloxi on August 26; and Shreveport on August 27.

Summary of CARES Commission Recommendations

I Consolidation/Realignment – Gulfport

- 1 The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life cycle cost analysis for the Gulfport campus.
- 2 The Commission recommends that there be a clear commitment from DoD for the utilization of Keesler Air Force Base (AFB) as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing health services.
- 3 The Commission concurs with the DNCP proposal to develop enhanced use lease (EUL) opportunities at Gulfport.
- 4 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-237)

II Small Facility – Muskogee

- 1 The Commission concurs with the DNCP proposal to maintain the inpatient medicine program at Muskogee. The Commission recommends that a more thorough study be conducted of meeting health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. A target date should be set for completion of this study. In the short term, inpatient medical services should be sustained. A decision to expand inpatient psychiatry should consider results of the study.

- 2 The Commission concurs with the DNCP proposal to close inpatient surgery and ICU beds at Muskogee and that ambulatory surgery should continue with surgery observation beds available.

(see page 5-240)

III Inpatient Care and VA/DoD Sharing

- 1 The Commission concurs with the DNCP proposal regarding VA/DoD sharing in the Eastern Southern Market with Pensacola Naval Hospital and Eglin AFB to provide inpatient services.
- 2 The Commission recommends contracting in the community to ensure essential inpatient care in the underserved Eastern Southern Market.
- 3 The Commission recommends that:
 - a Before taking action to alter existing VA services, VA must ensure there are viable alternatives in the community.
 - b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as having the availability of trained staff to negotiate cost-effective contracts.
- 4 The Commission recommends that VA direct inter-VISN coordination and action to address the demand for inpatient care from veterans in the Florida Panhandle.

(see page 5-243)

IV Outpatient Care

- 1 The Commission concurs with the DNCP proposals to add CBOCs in VISN 16 to resolve access to primary care gaps as well as gaps in capacity to meet demand for outpatient services.
- 2 The Commission recommends that:³⁴⁰
 - a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
 - b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
 - c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

³⁴⁰ Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

- d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
- e Whenever feasible, CBOCs provide basic mental health services.
- f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-245)

V Special Disability Programs – Blind Rehabilitation Center

- 1 The Commission concurs with the DNCP proposal to establish a blind rehabilitation center (BRC) in Biloxi. The Commission recommends further analysis to determine the size of the center.

(see page 5-248)

VI Special Disability Programs – Spinal Cord Injury Center

- 1 The Commission concurs with the DNCP proposal to establish a 30-bed Spinal Cord Injury (SCI) Center in VISN 16, but does not concur with locating it at North Little Rock.
- 2 The Commission recommends that VA further study where an SCI Center should be located, taking into consideration referral patterns and excess capacity at the closest SCI Centers.

(see page 5-249)

VII Excess VA Property

- 1 The Commission concurs with the DNCP proposal for an EUL cooperative arrangement to construct a high-rise medical arts building at the Houston VAMC.
- 2 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

(see page 5-250)

I Consolidation/Realignment – Gulfport

DNCP Proposal

“Gulfport’s current patient care services will be transferred to the Biloxi campus and possibly Keesler AFB. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility or other compatible uses to benefit veterans. Any revenues or in-kind services will remain in the VISN to invest in services for veterans.”

DNCP Alternatives

- 1 *Status quo*
- 2 *Original Market Plan:* Close Gulfport division and enter into an enhanced use leasing agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler Air Force Base.
- 3 *Alternative 1:* Close Gulfport division and enter into an EUL for the majority of the property. Construct new facilities at Biloxi to accommodate patient workload from Gulfport and Keesler AFB, and new expanded programs from the CARES planning initiatives.
- 4 *Alternative 2:* Close Gulfport and enter into an EUL agreement for the majority of the property. Enter into a sharing agreement for provision of clinical services with Keesler AFB. Additional space will be provided at Biloxi via minor and nonrecurring maintenance (NRM) construction.

Commission Analysis

The Gulfport and Biloxi VAMCs are located eight miles apart, and their services have been consolidated for more than 30 years. The DNCP would provide for additional consolidation of inpatient care by maximizing the use of vacant space at Biloxi to construct new facilities to absorb Gulfport’s inpatient workload. Further, because of the close proximity of the two campuses and the enhanced services, neither veterans, veterans’ families, nor VA employees would be negatively impacted.³⁴¹

Services at the Biloxi VAMC consist of 45 internal medicine beds (average daily census [ADC] 33), 12 surgery beds (ADC 8), a 171-bed domiciliary facility (ADC 148), 104 nursing home beds (ADC 99), and 20 intermediate care beds (ADC 18). Additionally, the Biloxi VAMC provides outpatient primary, specialty care, and mental health services.³⁴²

³⁴¹ Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.

³⁴² VSSC KLF Menu Database, *Bed Control, Occupancy Rates, and CBOC Workload and VAST Report*.

Services at the Gulfport VAMC consist of 144 inpatient psychiatry beds (ADC 67) and 56 nursing home beds (ADC 48). Outpatient primary, specialty care, and mental health services are provided as well.³⁴³

The Gulfport campus encompasses approximately 90 acres, 50 of which are desirable beachfront property. While touring the Gulfport campus in July, Commissioners learned that many buildings are of historical significance. However, they also learned that many of these historic buildings are vacant or used only for storage. The VISN's market plan includes long-term EUL agreements that would preserve these historic buildings but provide for appropriate reuse of the grounds.

Keesler AFB is likewise only a few miles from the Gulfport VAMC and actually abuts the Biloxi VAMC. Presently, VA provides inpatient psychiatric health care to Keesler's active duty military personnel with non-adjustment/stress-type mental health illnesses. During the Commission's site visit in July, Brigadier General David Young indicated that his primary goal through collaboration with VA is to support VA's infrastructure by meeting veterans' acute hospitalization, surgery, and rehabilitation needs. In return, General Young would like to engage in joint clinical research with VA as well as joint psychiatric services.

VISN leadership provided testimony that moving to a single facility will have a positive impact on patients at Gulfport. Ms. Julie Cattelier, Director of the VA Gulf Coast Veterans Health Care System, testified:

We believe that it is most critical to establish a single standard of care for our patients receiving mental health and long-term care, and that means that in the case of a medical crisis...they would receive exactly the same level of care and level of clinical support that any patient in a comprehensive health care system would receive.³⁴⁴

According to Dr. Robert Lynch, Director of VISN 16, "Veterans will not lose services. There will be more services here in the Biloxi/Gulfport area than there currently are."³⁴⁵ Stakeholders at the public hearing and site visits were generally supportive of the consolidation. The proposed timeline for implementing this closure is FY 2009.

The VISN realignment proposal contained a life cycle cost analysis with some inconsistencies, including \$44.6 million in new construction and renovation in the 100 Percent Contracting Alternative. If the costs are adjusted to correct for that error, the four alternatives to the Status quo are close in net present value.

³⁴³ VSSC KLF Menu Database, *Bed Control, Occupancy Rates, and CBOC Workload and VAST Report*.

³⁴⁴ Julie Cattelier, VA Gulf Coast Veterans Health Care System Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 31.

³⁴⁵ Robert Lynch, MD, VISN 16 Director, Transcribed Testimony from the Biloxi, MS, Hearing on August 26, 2003, page 16.

The preferred alternative would require \$60.5 million in new construction and renovation and would achieve a net present value savings of \$436.8 million. Although the net present value in excess of \$400 million is cited, the proposal states that enhanced lease revenue of \$44 million is expected and cost savings at Gulfport from reductions in staff and operating costs would save another \$48 million. Explanations for monetary savings are confusing if non-existent. A more thorough life cycle cost analysis must be completed.³⁴⁶

Commission Findings

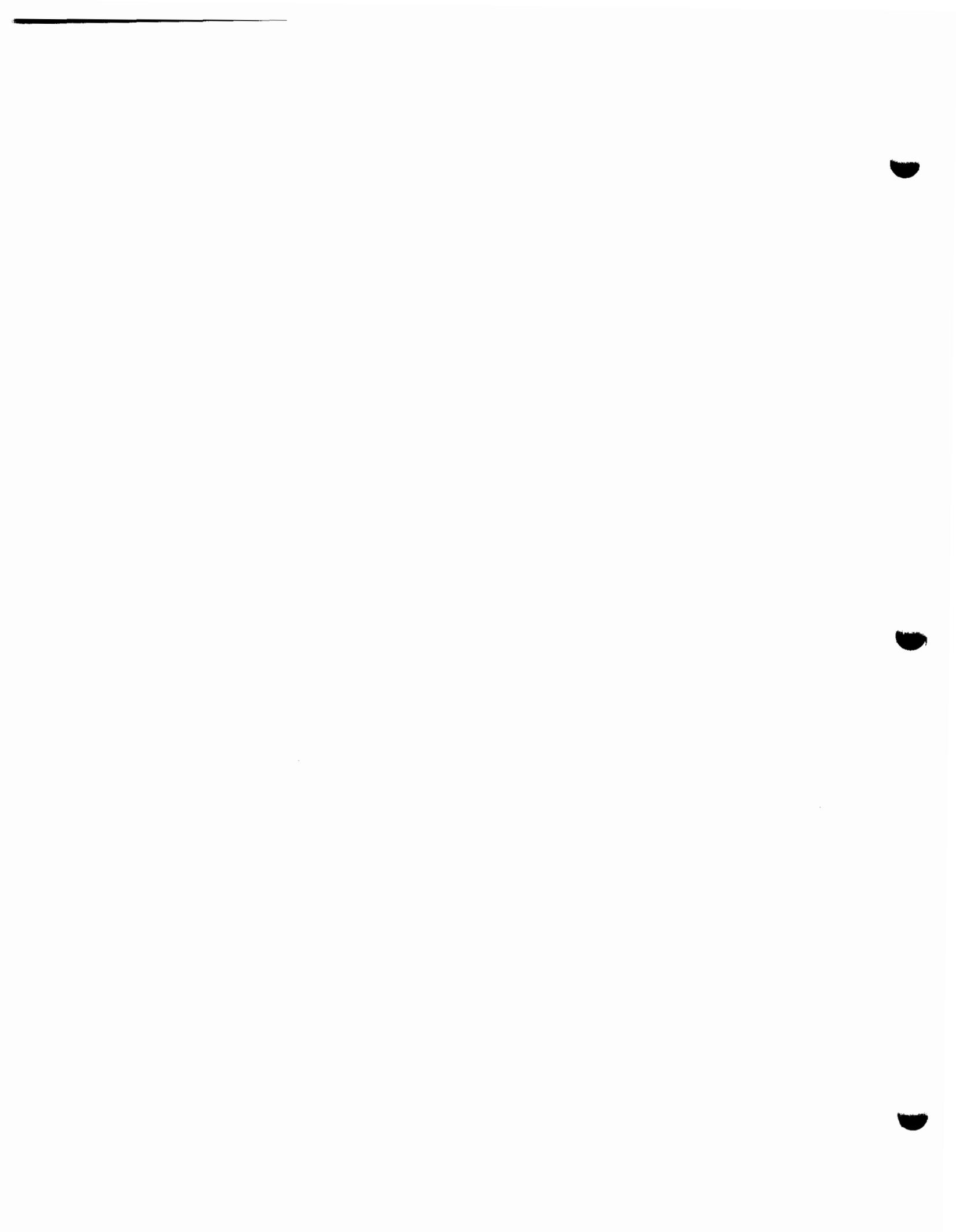
- 1 The Gulfport and Biloxi VAMCs are 8 miles apart.
- 2 The Gulfport Division has 90 acres, 50 of which are desirable beachfront.
- 3 New construction is needed for Biloxi to absorb Gulfport's workload.
- 4 The life-cycle cost analysis in the realignment proposal contains inconsistencies.
- 5 The VISN is currently in discussions with Keesler AFB to assess feasibility of entering into a sharing agreement to resolve space issues at Biloxi.
- 6 VISN leadership and stakeholders support consolidation.

Commission Recommendations

- 1 The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life-cycle cost analysis for the Gulfport campus.
- 2 The Commission recommends there be a clear commitment from DoD for the utilization of Keesler AFB as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing DoD and VA health services.
- 3 The Commission concurs with the DNCP proposal to develop EUL opportunities at Gulfport.
- 4 The Commission recommends that any study involving excess or surplus property should consider all options for divestiture, including outright sale, transfer to another public entity, and a reformed EUL process. VA should also consider using vacant space to provide supportive services to homeless veterans.

³⁴⁶ Office of Program Evaluation, Policy, Planning, and Preparedness, Department of Veterans Affairs, *Financial Review of CARES Realignment Proposals*, November 13, 2003.

| VISN | Facility | Type of Change | DNCP Proposal | CARES Commission Recommendation |
|------|------------------|--------------------|--|---|
| 15 | Leavenworth, KS | Campus Realignment | The secretary's Advisory Board was created prior to CARES to consider realignments within VISN 15. The Advisory Board developed a comprehensive plan for realignment and consolidation of services between Topeka and Leavenworth. This was approved by the DSH and incorporated into the VISN's CARES plan. It included realignments of ambulatory care, specialty and outpatient surgery. Under this plan, Leavenworth would maintain acute beds. Also, Leavenworth will provide additional primary care capacity in Kansas City, and both Leavenworth and Topeka would retain 24/7 emergency services at both campuses. | The Commission concurs with the DNCP proposal. |
| 15 | Poplar Bluff, MO | Small Facility | Maintain acute care beds. This facility currently operates as a CAH and will continue as such when VA develops its CAH criteria. | The Commission recommends that a target date be set for making a full cost-benefit analysis of sustaining inpatient services versus contracting for such services. The Commission further recommends that, based on the results of that assessment, a decision be made regarding whether or not to close inpatient services at Poplar Bluff. The Commission recommends that, regardless of the decision on inpatient services, outpatient services and long-term care remain at Poplar Bluff. The Commission does not concur with designating the facility a CAH. |
| 16 | Gulfport, MS | Campus Realignment | Current patient care services will be transferred to the Biloxi division and possibly to Keesler AFB. VA will no longer operate health care services at the Gulfport campus. Evaluate for EUL. | The Commission concurs with the DNCP proposal to transfer Gulfport's current patient care services to the Biloxi campus. The Commission, however, recommends that VA conduct a clearer and more thorough life cycle cost analysis for the Gulfport campus. The Commission recommends that there be a clear commitment from DoD for the utilization of Keesler Air Force Base (AFB) as a partner. Predicated upon such a commitment, the Commission endorses the VISN's efforts in sharing health services. |



Appendix I – Department of Defense (DoD) Collaborations

| CARES Joint VA-DoD Review Team -- Highest Priority | | | | | | | | | | | |
|--|----------------|----|----------------|-------|------|-------------------|---------------|----|-------|---------------------------|---|
| | | | | | | | | | | Collaboration Outcomes | |
| Bassett ACH | Ft. Wainwright | AK | Ft. Wainwright | 99703 | USA | VAM&ROC | Anchorage | AK | 99508 | VISN 20 | Ft. Wainwright is in Fairbanks AK and will establish Primary Care, Specialty Care and Mental Health for the patient population. |
| Dewitt ACH | Ft. Belvoir | VA | Ft. Belvoir | 22060 | USA | VAMC | Washington | DC | 20422 | VISN 5 | Army providing VA 6000 sq. ft. for primary and specialty care. |
| Reynolds ACH | Ft. Sill | OK | Ft. Sill | 73503 | USA | VAMC | Oklahoma City | OK | 73104 | VISN 16 | Location – Lawton, OK, Army providing 29 dental operatories for expansion of services and avoids NRM project at Lawton OPC. |
| Madigan AMC | Ft. Lewis | WA | Ft. Lewis | 98433 | USA | VAMC | American Lake | WA | 98493 | VISN 20 | Army providing space for inpatient medicine and ER for American Lake relocation. |
| Patterson AHC | Ft. Monmouth | NJ | Ft. Monmouth | 07703 | USA | VA New Jersey HCS | East Orange | NJ | 07018 | VISN 3 | Army is providing space for a CBOC to address primary care |
| 1st Medical Group | Langley AFB | VA | Hampton | 23665 | USAF | VAMC | Hampton | VA | 23667 | VISN 6 | Sharing agreement for pathology with a possible inpatient, ICU and Surgical capacity |

| | | | | | VA Facility | VISN | Collaboration Outcomes | |
|--------------------|---------------|----|-----------------|-------|--------------------------------------|---------------------------|------------------------|---|
| 42nd Medical Group | Maxwell AFB | AL | Montgomery | 36112 | USAF VAMC | Montgomery | AL 36109 VISN 7 | Air Force will provide space to VA for ambulatory surgery, eye, podiatry on Maxwell AFB. Maxwell AFB and VA plan to consolidate mammography contract to bid jointly. Additionally Air Force will provide a surgeon to VA Montgomery HCS.. |
| 3rd Medical Group | Elmendorf AFB | AK | Anchorage | 99506 | USAF VAM&ROC | Anchorage | AK 99508 VISN 20 | VA will build new OPC on Elmendorf AFB that will address specialty care and ancillary services in Anchorage. |
| 81st Medical Group | Keesler AFB | MS | Biloxi | 39534 | USAF VAMC | Biloxi | MS 39531 VISN 16 | Transition closure of the Gulfport Campus via Enhanced use project – addresses proximity acute medicine, psychiatry and joint venture inpatient. |
| 96th Medical Group | Eglin AFB | FL | Okaloosa County | 32542 | USAF VA Gulf Coast Healthcare System | Eastern Southern Hospital | FL 32543 VISN 16 | AF to provide contract hospital for inpatient medicine and surgery. Air Force will provide land for VA to build new CBOC. |

| Priority | | | | | | VA Facility | | | | VISN | Collaboration Outcomes |
|-------------------------------------|--------------|----|--------------|-------|---------|-----------------------------------|---------------------------|----|-------|--------|---|
| Michael O'Callahan Federal Hospital | Nellis AFB | NV | Las Vegas | 89191 | USAF | Southern Nevada Healthcare System | Las Vegas | NV | 89106 | 22 | AF to provide ER, Psychiatry and ICU project. VA requests land to build 120 bed Nursing Home Care Unit on the Nellis site. New OPC site to be determined & new hospital |
| NH Charleston | Charleston | SC | Charleston | 29405 | USN | VAMC | Charleston | SC | 29402 | VISN 7 | Navy project in FY 06 for new ambulatory care center. VA declined relocation of existing CBOC. Navy requesting reconsideration for participation in their \$40 million dollar cooperative agreement between VA and DoD. |
| NH Pensacola | Pensacola | FL | Pensacola | 32512 | USN | VA Gulf Coast Healthcare System | Eastern Southern Hospital | FL | 32543 | 16 | VA requests land to build replacement Pensacola OPC. Navy to provide contract hospitalization for medicine and surgical care. |
| AHC Ft. Buchanan | Ft. Buchanan | PR | Ft. Buchanan | 00934 | USN/USA | VAMC | San Juan | PR | | VISN 8 | US Army South vacating Buchanan in FY 05. Plans are in place to possibly reduce the strength of the area. Admiral has requested the VA look at relocation of services to that facility. |

| | | | | VA Facility | | | | VISN | | Collaboration Outcomes | |
|---------------------------|------------------|----|-------------|-------------|-----|------------------------------|---------------|------|-------|------------------------|---|
| NH Roosevelt Roads | Ceiba | PR | Ceiba | 34091 | USN | VAMC | San Juan | PR | | VISN 8 | Plans are in place to possibly reduce the strength of the Navy area. Admiral has requested the VA look at relocation of services to that facility. |
| Naval Healthcare Facility | Marianas Islands | | Guam | | USN | VAM&ROC | Honolulu | HI | 96819 | VISN 21 | New Navy hospital to provide VA with primary care and specialty care with an inpatient component. |
| NMC Portsmouth | Portsmouth | VA | Portsmouth | 23708 | USN | VAMC | Hampton | VA | 23667 | VISN 6 | Navy to provide Hyperbaric Chamber services to VA. Clarify current VA surgical referrals to Portsmouth and please refer to Langley that is interwoven into this agreement. Should be discussion for local facilities. |
| NACC Great Lakes | Great Lakes | IL | Great Lakes | 60088 | USN | VAMC | North Chicago | IL | 60088 | VISN 12 | Footnote - high priority included in the VISN 12 CARES pilot. |
| William Beaumont AMC | Ft. Bliss | TX | Ft. Bliss | 79920 | USA | VA El Paso Healthcare System | El Paso | TX | 79930 | VISN 18 | Sharing opportunities across the board. Increase sharing would be critical to solving access issues for the Market. |

| | | | | | | VA Facility | | | | VISN | Collaboration Outcomes |
|-------------------------|-------------|----|----------------|-------|------|-------------|------------|----|-------|---------|---|
| 460 MDS- Buckley AFB | Buckley AFB | CO | Buckley AFB | 80011 | USAF | VAMC | Denver | CO | 80220 | VISN 19 | I-25 Initiatives Possibility of new AF and VA clinic to relocate at Fitzsimons and will eliminate the need leased AF clinic in the area. Combined clinic in a new replacement hospital. |
| NH Beaufort | Beaufort | SC | Beaufort | 29902 | USN | VAMC | Charleston | SC | 29401 | VISN 7 | Navy now willing to wave upfront costs if VA would reconsider joining them in the Beaufort project. VISN 7 to reconsider the joint opportunity |

CARES Joint VA-DoD Review Team -- Near Term Further Development

| | | | | | | | | | | VISN | Collaboration Outcomes |
|----------------------------------|-------------|----|-------------|-------|----------|------|-------------|----|-------|---------|---|
| Kimbrough Ambulatory Care Center | Ft. Meade | MD | Ft. Meade | 20755 | USA | VAMC | Baltimore | MD | 21201 | VISN 5 | Possibility of Army incorporating a CBOC in FY 07 Project for VA. |
| Evans ACH | Ft. Carson | CO | Ft. Carson | 80913 | USA | VAMC | Denver | CO | 80220 | VISN 19 | (I 25) Initiative Army to provide VA Inpatient, outpatient and specialty care. Relocate CBOC from leased space to space at Ft. Carson. |
| Camp Bullis | Camp Bullis | TX | San Antonio | 78235 | USA/USAF | VAMC | San Antonio | TX | 78284 | VISN 17 | CBOC proposed Joint Venture -- Fairly significant planning efforts occurred Army/USAF. May result in the VA collocating with the Army clinic in a project scheduled in FY 07. |
| Tuttle AHC | Hunter AB | GA | Hunter AB | 31409 | USA | VAMC | Charleston | SC | 29402 | VISN 7 | Army to provide VA with space for relocating Savannah Clinic which lease runs out in FY 06 to the former Tuttle Hospital or at space available at the new Army Tuttle Hospital. |

| | | | | | | | | | | Branch | | | | Collaboration Outcomes |
|--------------------|----------------------|----|----------------|-------|------|---|-------------|----|-------|---------|--|--|--|---------------------------|
| | | | | | | | | | | State | | | | VISN |
| 78th Medical Group | Robins AFB | GA | Macon | 31098 | USAF | VAMC | Dublin | GA | 31021 | VISN 7 | Dublin may provide mental health, substance abuse treatment & surgery services to active duty airmen; and RAFB may provide Optometry services to veterans. | | | |
| 74th Medical Group | Wright-Patterson AFB | OH | Dayton | 45433 | USAF | VAMC | Dayton | OH | 45428 | VISN 10 | Ongoing Initiatives | | | |
| 6th Medical Group | MacDill AFB | FL | Tampa | 33621 | USAF | VAMC | Tampa | FL | 33612 | VISN 8 | Joint clinic possibilities with Bay Pines and other opportunities with Tampa FL. | | | |
| 60th Medical Group | Travis AFB | CA | Fairfield | 94535 | USAF | VAMC | Sacramento | CA | 94304 | VISN 21 | Ongoing Initiatives | | | |
| NH Jacksonville | Jacksonville | FL | Jacksonville | 32214 | USN | North Georgia HCS | Gainesville | FL | 32608 | VISN 8 | Navy to provide VA with Inpatient care that will improve access. | | | |
| BMC Fort Worth | Dallas | TX | Dallas | 75211 | USN | VAMC | Dallas | TX | 75216 | VISN 17 | Navy to provide space VA CBOC | | | |
| NH Corpus Christi | NHCorpus Christi-HCS | TX | Corpus Christi | | USN | South Texas Veterans Health Care System | San Antonio | TX | 78284 | VISN 17 | The NH Corpus Christi and the STVHCS have several initiatives to provide Primary Care and Specialty Care Services to Veterans in the Corpus Christi area. | | | |
| NH Bremerton | Bremerton | WA | Bremerton | 98312 | USN | VAMC | Seattle | WA | 98108 | VISN 20 | Acute Inpatient Medicine, ER and ancillary services in support of the CBOC in Bremerton. Future options for urology. | | | |

CARES Joint VA-DoD Review Team -- Future Development

| | | | | | VA Facility | | | VISN | Collaboration Outcomes | | |
|----------------------|----------------------|----|----------------------|-------|-------------|---------------------------------|---------------------------|------|------------------------|---------|---|
| NH Twenty nine Palms | NH Twenty nine Palms | CA | NH Twenty nine Palms | 92278 | USN | VAMC | Loma Linda | CA | 92357 | VISN 22 | Navy to provide primary care at this facility. |
| 325th Medical Group | Tyndall AFB | FL | Panama City | 32403 | USAF | VA Gulf Coast Healthcare System | Eastern Southern Hospital | FL | 32542 | VISN 16 | Only expansion for Panama City currently located on the NAS. |
| 56th Medical Group | Luke AFB | AZ | Phoenix | 85309 | USAF | VAMC | Phoenix | AZ | 85012 | VISN 18 | AF and VA exploring exchange use possibilities for primary care services. |
| Darnall ACH | Ft. Hood | TX | Ft. Hood | 76544 | USA | VAMC | Temple | TX | 76504 | VISN 17 | Pending outcome of Army medical master plan FY 03 |
| NH Camp Pendleton | Camp Pendleton | CA | Camp Pendleton | 92055 | USN | VA San Diego HCS | San Diego | CA | 92161 | VISN 22 | Navy is constructing a new hospital at Balboa and 3000 sq. ft. feet is reserved for VA to establish a CBOC. |
| NH Lemoore | Lemoore | CA | Lemoore | 93245 | USN | VAMC | Fresno | CA | 93703 | VISN 21 | Exchange use possibilities between the Navy and VA. |
| 375th Medical Group | Scott AFB | IL | Belleville | 62225 | USAF | VAMC | St. Louis | MO | 63106 | VISN 15 | Joint Facility in FY 10 anticipated to resolve specialty care issues. |
| Bayne-Jones ACH | Ft. Polk | LA | Ft. Polk | 71459 | USA | VAMC | Alexandria | LA | 71306 | VISN 16 | Army requests VA to consider Inpatient Psychiatry services initially. |
| 72nd Medical Group | Tinker AFB | OK | Oklahoma City | 73145 | USAF | VAMC | Oklahoma City | OK | 73104 | VISN 16 | Tinker plans on building replacement clinic in near future. |

CARES Joint VA-DoD Review Team -- Good Ideas

| | | | | | | | | | | VISN | Collaboration Outcomes |
|---------------------------------|-----------------|----|-----------------|-------|------|------|-------------|----|-------|---------|---|
| 311th Medical Squadron | Brooks AFB | TX | San Antonio | 78235 | USAF | VAMC | San Antonio | TX | | VISN 17 | These clusters of VA/DoD facilities represent a high potential for future explorations of collaborative agreements. |
| 12th Medical Group | Randolph AFB | TX | San Antonio | 78150 | USAF | | | | | | |
| 59th Medical Wing | Lackland AFB | TX | San Antonio | 78236 | USAF | | | | | | |
| Brooke AMC | Ft. Sam Houston | TX | Ft. Sam Houston | 78234 | USA | | | | | | |
| Walter Reed Army Medical Center | Washington DC | DC | Washington | 20307 | USA | VAMC | Washington | DC | 20422 | 5 | These clusters of VA/DoD facilities represent a high potential for future explorations of collaborative agreements. |
| 89th Medical Group | Andrews AFB | MD | Andrews AFB | 20762 | AFB | | | | | 5 | These clusters of VA/DoD facilities represent a high potential for future explorations of collaborative agreements. |
| NNMC Bethesda | Bethesda | MD | Bethesda | 20889 | USAF | VAMC | Baltimore | MD | 21201 | 5 | These clusters of VA/DoD facilities represent a high potential for future explorations of collaborative agreements. |
| Eisenhower AMC | Ft. Gordon | GA | Ft. Gordon | 30905 | USA | VAMC | Augusta | GA | 30901 | 7 | These clusters of VA/DoD facilities represent a high potential for future explorations of collaborative agreements. |

| Service | Facility Type | Facility Name | Location | State | City | ZIP | System | City | State | ZIP | VISN | Narrative |
|--------------|---------------|---------------------------|--------------------|-------|--------------------|-------|---------------------------------|---------------------------|-------|-------|---------|-----------|
| US Army | CLINIC | AHC FT. MCPHERSON | FT. MCPHERSON | GA | ATLANTA | 30330 | VAMC | Atlanta | GA | 30330 | VISN 7 | |
| US Army | HOSP | IRELAND ACH | FT. KNOX | KY | FT. KNOX | 40121 | VAMC | Louisville | KY | 40206 | VISN 9 | |
| US Army | HOSP | BLANCHFIELD ACH | FT. CAMPBELL | KY | FT. CAMPBELL | 42223 | VA Middle Tennessee HCS | Nashville | TN | 37212 | VISN 9 | |
| US Navy | CLINIC | BMC NSA MID-SOUTH | MILLINGTON | TN | MILLINGTON | 38054 | VAMC | Memphis | TN | 38104 | VISN 9 | |
| US Army | HOSP | IRWIN ACH | FT. RILEY | KS | FT. RILEY | 66442 | VAMC | Topeka | KS | 66622 | VISN 15 | |
| US Army | CLINIC | MUNSON ARMY HEALTH CENTER | FT. LEAVENWORTH | KS | FT. LEAVENWORTH | 66027 | VAMC | Leavenworth | KS | 66048 | VISN 15 | |
| US Air Force | CLINIC | 325th MEDICAL GROUP | TYNDALL AFB | FL | PANAMA CITY | 32403 | VA Gulf Coast Healthcare System | Eastern Southern Hospital | FL | 32543 | VISN 16 | |
| US Army | CLINIC | PINE BLUFF ARSENAL AHC | PINE BLUFF ARSENAL | AR | PINE BLUFF ARSENAL | 71601 | VA Central Arkansas HCS | Little Rock | AR | 72114 | VISN 16 | |
| US Air Force | CLINIC | 90th MEDICAL GROUP | F.E. WARREN AFB | WY | CHEYENNE | 82005 | VAMC | Cheyenne | WY | 82001 | VISN 19 | |
| US Air Force | CLINIC | 341st MEDICAL GROUP | MALMSTROM AFB | MT | GREAT FALLS | 59402 | VA Montana HCS | Ft. Harrison | MT | 59636 | VISN 19 | |
| US Air Force | HOSP | 366th MEDICAL GROUP | MOUNTAIN HOME AFB | ID | MOUNTAIN HOME | 83648 | VAMC | Boise | ID | 83702 | VISN 20 | |

| Branch of Service | Facility Category | Facility Name | Facility Name | State | City | Zip | VA Facility | VA Facility | VA Facility | VA Facility | VISN | Narrative |
|-------------------|-------------------|----------------------------------|--|-------|------------|-------|----------------------------|------------------|-------------|-------------|---------|--|
| US Navy | HOSP | NH OAK HARBOR | OAK HARBOR | WA | OAK HARBOR | 98278 | VA Puget Sound HCS | Seattle | WA | 98108 | VISN 20 | |
| US Army | HQ | HQ CALIFORNIA MEDICAL DETACHMENT | DEFENSE LANGUAGE INSTITUTE/NAVY POST GRADUATE SCHOOL | CA | SEASIDE | 93944 | Palo Alto HCS | Palo Alto | CA | 94304 | VISN 21 | Continue w/local development for JV outpatient clinic @ Monterey to provide primary & specialty care services to veterans & specialty care to DoD active duty & Tricare beneficiaries. |
| US Army | HOSP | Tripler AMC, Ft. Shafter | TRIPLER AMC | HI | HONOLULU | 96819 | VAM&ROC | Honolulu | HI | 96819 | VISN 21 | Continue w/JV to enhance access to tertiary/acute & specialty services. |
| US Air Force | CLINIC | 30th MEDICAL GROUP | VANDENBERG AFB | CA | LOMPOC | 93437 | VA Greater Los Angeles HCS | West Los Angeles | CA | 90073 | VISN 22 | |
| US Navy | HOSP | NMC SAN DIEGO | SAN DIEGO | CA | SAN DIEGO | 92134 | VA San Diego HCS | San Diego | CA | 92161 | VISN 22 | |

PERSPECTIVE

NOTES OF A SURGEON

Casualties of War — Military Care for the Wounded from Iraq and Afghanistan

Atul Gawande, M.D., M.P.H.

Each Tuesday, the U.S. Department of Defense provides an online update of American military casualties (the number of wounded or dead) from Operation Iraqi Freedom and Operation Enduring Freedom.¹ According to this update, as of November 16, 2004, a total of 10,726 service members had suffered war injuries. Of these, 1361 died, 1004 of them killed in action; 5174 were wounded in action and could not return to duty; and 4191 were less severely wounded and returned to duty within 72 hours. No reliable estimates of the number of Iraqis, Afghans, or American civilians injured are available. Nonetheless, these figures represent, by a considerable margin, the largest burden of casualties our military medical personnel have had to cope with since the Vietnam War.

When U.S. combat deaths in Iraq reached the 1000 mark in September, the event captured worldwide attention. Combat deaths are seen as a measure of the magnitude and dangerousness of war, just as murder rates are seen as a measure of the magnitude and dangerousness of violence in our communities. Both, however, are weak proxies. Little recognized is how fundamentally important the medical system is — and not just the enemy's weaponry — in determining whether or not someone dies. U.S. homicide rates, for example, have dropped in recent years to levels unseen since the mid-1960s. Yet aggravated assaults, particularly with firearms, have more than tripled during that period.² The difference appears to be our trauma care system: mortality from gun assaults has fallen from 16 percent in 1964 to 5 percent today.

We have seen a similar evolution in war. Though firepower has increased, lethality has decreased.

In World War II, 30 percent of the Americans injured in combat died.³ In Vietnam, the proportion dropped to 24 percent. In the war in Iraq and Afghanistan, about 10 percent of those injured have died. At least as many U.S. soldiers have been injured in combat in this war as in the Revolutionary War, the War of 1812, or the first five years of the Vietnam conflict, from 1961 through 1965 (see table). This can no longer be described as a small or contained conflict. But a far larger proportion of soldiers are surviving their injuries.



It is too early to make a definitive pronouncement that medical care is responsible for this difference. With the war ongoing and still intense, data on the severity of injuries, the care provided, and the outcomes are necessarily fragmentary. But from the data made available for this report and discussions with surgical teams that have returned home, a suggestive picture has emerged. It depicts a military medical system that has made fundamental — and apparently effective — changes in the strategies and systems of battle care, even since the Persian Gulf War.

One key constraint for planners has been the limited number of medical personnel available in a voluntary force to support the 130,000 to 150,000 troops fighting in Iraq. The Army is estimated to have only 120 general surgeons on active duty and a similar number in the reserves. It has therefore sought to keep no more than 30 to 50 general surgeons and 10 to 15 orthopedic surgeons in Iraq. Most have served in Forward Surgical Teams (FSTs) — small teams, consisting of just 20 people: 3 general surgeons, 1 orthopedic surgeon, 2 nurse anesthetists, 3 nurses, plus medics and other support



| War | No. Wounded or Killed in Action | No. Killed in Action | Lethality of War Wounds % |
|---|---------------------------------|----------------------|------------------------------|
| Revolutionary War, 1775–1783 | 10,623 | 4,435 | 42 |
| War of 1812, 1812–1815 | 6,765 | 2,260 | 33 |
| Mexican War, 1846–1848 | 5,885 | 1,733 | 29 |
| Civil War (Union Force), 1861–1865 | 422,295 | 140,414 | 33 |
| Spanish-American War, 1898 | 2,047 | 385 | 19 |
| World War I, 1917–1918 | 257,404 | 53,402 | 21 |
| World War II, 1941–1945 | 963,403 | 291,557 | 30 |
| Korean War, 1950–1953 | 137,025 | 33,741 | 25 |
| Vietnam War, 1961–1973 | 200,727 | 47,424 | 24 |
| Persian Gulf War, 1990–1991 | 614 | 147 | 24 |
| War in Iraq and Afghanistan, 2001–present | 10,369 | 1,004 | 10 |

*Data are from the Department of Defense.^{1,3}

personnel. In Vietnam, only 2.6 percent of the wounded soldiers who arrived at a surgical field hospital died, which meant that, despite helicopter evacuation, most deaths occurred before the injured made it to surgical care.⁴ The recent emphasis on leaner, faster-moving military units added to the imperative to push surgical teams farther forward, closer to battle. So they, too, were made leaner and more mobile — and that is their fundamental departure from previous wars.

Each FST is equipped to move directly behind troops and establish a functioning hospital with four ventilator-equipped beds and two operating tables within a difficult-to-fathom 60 minutes. The team travels in six Humvees. They carry three lightweight, Deployable Rapid Assembly Shelter (“drash”) tents that can be attached to one another to form a 900-ft² facility. Supplies to immediately resuscitate and operate on the wounded arrive in five backpacks: an ICU pack, a surgical-technician pack, an anesthesia pack, a general-surgery pack, and an orthopedic pack. They hold sterile instruments, anesthesia equipment, medicines, drapes, gowns, catheters, and a handheld unit allowing clinicians to obtain a hemogram and measure electrolytes or blood gases with a drop of blood. FSTs also carry a small ultrasound machine, portable monitors, transport ventilators, an oxygen concentrator providing up to 50 percent oxygen, 20 units of packed red cells, and six roll-up stretchers with

their litter stands. Teams have forgone angiography and radiography equipment. (Orthopedic surgeons detect fractures by feel and apply external fixators.) But they have sufficient supplies to evaluate, and perform surgery on, as many as 30 wounded soldiers. They are not equipped, however, for more than six hours of postoperative intensive care.

The 274th FST is led by a 42-year-old surgical oncologist who was my chief resident when I was a surgical intern. He went to West Point, Johns Hopkins Medical School in Baltimore, Brigham and Women’s Hospital in Boston for surgical residency, and then M.D. Anderson Cancer Center in Houston for a fellowship. He was known in training for three things: his unflappability, his intellect (he’d already published 17 papers on work toward a breast-cancer vaccine), and the five children he and his wife had during residency. He owed the Army 18 years of service when he finally finished his training, and neither I nor anyone I know ever heard him bemoan that commitment. In 1998, he was assigned to Walter Reed Army Medical Center in Washington, D.C., where he practiced surgical oncology. Then, in October 2001, after the September 11 attacks on the World Trade Center and the Pentagon, he and his team were sent with the first troops into Afghanistan. He returned after service there only to be sent to Iraq, in March 2003, with ground forces invading from Kuwait through the desert to Baghdad.

The 274th FST traveled 1100 miles with troops over the next four months, setting up in Nasiriyah, Najaf, Karbala, and points along the way in the southern desert, then in Mosul in the north, and finally in Baghdad. According to its logs, the unit cared for 132 U.S. and 74 Iraqi casualties during that time (22 of the Iraqis were combatants, 52 civilians). Some days were quiet. Others, overwhelming. On one day in Nasiriyah, the team received 10 critically wounded patients, among them 1 with right-lower-extremity shrapnel injuries; 1 with gunshot wounds to the stomach, jejunum, and liver; another with gunshot wounds to the liver, gallbladder, and transverse colon; 1 with shrapnel in the neck, chest, and back; 1 with a gunshot wound through the rectum; and 2 with extremity gunshot wounds. The next day, 14 more casualties arrived.

On the arrival of the wounded, teams carry out the standard Advanced Trauma Life Support protocols that civilian trauma teams follow. However, because of the high incidence of penetrating wounds — 80 percent of casualties seen by the 274th FST had gunshot wounds, shrapnel injuries, or blast



injuries — lifesaving operative management is required far more frequently than in civilian trauma centers. Today, military surgical strategy aims for damage control, not definitive repair, unless it can be done quickly. Teams pack off liver injuries, staple off perforated bowel, wash out dirty wounds — whatever is necessary to stop bleeding and control contamination without allowing the patient to lose body temperature or become coagulopathic. Surgeons seek to limit surgery to two hours or less, and then ship the patient off to a Combat Support Hospital (CSH), the next level of care. Abdomens can be left open, laparotomy pads left in, bowel unanastomosed, the patient paralyzed, sedated, and ventilated. For this approach to be successful, however, control of air space and major roadways and establishment of the next-level hospital (achieved early in Iraq but delayed in Afghanistan) are essential.

Two CSHs with four sites now exist in Iraq. These are 248-bed hospitals with six operating tables, some specialty surgery services, and radiology and laboratory facilities. Mobile hospitals, too, they arrive in modular units by air, tractor-trailer, or ship and can be fully functional in 24 to 48 hours. Even at the CSH level, the goal is not necessarily definitive repair. The maximal length of stay is intended to be three days. The policy is to transfer any American soldier who requires more to a level IV hospital — one was established in Kuwait, one in Rota, Spain, and one in Landstuhl, Germany. If expected to require more than 30 days of treatment, wounded soldiers are to be transferred home, mainly to Walter Reed or to Brooke Army Medical Center in San Antonio, Texas. (Iraqi prisoners and civilians, on the other hand, receive all their care in Iraq.)

It is a system that took some getting used to. Surgeons at every level initially tended to hold on to their patients, either believing that they could provide definitive care themselves or not trusting that the next level could do so. According to statistics from Walter Reed, during the first few months of the war, it took an injured soldier an average of eight days to go from the battlefield to a U.S. facility. Gradually, however, surgeons have embraced the wisdom of the system. The average time from battlefield to arrival in the United States is now less than four days. (In Vietnam, it was 45 days.)

One airman with devastating injuries from a

mortar attack outside Balad on September 11, 2004, was on an operating table at Walter Reed just 36 hours later. In extremis from bilateral thigh injuries, abdominal wounds, shrapnel in the right hand, and facial injuries, he was taken from the field to the nearby 31st CSH in Balad. Bleeding was controlled, volume resuscitation begun, a guillotine amputation at the thigh performed. He underwent a laparotomy with diverting colostomy. His abdomen was left open, with a clear plastic bag as covering. He was then taken to Landstuhl by an Air Force Critical Care Transport team. When he arrived in Germany, Army surgeons determined that he would require more than 30 days' recovery, if he made it at all. Therefore, although resuscitation



was continued and a further washout performed, he was sent on to Walter Reed. There, after weeks in intensive care and multiple operations, he did survive. This is itself remarkable. Injuries like his were unsurvivable in previous wars. The cost, however, can be high. The airman lost one leg above the knee, the other in a hip disarticulation, his right hand, and part of his face. How he and others like him will be able to live and function remains an open question.

As lifesaving as the new strategies have been, teams have been forced to confront numerous unanticipated circumstances. The war has gone on far longer than planned, the volume of wounded soldiers has increased, and the nature of the injuries has changed. Blast injuries from suicide bombs and land mines — improvised explosive devices (IEDs), in military lingo — have increased substantially and have proved particularly difficult to manage. They often combine penetrating, blunt, and burn injuries. The shrapnel include not only nails, bolts, and the like, but also dirt, clothing, even bone from assailants. Victims of IED attacks can exsanguinate from multiple seemingly small wounds, even those in the back. Teams have therefore learned to pack the bleeding sites before laparotomy or other interventions are performed. And they are now performing serial operative washouts to ensure adequate removal of infectious debris.

Surgeons also discovered a dismayingly high incidence of blinding injuries. Soldiers had been directed to wear eye protection, but they evidently found the issued goggles too ugly. As some soldiers put it, "They look like something a Florida senior



citizen would wear.” So the military bowed to fashion and switched to cooler-looking Wiley-brand ballistic eyewear. The rate of eye injuries has since decreased markedly.

Still, for many new problems, the answers remain unclear. Early in the war, for example, Kevlar vests proved dramatically effective in preventing torso injuries. Surgeons, however, now find that IEDs are causing blast injuries that extend upward under the armor and inward through axillary vents. Blast injuries are also producing an unprecedented burden of what orthopedists term “mangled extremities” — limbs with severe soft-tissue, bone, and often vascular injuries. These can be devastating, potentially mortal injuries, and whether to amputate is one of the most difficult decisions in orthopedic surgery. Military surgeons have relied on civilian trauma criteria to guide their choices, but those criteria have not proved reliable in this war. Possibly because the limb injuries are more extreme or more often combined with injuries to other organs, attempts to salvage limbs following the criteria have frequently failed, with life-threatening blood loss, ischemia, and sepsis.

Every other Thursday, surgeons at Walter Reed hold War Rounds by telephone conference with surgeons in Baghdad to review the American casualties received in Washington during the previous two weeks. The case list from October 21 provides a picture of the extent of the injuries. There was one gunshot wound, one antitank-mine injury, one grenade injury, three rocket-propelled-grenade injuries, four mortar injuries, eight IED injuries, and seven patients with no cause of injury noted. The least seriously wounded of these patients was a 19-year-old who had sustained soft-tissue injuries to the face and neck from a mine and required an exploration of the left side of the neck. Other cases involved a partial hand amputation; a hip disarticulation on the right, through-knee amputation on the left, and open pelvic débridement; a left nephrectomy and colostomy; an axillary artery and vein reconstruction; and a splenectomy, with repair of a degloving scalp laceration and through-and-through tongue laceration. None of the soldiers were more than 25 years of age.

Late complications have emerged as a substantial difficulty as well. Surgeons are seeing startling rates of pulmonary embolism and deep venous

thrombosis, for example, perhaps because of the severity of the extremity injuries and reliance on long-distance transport in management. Initial data show that 5 percent of the wounded at Walter Reed have had a pulmonary embolism, resulting in two deaths. The solution is not obvious. Using anticoagulants in patients with fresh wounds and in need of multiple procedures would seem unwise. On the other hand, there is no facility or expertise in Iraq for the routine placement of inferior vena cava filters.

Injured soldiers from Iraq have also brought an epidemic of multidrug-resistant *Acinetobacter baumannii* infection to military hospitals. It is not known how this has occurred. No such epidemic ap-

peared among soldiers from Afghanistan, and whether the drug resistance is being produced by antibiotic use or is already carried by the strains colonizing troops is still being debated. Regardless, data from 442 medical evacuees seen at Walter Reed showed that 37 (8.4 percent) were culture-positive for acinetobacter — a rate far higher than any previously experienced. The organism has infected wounds and prostheses and caused catheter-related sepsis in soldiers and, through nosocomial spread, in at least three other hospital patients. Medical evacuees from Iraq are now routinely isolated on arrival and screened for the bacteria.

These are just the medical challenges. Perhaps the most pressing difficulties arise from the changing conditions of the war. Medical teams were designed and outfitted for lightning-quick, highly mobile military operations. The war, however, has proved to be slow-moving and protracted. To adapt, CSHs have had to be converted into fixed facilities. In Baghdad, for example, the 28th CSH took over and moved into an Iraqi hospital in the Green Zone. This shift has brought increasing numbers of Iraqi civilians seeking care, and there is no overall policy about providing it. Some hospitals refuse to treat civilians for fear that some may be concealing bombs. Others are treating Iraqis but find themselves overwhelmed, particularly by pediatric patients, for whom they have limited personnel and few supplies.

Requests have been made for additional staff members and resources at all levels. As the medical needs facing the military have increased, however, the supply of medical personnel has gotten tighter.



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Many surgeons have been on a second deployment or an extended deployment, and even this has not been sufficient. As a result, military urologists, plastic surgeons, and cardiothoracic surgeons have been tasked to fill some general surgeon positions. Planners are having to contemplate pressing surgeons into yet a third deployment.

Compounding the difficulties, none of these realities have made it appealing to sign up as a military surgeon. Interest in joining the reserves has dropped precipitously. President George W. Bush has flatly declared that there will be no draft. However, the Selective Service, the U.S. agency that maintains draft preparations in case of a national emergency, has recently updated a plan to allow the rapid registration of 3.4 million health care workers 18 to 44 years of age.⁵ The Department of Defense has indicated that it will rely on improved financial incentives to attract more medical professionals. Whether this strategy can succeed remains unknown. The pay has never been competitive. One now faces a near-certain likelihood of leaving one's family for duty overseas. And without question, the work is dangerous.

The nation's military surgical teams are under tremendous pressure, but they have performed remarkably in this war. They have transformed the strategy for the treatment of war casualties. They have saved the lives of an unprecedented 90 percent of the soldiers wounded in battle. And they have

done so under extraordinarily difficult conditions and with heroic personal sacrifices.

One surgeon deserves particular recognition. Dr. Mark Taylor began his Army service in 2001, to fulfill the terms of his military scholarship to attend medical school several years before. He, like many, was deployed twice to Iraq — first from February through May 2003 and then from August 2003 through the following winter. On March 20, 2004, outside Fallujah, four days from returning home to Stockton, California, the 41-year-old surgeon was hit in a rocket-propelled-grenade attack while making a telephone call outside his barracks. Despite his team's efforts, he could not be revived.

None among us have paid a greater price.

From the Department of Surgery, Brigham and Women's Hospital, and the Department of Health Policy and Management, Harvard School of Public Health — both in Boston.

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Military looking for a few good medics

... and surgeons, and RNs, and radiologists, too

By Michael Moran

Senior correspondent

MSNBC

Updated: 7:09 a.m. ET June 10, 2005

NEWARK, N.J. — Sirens wailing, Ed Wheat's ambulance races through the streets of Newark en route to yet another GSW. In Wheat's world, that's shorthand for gun shot wound. Newark is a city so rough that no one but the state government is willing to take responsibility for emergency medical care. Wheat's crew is often the first on the scene of traumatic accidents, stabbings and gun battles.

This time, the initial report is wrong — not a gun shot victim, just a 300-pound diabetic, former professional boxer whose hypoglycemic state has him flailing at those who have come to his aid. Wheat, a 6'4" 250 pounds former military policeman, is the perfect candidate to step in and subdue the man. With several police and firefighters, he moves in and takes a hard punch in the eye before the man is loaded into the ambulance for treatment.

"It's like that some days," Wheat says, showing off a burgeoning shiner. "It can be quiet sometimes, but a lot of times it's run and gun, and you're fighting to stay focused on your job, almost robotic, instead of thinking about what could happen around you."

Coolness under pressure and his experience with gun and knife wounds makes the 34-year-old the perfect candidate for another job, one the Army and Marine Corps are more and more desperate to fill these days. A few months ago, Wheat and several of his colleagues here were approached by a Navy recruiter who promised a "tax-free \$120,000 bonus" if they agreed to sign on as medical consultants with a Marine Corps unit in Iraq.

"I knew what they were asking, and don't get me wrong, I was tempted," says Wheat. "That's a lot of money, and I really want to help. But I worried that I wouldn't be accepted by the Marines, as an outsider, and I won't kid you — I thought about getting killed or injured. And I decided. Hey, I'm already doing a job that's dangerous that no one else wants right here. So I said no."

Luring trained veterans like Ed Wheat back into the medical corps is a full-time headache for the military, which even in peace time is compelled to offer bonuses and perks that would compare with those available in the private sector. These days, with conflicts in Iraq and Afghanistan and the military attempting to add more than 40,000 new soldiers over the next few years, the challenge is more acute than ever.

"What's happening with our combat medics is not so much a recruiting problem as it is keeping up with the Army's expansion," says Lt. Gen. Kevin Kiley, the Army's surgeon general. "We're standing up entirely new brigades, and that has added to requirements, so we're having to hustle to continue to recruit highly qualified men and women who can make it through courses and get into the field."

More acute for specialties

The decline in general Army recruiting in recent months has been precipitous. On Wednesday, for instance, the Army said that it had missed its recruitment goal for May by more than 25 percent — that after lowering its monthly target. It was the fourth month in a row that recruitment fell short.

Perhaps more importantly, unlike February and March, which are traditionally slow periods for recruiters, May is usually a busy month as students begin to graduate or anticipate graduation from high school.

While media reports have focused on the problems the Army and Marine Corps are having with recruitment, the retention of highly trained specialists is as serious, if not more so, for the long-term ability of the military to sustain operations around the globe. Kiley notes that some 36,000 medical staff – doctors, nurses, technicians – have deployed to southwest Asia from the Army alone in the past four years. That is not only time away from home, but in some cases an interruption of their training as internists or medical students.

The bonuses offered to Wheat and others to work as private consultants are part of a series of strategies designed to bring in highly trained people and to hold on to those already in the service.

"In my experience, in the Army since 1976, it has never been easy to hold on to people who can command high salaries in the outside world," says Kiley. "But today we're also feeding into the larger issue of recruiting for the Army altogether, and we're having some issues of getting our total end strengths up to the maximums. And our ability to offer bonuses is key."

For instance, the Army is currently offering a \$20,000 bonus to those who agree to re-enlist after their first four year tour is up. But that amount can grow depending on the skills involved and the military's need for them.

Paging Dr. Dogface

Some of these specialties are perennially difficult to keep. For the most highly skilled – cardio-thoracic surgeons, neurological specialist, orthopedic surgeons -- bonuses can in some cases be up to \$70,000 a year. As Wheat attests, for those who prefer to work as private consultants on the front lines in Iraq, the amount can be much higher.

For the most part, the military's medical system trains its own doctors, either through ROTC-like scholarship programs, which trade medical school tuition and some expenses for a seven year commitment to the military, or more directly by educating them at the Uniformed Services Universities of the Health Sciences just north of Washington.

"We've been in a sustained deployment now and it has its impact on recruiting and retention," says Virginia Stephanakis, an Army Medical Command spokesperson. "It's something we're keeping an eye on. But the long commitment after training helps ensure we always have enough people to fight a war and to take care of military family medical needs."

Kiley and other military medical commanders recently appeared before Congress to urge them to increase the flexibility of the current bonus system. Kiley says if he had the flexibility to offer special packages when they were needed to certain specialties, "I'd fill every slot, I believe. As it is under the current system, I have 4,347 physicians authorized, but only 4,220 on duty."

Bonuses under the current system are set year-by-year by Congress, with little discretion exercised by military medical commanders.

"For instance, this year all obstetricians may get \$34,000, but that could drop next year to \$29,000," Kiley says. "A radiologist could get as high as \$50,000. And others further down the list could be offered a "multiple specialty bonus" — meaning if you sign on for two years you get \$20,000 over that period."

Steve Kosiak, an analyst with the Center for Strategic and Budgetary Assessments in Washington, notes that bonuses currently make up five percent of the total amount the Pentagon spends on

military pay. "Most of that is in across the board bonuses, like the \$20,000 being offered for reenlistment," he says. "If it were structured to target specialists better, it could be a more effective program."

Where are the nurses?

Other specialties in the medical and other fields also are experiencing serious shortfalls. These include information and internet specialists, as well as many mid-level officers who appear to be concluding that plotting a military career during wartime is not as attractive as it may have been during the 1990s.

Others, like registered nurses, who rank as officers in the military, and non-commissioned physicians assistants and certain engineering positions, reflect shortages that extend into the civilian economy, as well.

"We are having some problems retaining nurses," Gen. Kiley says. "They are in great demand in the civilian sector. And we're also having some trouble with physicians assistants, too. It's not just a question of Iraq, it's a question that there aren't enough slots open in universities — military or civilian — to fill current demand."

"Unfortunately, the way the military's pay and retirement and promotions system is structured creates a distortion," says Cindy Williams, an MIT military analyst who for years specialized in personnel issues for the Congressional Budget Office. "They wind up keeping too many of the wrong people — cooks and clerks and unskilled laborers where the salaries and benefits in the civilian economy would not be so different — and not enough of the right people who can make far more by leaving."

The problem with that, Williams says, "is that serving 14 to 20 years as a medical specialist probably means that at the end of your career you are a stellar medical specialist. Where as, say, someone who has been cooking in a mess hall for 20 years is likely to be only marginally better, if at all."

Kiley recognizes the problem, but says he has to live in the "real world" if he is to mitigate the consequences.

"You ask the doctors who are leaving where they're going, and it is stunning, mind-boggling what the cardiologists, radiologists and orthopedic surgeons are getting," Kiley says. "In a sustained way, we can't keep up. We have to rely, at least in part, on patriotism and a sense of duty, and the obligation that some of these doctors and nurses and other people owe the military because we trained them."

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DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
1000 NAVY PENTAGON
WASHINGTON DC 20350-1000

23 June 2005

The Honorable Gene Taylor
United States House of Representatives
Washington, DC 20515

Dear Congressman Taylor:

This is in response to the June 13, 2005 inquiry of your Chief of Staff, Mr. Stephen Peranich, to Commander Hochberg of the Navy Office of Legislative Affairs (OLA) concerning Naval Station (NS) Pascagoula as a follow-up to our meeting earlier that day. Our responses to your specific questions are provided below. We look forward to meeting with your staff to go over the Military Value determinations for Naval Station (NAVSTA) Pascagoula, Naval Air Station (NAS) Pensacola, and Naval Air Facility Key West as requested and to provide any additional details you may require.

1. How much MILCON (facility type and cost) is required in Norfolk and Mayport as a result of the recommendations?

The MILCON at NAVSTA Norfolk is \$183M for Aircraft Maintenance Hanger, Enlisted Unaccompanied Personnel Housing, General Administrative Building, Miscellaneous Operations Support Building, Recreation Center, Nursery and Child Care Facility, Piers, Applied Instruction Building, Marine Maintenance Support Facilities, Vehicle Maintenance Shop, and Vehicle Parking. The MILCON at NAVSTA Mayport is \$6.8M for Enlisted Unaccompanied Personnel Housing and Vehicle Parking. The details are contained in the enclosed COBRA report excerpts.

2. How does the condition (backlog not parametric estimate) and capability of the piers in Norfolk and Mayport compare to that in Pascagoula?

The details of the pier condition are contained in the Capacity Data Call. We will provide the results of this data call at the scheduled meeting as requested per Question #7, below.

3. What is the condition and capability of the waterfront facilities (pier, hotel services, magazines, berthing, repair, etc...) in Key West and Pensacola? What are the similarities and differences to what can be provided in Pascagoula?

The details of the pier condition and capability are contained in the Capacity Data Call. We will provide the results of this data call at the scheduled meeting as requested per Question #7 below.

4. It appears much of Navy's cost estimate is wrapped up in billet reductions. Stripping away the personnel piece, what is Pascagoula's MilVal/\$?



On page 3 of the "Total COBRA Realignment Detail Report" the following information is available: Of the recurring Net Savings (\$47M), \$47M is military and civilian personnel costs. Sustainment, Recapitalization, and Base Operations and Support (BOS) net savings (\$5.2M) is almost completely offset by the annual recurring cost of per diem for pre-commissioning units (\$4.7M).

5. Could you provide a side-by-side of area cost factors for Mayport, Norfolk, Key West, Pensacola and Pascagoula?

Mayport - 0.91; Norfolk - 0.94; Key West - 1.24; Pensacola - 0.87; Pascagoula - 0.84

6. Could you provide a detailed economic analysis of why divestiture of the Pascagoula Lakeside facility makes sense? Was a market survey done to show if there was an adequate number of affordable, quality units available in the economy?

The economic analysis is contained in the CORBA report for the recommendation. The estimated \$4.74M per diem cost to house pre-commissioning units was included in the COBRA analysis. An alternative scenario in which the Lakeside facility was retained in an enclave was evaluated and showed approximately the same net result in terms of costs, savings, and 20-year Net Present Value (NPV). The COBRA analysis for the scenario maintaining the Lakeside facility as an enclave is enclosed. Naval Station Pascagoula provided information that there were sufficient units available in the economy to house the pre-commissioning units.

7. Lastly, at some point, it would be helpful to get a detailed brief on the military value calculations for Pascagoula, Pensacola, and Key West.

We are coordinating a meeting to conduct this brief.

The enclosed CD contains data supporting answers to questions one and six. To the extent that information on the disk has been redacted, it is so marked. I trust you will find this information useful. If we can be of further assistance, please let me know.

Sincerely,



Anne Rathmell Davis
Special Assistant to the Secretary of the Navy
for Base Realignment and Closure

Enclosures:
As Stated

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1

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1

Analysis of Pascagoula COBRA Report

DOD Cost and Savings Estimates for Closing Naval Station Pascagoula, Relocating Some Activities to Naval Station Mayport, Some to Base X, and Eliminating Others

One-Time Costs:

| | |
|-------------------|--------------|
| NAVSTA Pascagoula | 11,068,784 |
| NAVSTA Mayport | \$6,870,675 |
| Combined | \$17,939,460 |

One-Time Savings:

| | |
|-------------------|-----------|
| NAVSTA Pascagoula | \$743,599 |
|-------------------|-----------|

Net One-Time Costs:

| | |
|-------------------|--------------|
| NAVSTA Pascagoula | \$10,325,185 |
| NAVSTA Mayport | \$6,870,675 |
| Combined | \$17,195,861 |

Recurring Costs:

| | |
|-------------------|-------------|
| NAVSTA Pascagoula | \$4,744,000 |
| NAVSTA Mayport | \$2,851,000 |
| Base X (Navy) | \$8,000 |
| Combined | \$7,603,000 |

Recurring Savings:

| | |
|-------------------|--------------|
| NAVSTA Pascagoula | \$54,820,000 |
| NAVSTA Mayport | \$45,000 |
| Combined | \$54,865,000 |

Net Recurring Costs/Savings:

| | |
|-------------------|---------------|
| NAVSTA Pascagoula | -\$50,076,000 |
| NAVSTA Mayport | 2,806,000 |
| Combined | -\$47,261,000 |

| | |
|--|----------------------|
| Total Net Savings Through 2011: | \$220,017,000 |
| Annual Savings After 2011: | 47,434,000 |

One-time Costs at Pascagoula:

| | |
|-----------------------------------|-------------|
| Civilian RIF | \$2,582,921 |
| Civilian Early Retirement | \$107,901 |
| Eliminated Military PCS | \$1,929,174 |
| Unemployment | \$200,295 |
| Program Overhead | \$1,995,187 |
| Support Contract Termination | \$118,600 |
| Mothball/Shutdown | \$82,440 |
| Civilian Moving | \$50,908 |
| Civilian Priority Placement (PPP) | \$780,912 |
| Military Moving | \$1,255,238 |
| Freight | \$288,518 |
| Information Technologies | \$83,400 |
| Housing Assistance Program | \$993,290 |
| One-Time Unique Costs | \$600,000 |

DOD proposes to eliminate of 33 officer billets, 396 enlisted billets, and 110 civilian positions, relocate 31 officer billets, 372 enlisted billets, and 2 civilian positions to Mayport, and assign 12 enlisted positions assigned to the DCGS-N2 (Distributed Common Ground Station) to a place to be determined, possibly remaining in Pascagoula as a tenant of the Coast Guard. DOD employs a standard model using DOD-wide average salaries of officers, enlisted, and civilians, averages of the percentage of civilians who will retire, move, take priority placement, or draw unemployment, DOD-wide averages of the weight of household goods and the distances to be moved for the military PCS leaving the service, in order to estimate the one-time costs of eliminating and realigning positions. The "one-time unique costs" of \$600,000 is \$200,000 per year described as "travel costs in support of MOA with USCG for each fiscal year (06-08)." In 2004, the Navy signed an MOA to transfer five Navy coastal patrol craft to Coast Guard custody and operational control. Navy agreed to fund and perform maintenance at the crafts' homeports. MOA in effect through FY 2008.

One-Time Costs at NAVSTA Mayport:

| | |
|--------------------------------|-------------|
| Military Construction | \$6,850,675 |
| Environmental Mitigation Costs | \$20,000 |

MilCon projects are listed as 39,050 sq. ft. barracks for \$6,548,000 and 5,985 sq. ft. parking lot for \$303,000.

One-time Savings at Pascagoula:

| | |
|-----------------|-----------|
| Military Moving | \$743,000 |
|-----------------|-----------|

No detailed explanation, but must be cost avoidance for personnel moves to Pascagoula that would be cancelled because of BRAC action. Of course, if those military personnel move elsewhere, the moving costs are not avoided.

Recurring Costs at NAVSTA Pascagoula:

| | |
|-------------------------|-------------|
| Miscellaneous Recurring | \$4,744,000 |
|-------------------------|-------------|

This is the estimated cost of berthing precommissioning crews in the community rather than in Lakeside Support Facility, computed from the difference between per diem rate and average Lakeside charges.

Recurring Costs at NAVSTA Mayport:

| | |
|----------------------------|-------------|
| Sustainment | \$137,000 |
| Recapitalization | \$55,000 |
| Base Operating Costs (BOS) | \$532,000 |
| TRICARE | \$392,000 |
| Housing Allowance | \$1,734,000 |

Sustainment and recapitalization, are estimated by formula based on the new square footage. BOS cost is estimated by formula based on the new personnel. TRICARE and housing allowance estimates are based on the higher costs in Mayport.

Recurring Costs at Base X (Navy):

| | |
|----------------------------|----------|
| Base Operating Costs (BOS) | \$13,000 |
| TRICARE | -\$5,000 |

Base X is the BRAC process designation for personnel or costs whose destination is unknown. In this case, the 12 enlisted positions assigned to the DCGS-N2 (Distributed Common Ground Station) will not be eliminated and will not move to Mayport, but their destination is uncertain. They might remain on Singing River Island as tenants of the Coast Guard. The estimate for BOS and TRICARE costs came from formulas.

Recurring Savings at NAVSTA Pascagoula:

| | |
|----------------------------|--------------|
| Sustainment | \$979,000 |
| Recapitalization | \$954,000 |
| Base Operating Costs (BOS) | \$3,840,000 |
| Civilian Salary | \$7,314,000 |
| Officer Salary | \$4,124,000 |
| Enlisted Salary | \$32,630,000 |
| Housing Allowance | \$4,718,000 |
| Miscellaneous Recurring | \$259,000 |

This confirms that almost all of the projected savings actually come from reducing military and civilian personnel. Military salaries and housing allowance account for \$41,472,000 of the projected annual savings and \$7,314,000 come from civilian salaries. The figures are based on the DOD-wide average salary for officers, enlisted, and civilians. The sustainment, recapitalization, and are estimated by formula based on the square footage eliminated. The BOS costs are based on the number and type of personnel being eliminated. The miscellaneous recurring savings are the estimated cost avoidance of dredging the Navy Channel.

Recurring Savings at NAVSTA Mayport:

| | |
|-------------------------|----------|
| Miscellaneous Recurring | \$45,000 |
|-------------------------|----------|

Scenario Data Call says that relocation of frigates to Mayport would save SIMA Mayport \$45,000 in travel costs of sending personnel and equipment.

NAVAL STATION PASCAGOULA PERSONNEL SUMMARY**NAVSTA Pascagoula Base Population FY 2005:**

| | |
|------------------|--------------|
| Officers | 115 |
| Enlisted | 1,432 |
| Civilians | 112 |
| TOTAL | 1,659 |

Non-BRAC Changes Programmed for FY 2006 & FY 2007:

| | |
|-----------------|-------------|
| Officers | -51 |
| Enlisted | -652 |
| TOTAL | 703 |

Base Population Baseline Prior to BRAC Action:

| | |
|------------------|------------|
| Officers | 64 |
| Enlisted | 780 |
| Civilians | 112 |
| TOTAL | 956 |

Personnel Realigned to NAVSTA Mayport:

| | |
|------------------|------------|
| Officers | 31 |
| Enlisted | 372 |
| Civilians | 2 |
| TOTAL | 405 |

Personnel Realigned to Base X (Navy):

| | |
|-----------------|-----------|
| Enlisted | 12 |
|-----------------|-----------|

Scenario Position Changes (i.e. Positions Eliminated):

| | |
|------------------|------------|
| Officers | 33 |
| Enlisted | 396 |
| Civilians | 110 |
| TOTAL | 539 |

PERSONNEL/SQUARE FOOTAGE/SUSTAINMENT/BOS CHANGES

Personnel Changes

| | |
|-------------------|-------------|
| NAVSTA Pascagoula | -956 |
| NAVSTA Mayport | 405 |
| Base X (Navy) | 12 |
| TOTAL | -539 |

Square Footage Changes

| | |
|-------------------|-----------------|
| NAVSTA Pascagoula | -458,000 |
| NAVSTA Mayport | 39,370 |
| TOTAL | -418,630 |

Base Operating Support Changes (2005\$/year)

| | |
|-------------------|---------------------|
| NAVSTA Pascagoula | -\$3,840,177 |
| NAVSTA Mayport | \$532,492 |
| Base X (Navy) | \$12,681 |
| TOTAL | -\$3,295,005 |

Sustainment Changes (2005\$/year)

| | |
|-------------------|---------------------|
| NAVSTA Pascagoula | -\$1,151,705 |
| NAVSTA Mayport | \$136,918 |
| TOTAL | -\$1,014,786 |

Recapitalization Changes (2005\$/year)

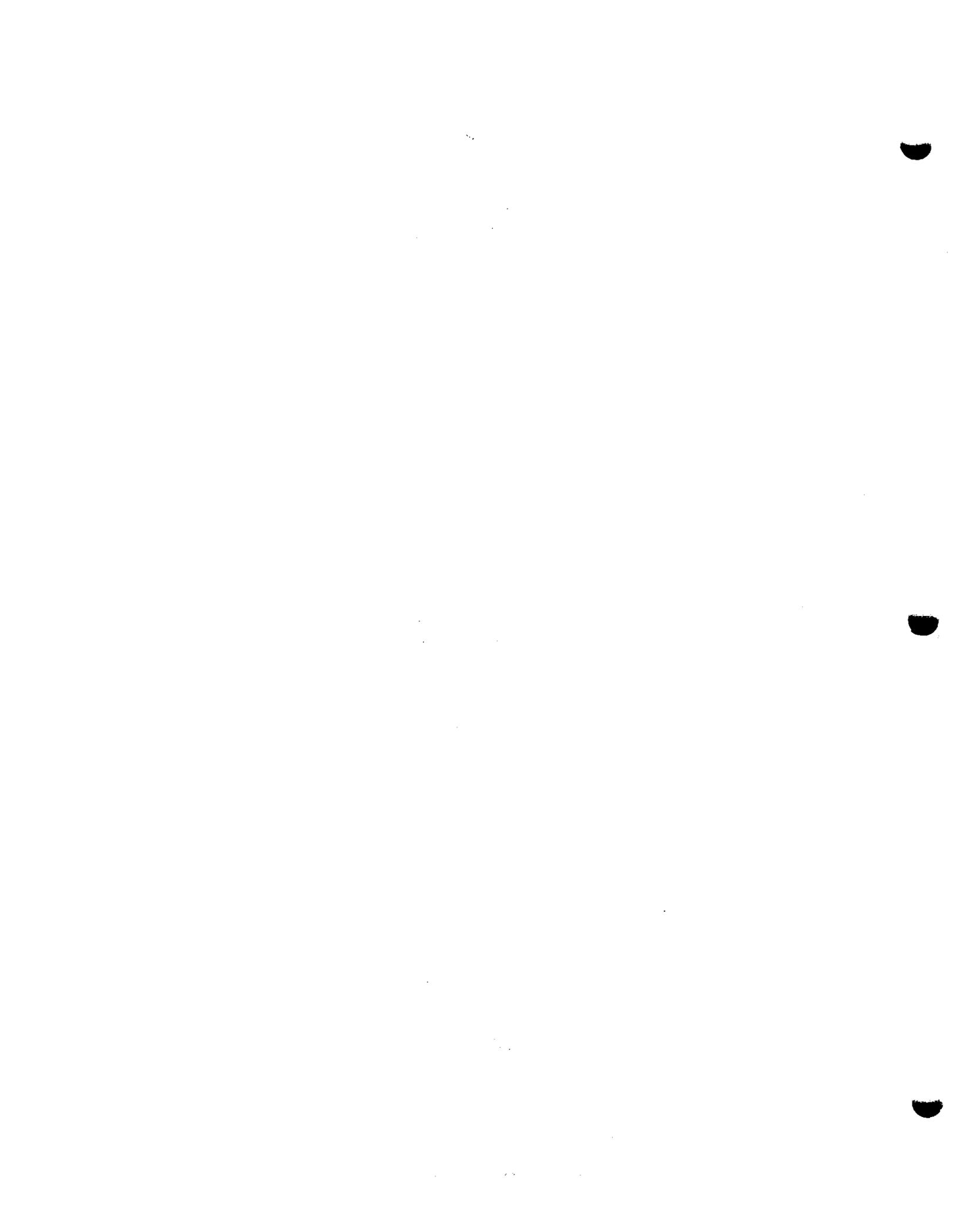
| | |
|-------------------|-------------------|
| NAVSTA Pascagoula | -\$954,517 |
| NAVSTA Mayport | \$55,132 |
| TOTAL | -\$899,386 |

Sustainment + Recapitalization + BOS Changes (2005\$/year)

| | |
|-------------------|---------------------|
| NAVSTA Pascagoula | -\$5,946,400 |
| NAVSTA Mayport | \$724,542 |
| Base X (Navy) | -\$12,681 |
| TOTAL | -\$5,209,177 |

Plant Replacement Value Changes

| | |
|-------------------|-----------------------|
| NAVSTA Pascagoula | -\$108,815,000 |
| NAVSTA Mayport | \$6,285,023 |
| TOTAL | -\$102,529,977 |



Strategy for Homeland Defense and Civil Support



**Department of Defense
Washington, D.C.**

June 2005





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Foreword

Protecting the United States from direct attack is the highest priority of the Department of Defense. The military has traditionally secured the United States by projecting power overseas. While our current missions abroad continue to play a vital role for the security of our Nation, the terrorist attacks of September 11, 2001 emphasized that we are confronting fundamentally different challenges from those faced during the Cold War.

President George W. Bush activated all instruments of American power to respond to the attacks of September 11th, and directed the United States Government to better prepare for the reality of the 21st century threat. Working with Congress, President Bush established the Department of Homeland Security to prevent terrorist attacks in the United States. The Department of Defense, the traditional vanguard of America's security, began transforming as well. The stand-up of US Northern Command was an important first step—created to deter, prevent, and defeat aggression aimed at the United States.

The *Strategy for Homeland Defense and Civil Support* marks the next significant milestone in reshaping the Department's approach to homeland defense. Building upon the concept of an active, layered defense outlined in the *National Defense Strategy*, the *Strategy for Homeland Defense and Civil Support* constitutes the Department's vision for transforming homeland defense and civil support capabilities. It will fundamentally change the Department's approach to homeland defense in an historic and important way.

In the hands of the dedicated men and women of our military and the civilians who support them, I am confident the *Strategy for Homeland Defense and Civil Support* will improve significantly the Department's ability to counter the threats of the 21st century.

A handwritten signature in black ink that reads "Gordon England" with a stylized flourish at the end.

Gordon England
Deputy Secretary of Defense

Foreword



Executive Summary

"The world changed on September 11, 2001. We learned that a threat that gathers on the other side of the earth can strike our own cities and kill our own citizens. It's an important lesson; one we can never forget. Oceans no longer protect America from the dangers of this world. We're protected by daily vigilance at home. And we will be protected by resolute and decisive action against threats abroad."

President George W. Bush

September 17, 2002

Protecting the United States homeland from attack is the highest priority of the Department of Defense (DoD). On September 11, 2001, the world changed dramatically. For the first time since Pearl Harbor, we experienced catastrophic, direct attacks against our territory. This time, however, the foe was not another nation but terrorists seeking to undermine America's political will and destroy our way of life. As a result, the United States has become a nation at war, a war whose length and scope may be unprecedented.

We now confront an enemy who will attempt to engage us not only far from US shores, but also at home. Terrorists will seek to employ asymmetric means to penetrate our defenses and exploit the openness of our society to their advantage. By attacking our citizens, our economic institutions, our physical infrastructure, and our social fabric, they seek to destroy American democracy. We dare not underestimate the devastation that terrorists seek to bring to Americans at home.

To defeat 21st century threats, we must think and act innovatively. Our adversaries consider US territory an integral part of a global theater of combat. We must therefore have a strategy that applies to the domestic context the key principles that are driving the

transformation of US power projection and joint expeditionary warfare.

Secure the United States from Attack through an Active, Layered Defense

Directed by the Strategic Planning Guidance (March 2004), this Strategy for Homeland Defense and Civil Support focuses on achieving the Defense Department's paramount goal: securing the United States from direct attack. The Strategy is rooted in the following:

- Respect for America's constitutional principles;
- Adherence to Presidential and Secretary of Defense guidance;
- Recognition of terrorist and state-based threats to the United States; and
- Commitment to continue transformation of US military capabilities.

Protecting the United States in the ten-year timeframe covered by this Strategy requires an active, layered defense. This active, layered defense is global, seamlessly integrating US capabilities in the forward regions of the world, the global commons of space and cyberspace, in the geographic

approaches to US territory, and within the United States. It is a defense in depth. To be effective, it requires superior intelligence collection, fusion, and analysis, calculated deterrence of enemies, a layered system of mutually supporting defensive measures that are neither passive nor ad hoc, and the capability to mass and focus sufficient warfighting assets to defeat any attack.

This active, layered defense employs tactical defenses in a strategic offense. It maximizes threat awareness and seizes the initiative from those who would harm us. In so doing, it intends to defeat potential challengers before they threaten the United States at home.

Organizing Construct—Lead, Support, and Enable

Although the active, layered defense extends across the globe, this Strategy for Homeland Defense and Civil Support focuses primarily on DoD's activities in the US homeland and the approaches to US territory. In those geographic layers, the Department undertakes a range of activities to secure the United States from direct attack. These generally divide into the following categories:

- **Lead:** At the direction of the President or the Secretary of Defense, the Department of Defense executes military missions that dissuade, deter, and defeat attacks upon the United States, our population, and our defense critical infrastructure.
- **Support:** At the direction of the President or the Secretary of Defense, the Department of Defense provides support to civil authorities. This support is part of a comprehensive national response to prevent and protect against terrorist

incidents or recover from an attack or disaster. DoD provides support to a lead Federal agency when directed by the President or the Secretary of Defense.

- **Enable:** The Department of Defense seeks to improve the homeland defense and homeland security contributions of our domestic and international partners and, in turn, to improve DoD capabilities by sharing expertise and technology, as appropriate, across military and civilian boundaries.

Key Objectives of the Strategy

Within the lead, support, and enable framework for homeland defense and civil support, the Department is focused on the following paramount objectives, listed in order of priority:

- **Achieve maximum awareness of potential threats.** Together with the Intelligence Community and civil authorities, DoD works to obtain and promptly exploit all actionable information needed to protect the United States. Timely and actionable intelligence, together with early warning, is the most critical enabler to protecting the United States at a safe distance.
- **Deter, intercept and defeat threats at a safe distance.** The Department of Defense will actively work to deter adversaries from attacking the US homeland. Through our deterrent posture and capabilities, we will convince adversaries that threats to the US homeland risk unacceptable counteraction by the United States. Should deterrence fail, we will seek to intercept and defeat threats at a safe distance from the United States. When directed by the President or the Secretary

of Defense, we will also defeat direct threats within US airspace and on US territory. In all cases, the Department of Defense cooperates closely with its domestic and international partners and acts in accordance with applicable laws.

- **Achieve mission assurance.** The Department of Defense performs assigned duties even under attack or after disruption. We achieve mission assurance through force protection, ensuring the security of defense critical infrastructure, and executing defense crisis management and continuity of operations (COOP).
- **Support civil authorities in minimizing the damage and recovering from domestic chemical, biological, radiological, nuclear, or high-yield explosive (CBRNE) mass casualty attacks.** The Department of Defense will be prepared to provide forces and capabilities in support of domestic CBRNE consequence management, with an emphasis on preparing for multiple, simultaneous mass casualty incidents. DoD's responses will be planned, practiced, and carefully integrated into the national response.

With the exception of a dedicated command and control element (currently the Joint Task Force-Civil Support) and the Army National Guard Weapons of Mass Destruction (WMD) Civil Support Teams, DoD will rely on dual-capable forces for the domestic consequence management mission. These dual-capable forces must be trained, equipped, and ready to provide timely assistance to civil authorities in times of domestic CBRNE catastrophes, programming for this capability when directed.

- **Improve national and international capabilities for homeland defense and homeland security.** The Department of Defense is learning from the experiences of domestic and international partners and sharing expertise with Federal, state, local, and tribal authorities, the private sector, and US allies and friends abroad. By sharing expertise, we improve the ability of the Department of Defense to carry out an active, layered defense.

Capabilities for Homeland Defense and Civil Support

Consistent with the National Defense Strategy's call to develop and sustain key operational capabilities, the Strategy for Homeland Defense and Civil Support promotes the development of core capabilities to achieve its objectives. Prominent capability themes include:

- **Intelligence, Surveillance, and Reconnaissance Capabilities.** The Department of Defense requires current and actionable intelligence identifying potential threats to US territory. DoD must also ensure that it can identify and track suspect traffic approaching the United States. DoD must conduct reconnaissance and surveillance to examine wide areas of the maritime and air domains and, working with lead domestic partners and Canada and Mexico in the land domain, discover potential threats before they reach the United States.
- **Information-Sharing.** Together with domestic and international partners, DoD will integrate and share information collected from a wide range of sources. The events of September 11, 2001 high-

lighted the need to share information across Federal agencies and, increasingly, with state, local, and tribal authorities, the private sector, and international partners.

- **Joint Operational Capabilities for Homeland Defense.** DoD will continue to transform US military forces to execute homeland defense missions in the forward regions, approaches, US homeland, and global commons.
- **Interagency and Intergovernmental Coordination.** The Department of Defense and our domestic and international partners will continue to cooperate closely in the execution of homeland defense and civil support missions.

When fully realized, this Strategy for Homeland Defense and Civil Support will transform and improve DoD capabilities in each of these areas.

Projected Implications of the Strategy

In developing this Strategy, the Department took into account its likely force structure, resource, and technology implications. Given scarce resources, this Strategy's objectives must be balanced against other priorities outlined in the National Defense Strategy. As DoD components implement the strategic tenets outlined in this document, a more

precise accounting of the forces, technological advances, and financial resources it requires will be needed.

Because DoD's forces and resources are finite, the Strategy recognizes the need to manage risks in the homeland defense and civil support mission areas. It therefore prioritizes DoD's efforts, focusing on the requirement to fulfill DoD's lead responsibilities for homeland defense. As a second priority, we will ensure the Department's ability to support civil authorities in recovering from multiple, catastrophic mass casualty CBRNE incidents within the United States.

The Department of Defense will expeditiously implement the Strategy for Homeland Defense and Civil Support. Fundamentally, this will require the Department to integrate strategy, planning, and operational capabilities for homeland defense and civil support more fully into DoD processes. **The Strategy for Homeland Defense and Civil Support is not a static document.** Even as the Department of Defense implements this Strategy, it will continue to adapt to changes in the strategic environment, incorporate lessons learned from operational experience, and capitalize on emerging technology and operational concepts.



I. Context

"For most of the twentieth century, the world was divided by a great struggle over ideas: destructive totalitarian visions or freedom and equality. That great struggle is over. The militant visions of class, nation, and race which promised utopia have been defeated and discredited. America is now threatened less by conquering states than we are by failing ones. We are menaced less by fleets and armies than by catastrophic technologies in the hands of the embittered few. We must defeat these threats to our Nation, allies, and friends."

*The National Security Strategy of the United States of America
September 2002*

The Strategy for Homeland Defense and Civil Support embodies the core principles articulated in the US Constitution, the Nation's laws, and in Presidential and Secretary of Defense guidance. It also responds to the challenges posed by the security environment over the next decade.

Key Definitions

Homeland security, as defined in the National Strategy for Homeland Security, is "a concerted national effort to prevent terrorist attacks within the United States, reduce America's vulnerability to terrorism, and minimize the damage and recover from attacks that do occur." The Department of Homeland Security is the lead Federal agency for homeland security. In addition, its responsibilities extend beyond terrorism to preventing, preparing for, responding to, and recovering from a wide range of major domestic disasters and other emergencies.

It is the primary mission of the Department of Homeland Security to prevent terrorist attacks within the United States. The Attorney General leads our Nation's law enforcement effort to detect, prevent, and investigate terrorist activity within the United States. Accordingly, the Department

of Defense does not have the assigned responsibility to stop terrorists from coming across our borders, to stop terrorists from coming through US ports, or to stop terrorists from hijacking aircraft inside or outside the United States (these responsibilities belong to the Department of Homeland Security). Nor does DoD have the authority to seek out and arrest terrorists in the United States (these responsibilities belong to the Department of Justice).

Homeland defense is the protection of US sovereignty, territory, domestic population, and critical defense infrastructure against external threats and aggression, or other threats as directed by the President.¹ The Department of Defense is responsible for homeland defense.

Defense support of civil authorities, often referred to as civil support, is DoD support, including Federal military forces, the Department's career civilian and contractor personnel, and DoD agency and component

¹ Homeland Defense includes missions such as domestic air defense. The Department recognizes that threats planned or inspired by "external" actors may materialize internally. The reference to "external threats" does not limit where or how attacks could be planned and executed. The Department is prepared to conduct homeland defense missions whenever the President, exercising his constitutional authority as Commander in Chief, authorizes military actions.

I. Context

assets, for domestic emergencies and for designated law enforcement and other activities. The Department of Defense provides defense support of civil authorities when directed to do so by the President or Secretary of Defense.

Standing Guidance from National and Defense Strategies

Directed by the Strategic Planning Guidance (March 2004), the Strategy for Homeland Defense and Civil Support integrates the objectives and guidance expressed in the National Security Strategy, the National

Strategy for Homeland Security, and the National Defense Strategy to guide Department of Defense operations to protect the US homeland.

- The National Security Strategy (2002) expands the scope of US foreign and security policy to encompass forward-reaching preventive activities, including preemption, against hostile states and terrorist groups.
- The National Strategy for Homeland Security (2002) guides the national effort to secure the US homeland against terrorist attacks. It provides a framework for action at all levels of government that play a role in homeland security.

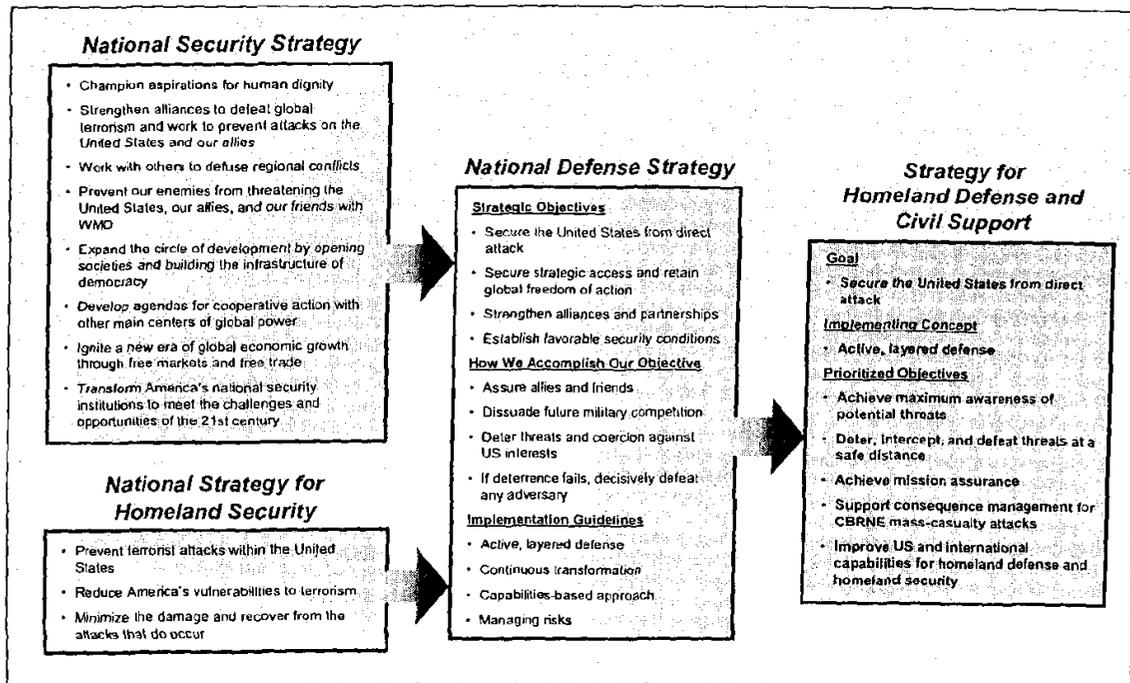


Figure 1: Strategic Underpinnings of the Homeland Defense and Civil Support Strategy

- The National Defense Strategy (2005) identifies as its top priority the dissuasion, deterrence, and defeat of direct threats to the United States. The Strategy's implementation hinges on an active, layered defense that is designed to defeat the most

dangerous challenges early and at a safe distance, before they are allowed to mature. It directs military leadership to properly shape, size, and globally posture to 1) defend the US homeland; 2) operate in and from the forward regions;

3) swiftly defeat adversaries and achieve decisive, enduring results; and 4) conduct a limited number of lesser contingencies.

In addition to these overarching strategies, the Strategy for Homeland Defense and Civil Support is informed by, and complements, other key strategic and planning documents. These include standing National Security and Homeland Security Presidential Directives, the National Military Strategy, the National Military Strategic Plan for the War on Terrorism, the DoD Homeland Security Joint Operating Concept, and Military Transformation: A Strategic Approach (Office of the Director for Force Transformation).

Security Environment

The defining characteristic of the security environment over the next ten years is the risk of substantial, diverse, and asymmetric challenges to the United States, our allies, and interests. In this context, we are faced with great *uncertainty* regarding the specific character, timing, and sources of potential attacks. The Strategy for Homeland Defense and Civil Support aims to mitigate that uncertainty, addressing the full range of challenges to the US homeland over the next decade.

Nation-state military threats to the United States will persist throughout the next decade. Rogue nations, for example, pose immediate and continuing challenges to the United States and our allies, friends, and interests. In addition, we must prepare for the potential emergence of regional peer competitors.

The United States will also face a range of asymmetric, transnational threats. Of greatest concern is the availability of weapons of mass destruction, heretofore the exclusive domain of nation-states, to terrorist groups. **In the**

next ten years, these terrorist groups, poised to attack the United States and actively seeking to inflict mass casualties or disrupt US military operations, represent the most immediate challenge to the nation's security.

Transnational terrorist groups view the world as an integrated, global battlespace in which to exploit perceived US vulnerabilities, wherever they may be. This battlespace includes the US homeland. Terrorists seek to attack the United States and its centers of gravity at home and abroad and will use asymmetric means to achieve their ends, such as simultaneous, mass casualty attacks. On September 11, 2001, terrorists demonstrated both the intent and capability to conduct complex, geographically dispersed attacks against the United States and our allies. It is foreseeable that adversaries will also develop or otherwise obtain chemical, biological, radiological, nuclear, or high-yield explosives (CBRNE) capabilities, with the intent of causing mass panic or catastrophic loss of life. Although America's allies and interests abroad will be the most likely targets of terrorism in the coming decade, we must also anticipate enemy attacks aimed at Americans at home.

Organizing for Homeland Defense and Civil Support

In light of the importance of homeland defense and DoD's contributions to homeland security, the Secretary of Defense, with the support of Congress, has improved the Department's organization and oversight structure for homeland defense and civil support.

- **The Assistant Secretary of Defense for Homeland Defense.** As stated in the 2003 National Defense Authorization Act, the

Assistant Secretary of Defense for Homeland Defense provides overall supervision of DoD's homeland defense activities. The establishment of the Assistant Secretary of Defense for Homeland Defense responded to the need for improved policy guidance to DoD Components on homeland defense and civil support issues.

- **Chairman of the Joint Chiefs of Staff.** The Chairman of the Joint Chiefs of Staff coordinates with and assists US Northern Command, US Pacific Command, the North American Aerospace Defense Command, and all other combatant commands with the strategic direction and planning for, as well as the execution of, homeland defense and civil support missions.
- **US Northern Command**, headquartered in Colorado Springs, Colorado. Established in 2002, US Northern Command (USNORTHCOM) is responsible for planning, organizing, and executing homeland defense and civil support missions within the continental United States, Alaska, and territorial waters. It also coordinates security cooperation with Canada and Mexico. In addition to the landmasses of the United States, Canada, and Mexico, US Northern Command's area of responsibility includes the coastal approaches, the Gulf of Mexico, Puerto Rico, and the US Virgin Islands.
- **US Pacific Command**, headquartered in Honolulu, Hawaii. US Pacific Command (USPACOM) has homeland defense and civil support responsibilities for Hawaii

and US territories, possessions, and freely associated states in the Pacific.²

- **North American Aerospace Defense Command**, headquartered in Colorado Springs, Colorado. The bi-national North American Aerospace Defense Command (NORAD) is responsible for protecting the North American airspace over the United States and Canada. Aerospace warning and control are the cornerstones of the NORAD mission.

In addition to these organizations, all other regional and functional combatant commands, the Military Departments, and DoD elements contribute to the protection of the US homeland from attack.

- Other regional combatant commanders can promote international cooperation on homeland defense through exercises and military-to-military contact programs. Together with the functional combatant commanders, these regional commanders can also intercept and defeat adversaries intent on attacking US territory.

Of particular note, US Strategic Command provides significant support to USNORTHCOM, USPACOM, and NORAD. US Strategic Command is responsible for planning, integrating, and coordinating global missile defense operations and support for missile defense, including providing warning of missile attack, across all combatant

² The Pacific territories, possessions, and freely associated states that are included in the US homeland are: Guam, American Samoa, and Jarvis Island; the Commonwealth of Northern Mariana Islands; the Freely Associated States under the Compacts of Free Association, which include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau; and the following US possessions: Wake Island, Midway Islands, Johnston Island, Baker Island, Howland Island, Palmyra Atoll, Jarvis Island, and Kingman Reef.

commands. US Strategic Command is further charged with the global missions to undertake military space operations, to conduct information operations as well as computer network operations, and to integrate and synchronize DoD efforts in combating weapons of mass destruction.

- The Military Departments organize, train, and equip US military forces across operational domains. The Military Departments provide the bulk of the DoD capabilities likely to be requested for civil support.
- Other DoD Components contribute to homeland defense through intelligence collection, analysis, and prioritization; capability assessments; and oversight of relevant policy, acquisition, logistics, personnel, readiness, and financial matters.

The Strategy for Homeland Defense and Civil Support will guide all DoD Components across the full range of homeland defense and civil support activities.

Assumptions

This Strategy makes the following key assumptions:

- The United States will continue to face traditional military challenges emanating from hostile nation-states. Nation-state adversaries will incorporate asymmetric threats into their broader strategies of competition and confrontation with the United States.
- Terrorists will seek and potentially gain surreptitious entry into the United States to conduct mass casualty attacks against Americans on US soil.
 - Terrorists will exploit our vulnerabilities to create new methods of attack.
 - Terrorists and/or rogue states will attempt multiple, simultaneous mass casualty CBRNE attacks against the US homeland.
 - Terrorists will try to shape and degrade American political will in order to diminish American resistance to terrorist ideologies and agendas.
- Allies and friends will cooperate with the United States in mutually beneficial security cooperation arrangements.
- The Department of Homeland Security and other Federal, state, local, and tribal authorities will continue to improve their prevention, preparedness, response, and recovery capabilities throughout the decade.
- In the event of major catastrophes, the President will direct DoD to provide substantial support to civil authorities. DoD's responses will be planned, practiced, and carefully integrated into the national response.
- The likelihood of US military operations overseas will be high throughout the next ten years.



II. Active, Layered Defense

"The war on terror will not be won on the defensive. We must take the battle to the enemy, disrupt his plans, and confront the worst threats before they emerge. In the world we have entered, the only path to safety is the path of action. And this nation will act."

President George W. Bush

June 1, 2002

As set forth in the National Defense Strategy (2005), the Department of Defense is transforming its approach to homeland defense just as it is transforming national defense capabilities overall. **Guiding homeland defense planning is the concept of an active, layered defense, predicated on seizing the initiative from adversaries.**

"Our most important contribution to the security of the US homeland is our capacity to disrupt and defeat threats early and at a safe distance, as far from the US and its partners as possible. Our ability to identify and defeat threats abroad — before they can strike — while making critical contributions to the direct defense of our territory and population is the sine qua non of our nation's security."

The National Defense Strategy

The United States has multiple points of vulnerability that adversaries seek to exploit. Commerce relies on the flow of goods and people across the nation's borders, through our seaports and airports, and on our streets and highways. The US free market economy requires trust in the uninterrupted electronic movement of financial data and funds through cyberspace. The symbols of American heritage — monuments and public buildings — are a source of national pride and are open to all. Vast and potentially

vulnerable natural resources provide power to our homes and food for our tables.

To safeguard the American way of life and to secure our freedom we cannot depend on passive or reactive defenses. A strictly defensive strategy would involve a potential curtailment of the American people's freedoms and civil liberties. It would be subject to enemy reconnaissance and inevitable defeat. By contrast, an active, layered defense relies on early warning of an emerging threat in order to quickly deploy and execute a decisive response. This active defense is a powerful deterrent, dissuading adversaries and denying them any benefit from attacking the US homeland and imposing costs on those who attempt it.

The United States must keep potential adversaries off balance by both an effective defense of US territory and, when necessary, by projecting power across the globe. **We must seize the initiative from adversaries and apply all aspects of national power to deter, intercept, and disrupt attacks against us and our allies and friends. In short, the United States must act in ways that an enemy cannot predict, circumvent, or overcome.** Multiple barriers to attack must be deployed across the globe — in the forward regions, in the approaches to the United States, in the US homeland, and in the global commons — to create an unpredictable web of

II. Active, Layered Defense

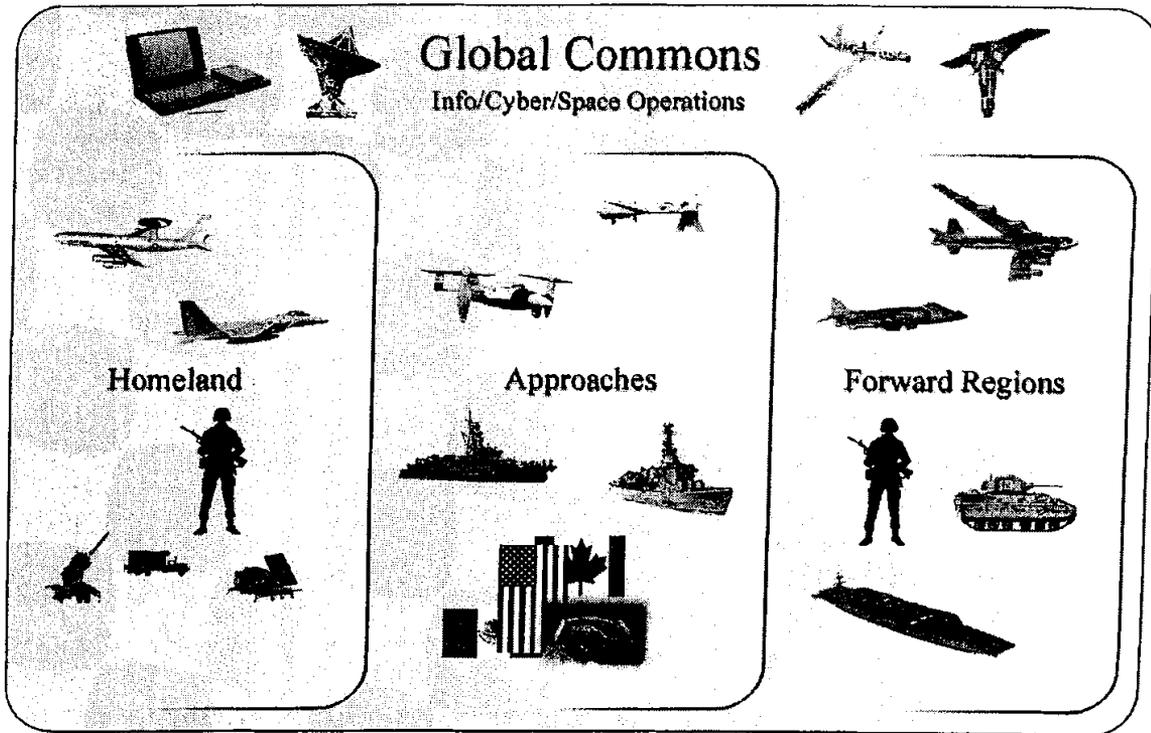


Figure 2: Active, Layered Defense Concept

land, maritime, and air assets that are arrayed to detect, deter, and defeat hostile action. When the United States identifies specific threats or vulnerabilities, it will strengthen deterrence through force projection, flexible deterrent options, heightened alert status, and tailored strategic communications.

The Forward Regions. The forward regions are foreign land areas, sovereign airspace, and sovereign waters outside the US homeland. The Department of Defense is a key contributor to the President's integrated national security effort abroad. To respond quickly to rising threats, the United States requires timely and actionable intelligence. Improved human intelligence (HUMINT) collection, improved intelligence integration and fusion, improved analysis of terrorist threats and targets, and improved technical collection against potential CBRNE weapons are all critical in this regard. In addition, the United States must counter and delegitimize

ideological support for terrorist groups, disrupt their flow of funding, and create an environment that curtails recruitment. US military forces must be trained, ready, and postured to intercept potential enemies, eliminate enemy sanctuaries, and maintain regional stability, in conjunction with allies and friendly states.

The Approaches. The land approaches to the continental United States are within the sovereign territory of Canada and Mexico. These nations, in close cooperation with the United States, contribute to North American security through their law enforcement, defense, and counterterrorism capabilities.

The waters and airspace geographically contiguous to the United States are critical homeland defense battlespaces. In these approaches, US Northern Command, the North American Aerospace Defense Command, and US Pacific Command,

II. Active, Layered Defense

working in concert with other combatant commands, the Intelligence Community, the US Coast Guard, and other domestic and international partners, have the opportunity to detect, deter, and, if necessary, defeat threats en route—before they reach the United States.³ This requires **maximum awareness of threats in the approaches as well as the air and maritime interception capabilities necessary to maintain US freedom of action, secure the rights and obligations of the United States, and protect the nation at a safe distance.**

The US Homeland. The US homeland includes the United States, its territories and possessions, and the Commonwealths and Compact States of the Pacific. It also includes the surrounding territorial seas. Among its responsibilities within US territory, DoD focuses on the following areas:

- DoD is responsible for deterring and, when directed by the President, defeating direct attacks against the United States. NORAD is the cornerstone of our homeland air defense capability. Our air defense success rests on an integrated system for air surveillance and defense against air threats at all altitudes. DoD also maintains land forces capable of responding rapidly, when so directed, to threats against DoD personnel, defense critical infrastructure, or other domestic targets. Finally, DoD supports the US Coast Guard in the exercise of its maritime authorities under domestic and international law.

³ The US Coast Guard is inherently flexible, as both a military service and law enforcement agency within the Department of Homeland Security. The US Coast Guard supports DoD in its homeland defense role, while DoD supports the Coast Guard in its homeland security role, across the forward regions, the global commons, the approaches, and within the US homeland.

- DoD supports civilian law enforcement and counterterrorism authorities consistent with US law. The Attorney General coordinates the activities of the law enforcement community to detect, prevent, preempt, and disrupt terrorist attacks against the United States. DoD support to the Department of Justice and other domestic law enforcement authorities includes providing expertise, intelligence, equipment, and training facilities to these authorities when so directed. It can also include the use of US military forces to support civilian law enforcement in responding to civil disturbances, as provided in US law.
- DoD provides critical CBRNE consequence management capabilities in support of civil authorities. With few exceptions, DoD's consequence management capabilities are designed for the wartime protection of the Department's personnel and facilities. Nevertheless, civil authorities are likely to call upon these capabilities if a domestic CBRNE catastrophe occurs in the ten-year period of this Strategy. **DoD must therefore equip and train these war-fighting forces, as necessary, for domestic CBRNE consequence management. Beyond an already dedicated command and control element designed for this purpose, however, DoD will continue to rely on dual-capable forces for domestic consequence management missions.**

The Global Commons. The global commons consist of international waters and airspace, space, and cyberspace. America's ability to deter threats against the global commons and to operate from them effectively is critical to the conduct of all its military missions, from

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the forward regions to the US homeland. Of particular note is the importance of space and cyberspace to US net-centric capabilities. **An active, layered defense requires a trustworthy information system, impervious to disabling digital or physical attacks.**

Computer network defense must ensure that networks can self-diagnose problems and build immunity to future attacks. At the same time, networks must remain operational and

consistently available for the execution of US military missions.

An active defense also requires the ability to detect and defeat threats from space. This includes the need for capable defenses against ballistic missiles. Ground facilities that support US military space systems are potential targets of attacks, and the Department will protect them.



III. Strategic Goal and Key Objectives

"We must build and maintain our defenses beyond challenge. Our military's highest priority is to defend the United States . . . The threats and enemies we must confront have changed, and so must our forces."

The National Security Strategy of the United States of America

September 2002

The employment of an active, layered defense across the globe is fundamental to achieving the Department of Defense's strategic goal for homeland defense. That is, **we will secure the United States from direct attack**. The National Defense Strategy emphasizes the Department of Defense's role in the forward regions and the global commons and how that role is critical to the defense of US territory. **This Strategy for Homeland Defense and Civil Support therefore focuses particular attention on the US homeland and its approaches**. In these geographic layers, the Department's activities to protect the United States generally fall into one of the following categories:

- **Lead:** DoD leads military missions to deter, prevent, and defeat attacks on the United States, its population, and its defense critical infrastructure. This includes defending the maritime and air approaches to the United States and protecting US airspace, territorial seas, and territory from attacks. The Department is also responsible for protecting DoD personnel located in US territory.
- **Support:** At the direction of the President or the Secretary of Defense, the Department provides defense support of civil authorities in order to prevent terrorist incidents or manage the consequences of an attack or a disaster. Civil authorities are most likely to request DoD support

where we have unique capabilities to contribute or when civilian responders are overwhelmed. DoD's contributions to the comprehensive national response effort can be critical, particularly in the near-term, as the Department of Homeland Security and other agencies strengthen their preparedness and response capabilities.

- **Enable:** Efforts to share capabilities and expertise with domestic agencies and international partners reinforce the Department's lead and support activities. At home, the Department works to improve civilian capabilities for homeland security by lending expertise and sharing relevant technology. For example, DoD is assisting the Department of Homeland Security in its efforts to develop intelligence analytical capabilities. We are also sharing training and simulation technologies, as well as unmanned aerial vehicle technologies for civilian surveillance along the Nation's borders. Abroad, the Department's security cooperation initiatives improve collective capabilities for homeland defense missions through exercises, information-sharing agreements, and formal defense agreements, such as NORAD.

To fulfill the key strategic goal of protecting the United States from attack, the Department of Defense will focus on achieving five key

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objectives directly related to the lead, support, and enable framework. In order of priority, these objectives are:

1. Achieve maximum awareness of potential threats (Lead);
2. Deter, intercept, and defeat threats at a safe distance from the United States, and US territories and possessions (Lead);
3. Achieve mission assurance (Lead);
4. Ensure DoD's ability to support civil authorities in domestic CBRNE consequence management (Support); and
5. Improve domestic and international partner capabilities for homeland defense and homeland security (Enable).

| ACTIVITIES | OBJECTIVES | CORE CAPABILITIES |
|------------|--|--|
| LEAD | Achieve Maximum Awareness of Threats | <ul style="list-style-type: none"> • Maintain agile and capable defense intelligence architecture • Analyze and understand potential threats • Detect, identify, and track emerging threats in all operational domains • Ensure shared situational awareness within DoD and with domestic and foreign partners |
| | Deter, Intercept, and Defeat Threats at a Safe Distance | <ul style="list-style-type: none"> • Deter adversaries from attacking the US homeland • Intercept and defeat national security threats in the maritime and air approaches and within US territory |
| | Achieve Mission Assurance | <ul style="list-style-type: none"> • Ensure force protection, to include DoD installations, especially against the threat of CBRNE attacks • Prepare and protect defense critical infrastructure • Ensure preparedness of the Defense Industrial Base • Prepare to protect designated national critical infrastructure • Ensure DoD crisis management and continuity preparedness |
| SUPPORT | Support Consequence Management for CBRNE Mass Casualty Attacks | <ul style="list-style-type: none"> • Manage consequences of CBRNE mass casualty attacks |
| ENABLE | Improve National and International Capabilities for Homeland Defense and Homeland Security | <ul style="list-style-type: none"> • Effective interagency planning and interoperability • Improved Federal, state, and local partnership capacity and effective domestic relationships • Improved international partnership capacity and effective defense-to-defense relationships |

Figure 3: DoD Objectives and Core Capabilities for Protecting the United States from Attack

Lead

Objective 1: Achieve maximum awareness of threats

To defend the nation in the 21st century, the Department requires sufficient forewarning and immediate situational awareness of potential attacks. No longer is it sufficient to track the movement of hostile military aircraft

and warships. In the 21st century threat environment, transnational terrorists and rogue states may employ a wide range of civilian vessels and aircraft as weapons, engage in cyber attacks, or target civilian infrastructure to achieve devastating effects.

To protect the United States in this environment, the Department of Defense, in cooperation with domestic and international partners,

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will seek to achieve maximum awareness of threats. By so doing, the United States increases the time available for an effective operational response. **Threat awareness includes the ability to obtain comprehensive, accurate, timely, and actionable intelligence and information; exploiting relevant information; and making it available to the warfighters, policy makers, and interagency and international partners responsible for identifying and responding to threats.**

An active, layered defense requires information to flow freely regardless of operational boundaries. Relevant information may originate in one or several of the operational domains—land, maritime, air, cyberspace, or space. It may originate from an array of domestic and foreign sources. To achieve maximum awareness of threats, information will be posted to DoD's Global Information Grid, integrating operational domains and facilitating information sharing across traditional military-civilian boundaries.

Objective 2: Deter, intercept, and defeat threats at a safe distance

During the Cold War, the United States focused on preventing Soviet submarines, ballistic missiles, and long-range bombers from attacking the American homeland. Although concerns about traditional conventional and nuclear threats to the US homeland remain, we recognize that in the next ten years, adversaries will present a host of new challenges. They may attempt to use commercial vessels to transport terrorists or weapons to the United States. They may attempt to intrude on US airspace with low-altitude aircraft, cruise missiles, and unmanned aerial vehicles. They may attempt to convert maritime vessels, aircraft, and other

modes of transportation into weapons. Through these and other means, our enemies will constantly employ asymmetric means to challenge the security of the United States.

In the maritime approaches, DoD is working with the Department of Homeland Security to integrate US maritime defense and to optimize the mutually supporting capabilities of the US Navy and the US Coast Guard. As the Chief of Naval Operations (CNO) has stated, **"forward deployed naval forces will network with other assets of the Navy and the Coast Guard, as well as the intelligence agencies to identify, track and intercept threats long before they threaten this nation."** This will require a level of situational awareness in the maritime domain similar to that in the air approaches. The goal, as the CNO explains, is to **"extend the security of the United States far seaward, taking advantage of the time and space purchased by forward deployed assets to protect the US from impending threats."**

In the air domain, DoD has primary responsibility for defending US airspace and protecting the United States from ballistic missiles, cruise missiles, and other aerospace attacks. For North America, this defense is carried out in partnership with Canada, through NORAD. In addition, the Department of Defense relies heavily on the Federal Aviation Administration (FAA) and the Department of Homeland Security (Transportation Security Administration) for early identification of air threats. As in the maritime environment, cooperation and operational coordination with our inter-agency partners, as well as our neighbors and other allies, is critical to protecting the United States from air threats.

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Within US territory, we face the challenge of intercepting and defeating enemies determined to cause fear, death, and economic disruption. Although we must not dismiss traditional foreign military threats, in the period covered by this Strategy, domestic employment of the US military in a homeland defense role will likely come in response to transnational terrorist, rogue state, or other threats that exceed the capabilities of domestic counterterrorism and law enforcement authorities.

Therefore, the Department must approach the interception and defeat of threats to US territory from a joint, interagency, and, ultimately, intergovernmental perspective. DoD must not conduct operations in separate and distinct land, maritime, and air operational domains. Over the coming decade, US Northern Command, the North American Aerospace Defense Command, and US Pacific Command will continue to develop mature homeland defense capabilities in the air, land, and maritime domains, with appropriate support provided by other combatant commands.

Objective 3: Achieve mission assurance

The Department cannot fulfill any of the Strategy's key objectives without having the core capabilities in place to assure mission success. **Mission assurance, the certainty that DoD components can perform assigned tasks or duties in accordance with the intended purpose or plan, is therefore itself a key objective.** The Department of Defense achieves mission assurance through a range of programs and efforts that are aimed at securing DoD warfighting capabilities even when under attack or after disruption. These include force protection, the defense critical infrastructure program, and defense crisis

management and continuity of operations efforts.

Force Protection. Force protection is central to achieving DoD mission assurance. It includes actions taken to prevent or mitigate hostile actions against DoD personnel (to include family members), resources, facilities, and critical information in an all hazards environment. Force protection measures can be defensive in nature, such as those used to reduce force and installation vulnerability to terrorist attacks or protect against CBRNE effects, or offensive, such as those taken to prevent, deter, and respond to terrorism. By conserving the force's fighting potential so that they can apply it at the decisive time and place, force protection ensures the effective employment of the joint force while degrading the enemy's opportunities.

An attack on DoD facilities could directly affect the Department's ability to project power overseas or carry out vital homeland defense functions. Installation commanders and facility managers have an inherent responsibility to protect the forces and installations under their command. Of particular concern is the threat to DoD personnel and installations posed by domestic CBRNE attacks.

CBRNE Preparedness. The Department of Defense will develop and implement a comprehensive preparedness plan for CBRNE attacks. This plan will leverage capabilities and programs throughout the Department (e.g. Critical Infrastructure Protection, Antiterrorism/Force Protection, Project Guardian) including required intelligence support. In accordance with DoD responsibilities in National Biodefense Policy, the Department is especially attentive to the unique challenges posed by biological agents.

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Defense Critical Infrastructure. Related to its force protection responsibilities for DoD facilities, the Department of Defense has the responsibility to assure it has access to *defense critical infrastructure*. This is defined as DoD and non-DoD cyber and physical assets and associated infrastructure essential to project and support military forces worldwide. When these infrastructures are located on Department of Defense installations, their protection is the responsibility of the installation commander or facility manager. In some instances, however, critical defense assets are located at public or private sites beyond the direct control of DoD. In either case, the protection of designated defense critical infrastructure must be assured on a priority basis.

In some scenarios, assurance of non-DoD infrastructures might involve protection activities, in close coordination with other Federal, state, local, tribal, or private sector partners. This could include elements of the Defense Industrial Base, which is a worldwide industrial complex with capabilities to perform research and development and design, produce, and maintain military weapons systems, subsystems, components, or parts to meet military requirements. These defense-related products and services are essential to mobilize, deploy, and sustain military operations. Moreover, defense critical infrastructure could also include selected civil and commercial infrastructures that provide the power, communications, transportation, and other utilities that military forces and DoD support organizations rely on to meet their operational needs.

In addition, the President or the Secretary of Defense might direct US military forces to protect non-DoD assets of national significance that are so vital to the nation that their

incapacitation could have a debilitating effect on the security of the United States.

Defense Crisis Management and Continuity of Operations. During an emergency, the nation's leaders, including DoD decision-makers, must be able to carry out vital government functions. **The Department must provide the President and Secretary of Defense with survivable and enduring national command and control of DoD assets and US military forces.** DoD also plays an important supporting role in ensuring Continuity of Government and Enduring Constitutional Government in times of crisis. In the Cold War era, DoD continuity efforts focused on survival of senior leadership to prosecute war in the aftermath of a massive nuclear attack. Today, DoD's crisis management efforts are broader, responsive to the full range of potential threats to the nation. Meeting the Department's crisis management objectives requires ready DoD transportation assets, capable and survivable remote operation sites, and advanced communications capabilities throughout the DoD continuity architecture.

Support

Objective 4: Support consequence management for CBRNE mass-casualty attacks

The Department has traditionally supported civil authorities in a wide variety of domestic contingencies, usually natural disasters. DoD typically does so using military forces and DoD capabilities designed for use in expeditionary warfighting missions. That support continues today. For example, unique national intelligence capabilities located within the Defense intelligence community continuously support other US Government

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agencies. Although these traditional types of defense support of civil authorities are likely to continue, they are not likely to impede DoD's ability to execute other missions specified in the National Defense Strategy.

At the high end of the threat spectrum, however, the 21st century environment has fundamentally altered the terms under which Department of Defense assets and capabilities might be called upon for support. **The potential for multiple, simultaneous, CBRNE attacks on US territory is real.** It is therefore imperative that the Department of Defense be prepared to support civilian responders in responding to such mass casualty events.

Support to domestic authorities for consequence management is a core element of active, layered defense. The Department of Defense maintains considerable CBRNE recovery expertise and equipment. When directed by the President or the Secretary of Defense, DoD will employ these capabilities to assist the Secretary of Homeland Security, the principal Federal official for domestic incident management, or other domestic authorities. DoD must be prepared to support its interagency partners in responding to a range of CBRNE incidents, including multiple, simultaneous mass casualty attacks within the United States.

Enable

Objective 5: Improve national and international capabilities for homeland defense and homeland security

The broad range of threats posed by terrorists and other transnational actors has expanded

our traditional concept of national security. In the past, the Department of Defense could largely fulfill its responsibility for protecting the nation by integrating its activities with the Department of State and the Intelligence Community. Today, the expertise and responsibility for managing security challenges is much more widely shared among Federal departments and agencies. State, local, and tribal authorities, the private sector, and our allies and friends abroad are also critical contributors to US national security.

In such an environment, DoD must unify its efforts with those of its key interagency partners and international friends and allies to ensure the nation's security. The Department will promote the integration and sharing of applicable DoD capabilities, equipment, and technologies with Federal, state, local, and tribal authorities and the private sector. Sharing technology, capabilities, and expertise strengthens the nation's ability to respond to hostile threats and domestic emergencies. Likewise, cooperative homeland defense education and training initiatives will help partners build capacity for homeland defense and will foster a common understanding of shared threats and how best to address them. In turn, DoD can readily leverage the expertise of other Federal, state, local, and tribal authorities and international partners to improve its own capabilities for counterterrorism, maritime interception, and other missions critical to an active, layered defense.



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"Some believe that, with the U.S. in the midst of a dangerous war on terrorism, now is not the time to transform our armed forces. I believe that quite the opposite is true. Now is precisely the time to make changes. The impetus and the urgency added by the events of September 11th powerfully make the case for action."

*Secretary of Defense Donald Rumsfeld
January 31, 2002*

The Department of Defense will provide the homeland defense and civil support capabilities necessary to support implementation of the National Security Strategy, the National Strategy for Homeland Security, and the National Defense Strategy. Over the next ten years, DoD will protect the United States from attack by developing the core capabilities necessary to achieve each of the key objectives detailed in Section III.

Capabilities for Achieving Maximum Awareness of Threats

Core Capability: Capable and agile defense intelligence architecture

Protecting the United States against the full-range of 21st century threats requires the US Intelligence Community to restore its human intelligence capabilities, reprioritize intelligence collection to address probable homeland defense threats, and continue to invest in intelligence, reconnaissance, and surveillance (ISR) sensor capabilities. In the Cold War, we knew both the nature of the threat to our country and the source of that threat. Today, intelligence and warning must extend beyond conventional military and strategic nuclear threats to cover a wide range of other state

and non-state challenges that may manifest themselves overseas or at home.

The Intelligence Community is adjusting to this changing strategic landscape to meet the nation's homeland security needs. The establishment of a National Intelligence Director, the National Counterterrorism Center (NCTC), the Department of Homeland Security's Information Analysis and Infrastructure Protection Directorate, and the DoD's Joint Intelligence Task Force for Combating Terrorism (JITF-CT) exemplifies this shift. Executive Orders for strengthened management of the Intelligence Community also ensure a more collaborative, comprehensive approach to intelligence support for national security. While these changes are taking place, the Department of Defense is reorienting its intelligence capabilities in line with the full range of homeland defense priorities. Specifically, the Department will:

- Focus on integrated collection management of foreign and military information and its application to homeland defense and homeland security;
- Better utilize national intelligence capabilities to increase early warning and support prevention, interception, and disruption of potential threats overseas or in the approaches to the United States;

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- Collect homeland defense threat information from relevant private and public sector sources, consistent with US constitutional authorities and privacy law;
- Identify capability needs for CBRNE sensors to meet homeland defense requirements; and
- Develop automated tools to improve data fusion, analysis, and management, to track systematically large amounts of data, and to detect, fuse, and analyze aberrant patterns of activity, consistent with US privacy protections.

Core Capability: Collect, analyze, and understand potential threats

Improving our understanding of America's foreign enemies—in advance of an attack—is at the heart of DoD's efforts to achieve maximum awareness of potential threats. In accordance with the National Strategy for Combating Terrorism (2002), we are strengthening DoD's knowledge of foreign terrorist networks and the inner workings of their operations.

Improved human intelligence, particularly in the forward regions of the world, is the single most important factor in understanding terrorist organizations. The Department of Defense is currently undertaking a focused review of DoD human intelligence capabilities, including reforms to improve HUMINT career development, policies, practices, and organizations. DoD HUMINT operators must have relevant linguistic skills and cultural understanding as well as the technical skills needed to provide high-quality information to the analysts.

In addition, we will **develop a cadre of specialized terrorism intelligence analysts within the Defense intelligence community**

and deploy a number of these analysts to interagency centers for homeland defense and counterterrorism analysis and operations. The Department will maintain significant counterterrorism collection and analytical capability to support military activities overseas and in the approaches to the United States.

National agencies within the Department, such as the National Security Agency and the National Geospatial-Intelligence Agency, will continue to provide their unique capabilities in support of the national homeland security mission in accordance with applicable laws and regulations. The Department will also maintain an analytical capability to identify threats to defense critical infrastructure.

Core Capability: Detection, identification, and tracking of emerging threats in all operational domains

We face challenges in our ability to detect, identify, and track objects in all operational environments. Every day, thousands of US and foreign vessels and aircraft approach and depart North American ports and airports, and many times that number of individuals and vehicles cross our borders. For the Department of Defense, these challenges are especially pertinent in the air and maritime domains, where the military plays a much more substantial role.

To detect and track anticipated air and maritime threats effectively, the United States must have capabilities to cue, surveil, identify, engage, and assess potential threats in real time. Detection and tracking capabilities must be all-weather, around-the-clock, and effective against moving targets. The United States must also have the ability to detect CBRNE threats emanating from any operating environment. This requires a

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comprehensive, all-domain CBRNE detection architecture, from collection to dissemination.

The maritime domain is multi-jurisdictional, with various US agencies responsible for tracking vessels from their departure at foreign ports to their arrival in the United States. Recognizing the potential vulnerability this situation creates, DoD is working closely with interagency partners, especially the Department of Homeland Security, to finalize a unified concept for maritime domain awareness (MDA)—the effective understanding of anything associated with the global maritime domain that could affect the security, safety, economy, or environment of the United States. The purpose of MDA is to facilitate timely, accurate decision-making.

Based on the emerging MDA concept and related efforts that will result from the implementation of National Security Presidential Directive-41/Homeland Security Presidential Directive-13: National Maritime Security, the Department of Defense will work with interagency partners to develop a comprehensive capability to detect threats as far forward of the US homeland as possible, ideally before threat vessels depart foreign ports. **DoD will ensure persistent wide-area surveillance and reconnaissance of the US maritime approaches, layered and periodically varied in such a manner that an adversary cannot predict or evade observation.** The nation will benefit from the Department of Homeland Security's work to institute worldwide cargo and crew reliability mechanisms. DoD, in concert with the Department of Homeland Security, will receive and share data from improved identification systems for small commercial and other vessels, just as it has done for

maritime vessels of over 300 gross tons that are on international voyages.

Achieving threat awareness in the air operational domain presents similar challenges. Throughout the Cold War, the Department of Defense focused on maintaining awareness of external threats that entered US airspace from overseas. The attacks on September 11, 2001, however, originated in US airspace and highlighted weaknesses in domestic radar coverage and interagency air defense coordination. Adversaries might maintain low altitude flight profiles, employ stealth and other defense countermeasures, or engage in deception to challenge US air defenses.

Since the attacks of September 11, 2001, DoD has coordinated with interagency partners to improve significantly the air defense of the United States. DoD has worked with the Federal Aviation Administration to integrate domestic radar coverage and has conducted Operation Noble Eagle air patrols to protect designated US cities and critical assets. We have placed particular emphasis on implementing a robust air defense capability for the National Capital Region, using both air and ground air defense forces.

The Department of Defense will continue to work with domestic and international partners to develop a persistent, wide-area surveillance and reconnaissance capability for the airspace within US borders, as well as over the nation's approaches. This capability could require the development of advanced technology sensors to detect and track low-altitude air vehicles across a wide geographic area. DoD is investigating various technologies that could provide an over-the-horizon engagement capability to detect

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enemy threats in the approaches or over US territory. The United States and our allies must also integrate sensor and intelligence data to identify hostile air vehicles by observing their performance characteristics, suspicious activities, or other attributes. These capabilities in the air domain will provide timely threat detection, extending the depth of air defenses and the time for response, thereby providing multiple engagement opportunities to defeat identified threats.

Core Capability: Shared situational awareness within DoD and with domestic and foreign partners

Shared situational awareness is defined as a common perception of the environment and its implications. All domestic and foreign partners within the homeland defense mission space require situational awareness for three reasons: to identify threats as early and as distant from US borders as possible; to provide ample time for an optimal course of action; and to allow for a flexible operational response. From the March 2003 Homeland Security Information Sharing Memorandum of Agreement, to the aggressive and unprecedented information sharing underway at the NCTC, the US Government continues to make great strides in overcoming obstacles to shared situational awareness.

During the Cold War, the Department of Defense sought shared situational awareness with the Department of State, the Intelligence Community, and allied nations to deter and defeat threats posed by the Soviet Union and other nations. At the same time, the American law enforcement community worked with its international counterparts to thwart international drug cartels and worldwide crime syndicates.

Today, transnational terrorists have blurred the traditional distinction between national security and international law enforcement. Together with the development of other security threats, **this expanded national security challenge necessitates an unprecedented degree of shared situational awareness among Federal agencies, with state, local, tribal, and private entities, and between the United States and its key foreign partners.**

As a first step, the Department of Defense must provide seamless connectivity and timely, accurate, and trusted information to all DoD Components—any time, any place—to achieve maximum awareness of potential attacks against the United States. The Department will therefore ensure that DoD's information infrastructure provides an integrated, interoperable worldwide network of information technology products and management services. This will allow users across DoD to process information and move it to warfighters, policymakers, and support personnel on demand. Network connectivity must be flexible enough to support global operations while allowing for local requirements and innovation. **It must also create a real-time link among sensors, decision makers, and warfighters to facilitate the rapid engagement of enemy targets.**

Beyond building an integrated information infrastructure, DoD must also populate that network with accurate, timely, and actionable data. Today, information relevant to protecting the United States is widely dispersed. The Department, in concert with the intelligence and law enforcement communities and foreign partners, will build on the great strides already made to diminish existing cultural, technological, and bureaucratic obstacles to information sharing. The

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Intelligence Community and Department of Defense will drive improved information sharing within a "need to share" context. The resulting information exchange, commonly referred to as "horizontal integration of intelligence," will provide analysts across the US Government and partner nations with timely and accurate all-source information, vastly improving the creation of a coherent and fully integrated threat picture. Such an expansion in information sharing requires appropriate safeguards to ensure that DoD intelligence components rigorously apply laws that protect Americans' civil liberties and privacy.

Capabilities for Detering, Intercepting, and Defeating Threats at a Safe Distance

Core Capability: Deter adversaries from attacking the US homeland.

DoD's efforts to secure the United States from direct attack are intrinsically linked to the concept of deterrence. The objective of deterrence is to convince potential adversaries that threatening courses of action will result in outcomes decisively worse than they could achieve through other, non-threatening, means.

Just as the range of potential adversaries of the United States varies, so, too, do the most effective means of deterrence. Generally, however, our deterrent is enabled by global situational awareness, effective command and control, military presence abroad, the strength and agility of US military forces, strong domestic and international cooperation and sustained global influence, and a coherent national strategic communications campaign. Information operations, influence

operations, control of the operational domains, conventional and nuclear global strike capabilities, and active and passive defense measures all contribute significantly to deterring threats to the US homeland.

Core Capability: Interception and defeat of national security threats in the maritime and air approaches and within US territory

Maritime Operational Domain. The United States must be able to detect terrorists on the high seas armed with weapons of mass destruction. Accordingly, we will fully integrate our surface, subsurface, air, and surveillance assets, focus them forward, and identify, track and intercept threats at a safe distance from the US. In so doing, we will work with our domestic and international partners and take action consistent with applicable law.

Improving our ability to intercept enemies in the maritime domain requires an integrated system of overlapping defenses—both adaptable and flexible—to frustrate enemy observation and avoid predictability. This begins in the forward regions with improved surveillance capability, increased HUMINT collection, and strengthened international partnerships through programs like the Container Security Initiative and Proliferation Security Initiative. To maximize maritime domain awareness, successive layers of surveillance must be fully coordinated with the operational activity of our forward deployed forces.

DoD has established standing orders for conducting maritime homeland defense and maritime interception operations. Given this guidance, geographic combatant commanders will include interception exercises in their

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security cooperation plans and conduct such exercises on a periodic basis. The US Navy and US Coast Guard will conduct routine and frequent maritime interception exercises to ensure a high state of readiness.

To intercept and defeat transnational threats, the Department of Defense and Department of Homeland Security must have a predetermined process for ensuring rapid, effective US Coast Guard support to the US Navy and vice versa. Although DoD has the lead role in defending the United States from direct maritime attack, we recognize and support the US Coast Guard's responsibilities for maritime law enforcement and homeland security. Together with the US Coast Guard, we must strengthen the security in our ports and littorals, expanding maritime defense capabilities further seaward.

The United States must have a concept of operations for the active, layered maritime defense of the US homeland. Such a concept will require naval forces be responsive to US Northern Command, consistent with maritime mission requirements, and will require that Navy forces be placed under periodic command and control of US Northern Command as appropriate. DoD will also consider the use of US Naval Reserve forces to undertake unique roles in maritime homeland defense. In addition, the US Navy should assess how forces currently used in support of Operation Noble Eagle, together with available coastal patrol craft and future Naval and Joint capabilities, such as the Navy's littoral combat ship, might be used to execute maritime homeland defense missions.

Air Operational Domain. The Department of Defense will defeat air threats to the United States, such as ballistic and cruise missiles

and attacking military aircraft. DoD must also be prepared to intercept non-traditional air threats, even when the intent to harm the United States is uncertain, as initially occurred on September 11, 2001. These threats could include commercial or chartered aircraft, general aviation, ultralight airplanes, unmanned aerial vehicles, radio controlled aircraft, or even balloons. Early detection and successful interception of these types of potential threats requires very close cooperation with DoD's interagency partners.

Since September 11, 2001, the Department of Defense, through Operation Noble Eagle, has conducted air patrols to protect major US population centers, critical infrastructure, and other sites. Working with our interagency partners, DoD will continue these patrols to intercept air threats to the US homeland as long as required.

The Department of Defense will continue to improve the air-to-air and ground-to-air capabilities and associated forces necessary to intercept and defeat all domestic air threats. For air patrol missions, DoD will use more capable aircraft as they are fielded and explore the potential for employing unmanned combat air vehicles. DoD is also upgrading ground-based air defense assets with improved detection and targeting capabilities.

The Department of Defense will devote significant attention to defending US territory against cruise missile attacks. Defense against cruise missiles poses unique challenges, given that their low altitude and small size make them more difficult to identify and track than traditional air threats. The Department of Defense is developing integrated capabilities to defend against cruise missiles, as well as other types of

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unmanned aerial vehicles. As an interim step, DoD is developing a deployable air and cruise missile defense capability to protect designated areas. This capability aims to integrate Service tactical air defense assets, the NORAD air defense system, interagency information sources, and advanced technology sensors. **Future air and cruise missile defense assets will be fully interoperable, increase the size of the defended area, and engage threats at increased range.**

DoD will also continue to work with interagency partners to develop a common air surveillance picture that will improve our ability to identify and, ultimately, defeat enemy targets. An improved capability is required to detect and track potential air threats within the United States. The current radars maintained by the Federal Aviation Administration to track air traffic within the United States are aging, with high maintenance costs, poor reliability, and reduced capability to track emerging threats. **The nation will need to develop an advanced capability to replace the current generation of radars to improve tracking and identification of low-altitude threats.**

Land Operational Domain. The Department of Defense will be prepared to detect, deter and defeat direct, land-based attacks conducted by hostile nations against the United States. When directed by the President, the Department will execute land-based military operations to detect, deter, and defeat foreign terrorist attacks within the United States. To achieve these mission requirements, we must work closely with our neighbors, establish seamless relationships and organizational structures with interagency partners, and be prepared to respond with military forces on our own soil quickly, responsively, and in a manner that is

well coordinated with civilian law enforcement agencies.

Historically, the United States relied almost exclusively on forward deployed forces to confront and defeat nation-state adversaries overseas. Although military power projection remains crucial, transnational terrorism has significantly reduced the effectiveness of this singular approach. Now and in the future, we must be prepared in every part of the globe—most especially the US homeland—to deter, prevent, and defeat terrorist or other asymmetric threats.

The employment of military forces to conduct missions on US territory is constrained by law and historic public policy. It is the primary mission of the Department of Homeland Security to prevent terrorist attacks within the United States. The Attorney General leads our Nation's law enforcement effort to detect, prevent, and investigate terrorist activity within the United States. The scope of DoD's role in preventing terrorist attacks within the US land domain is defined by the President's constitutional authority as Commander in Chief and limited by statutory authority related to military support of civilian law enforcement. Domestic security is primarily a civilian law enforcement function.

The following three-tiered approach provides the parameters under which the military would likely operate:

Tier 1: Local and Federal law enforcement. When directed by the President or the Secretary of Defense, DoD will provide appropriate defense assets in support of domestic law enforcement authority, normally in support of a lead Federal agency such as

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the FBI. Under these circumstances, military forces and assets will remain under the command and control of DoD.

Tier 2: National Guard forces not on Federal Active Duty. When directed by the Governor or appropriate state authority, National Guard forces and assets in state active duty status can respond quickly to perform homeland defense and homeland security activities within US territory.

Newly expanded authorities under Title 32 of US Code—and the National Guard’s on-going transformation—provide Governors and state authorities with the authority to use flexible, responsive National Guard units for a limited period to perform homeland defense activities, when approved by the Secretary of Defense. For example, National Guard forces may, when the Secretary of Defense determines that doing so is both necessary and appropriate, provide security for critical infrastructure and support civilian law enforcement agencies in responding to terrorist acts.

Tier 3: US military forces responding to Presidential direction. If circumstances warrant, the President or the Secretary of Defense may direct military forces and assets to intercept and defeat threats on US territory. **When conducting land defense missions on US territory, DoD does so as a core, warfighting mission, fulfilling the Commander in Chief’s Constitutional obligation to defend the nation.** To fulfill this responsibility, DoD will ensure the availability of appropriately sized, trained, equipped, and ready forces. Currently, this capability is

provided by quick reaction forces (QRFs) and rapid reaction forces (RRFs).

Capabilities for Achieving Mission Assurance

Core Capability: Ensure Force Protection

As previously noted, force protection is that set of measures taken to prevent or mitigate hostile actions against Department of Defense personnel (to include family members), resources, facilities, and critical information. The Department of Defense has institutionalized force protection as a core capability across the Services to lessen the adverse effects of incidents, whether man-made or natural, on key infrastructure within DoD installations and facilities.

CBRNE Preparedness. Although force protection is an all-hazards concept, the Department is particularly concerned about the threat that adversary use of CBRNE poses to DoD personnel and installations. Improving DoD’s capabilities for mitigating and, if necessary, operating in a CBRNE-contaminated environment will require progress in detecting and identifying threats (sense), providing early warning (shape), protecting forces and installations (shield), and ensuring the ability to operate in a contaminated environment (sustain). DoD’s Joint Chemical and Biological Defense Program is focused on developing and fielding technologies to mitigate, and if necessary, to allow forces to operate in, CBRNE contaminated environments.

Sense. DoD currently has a range of capabilities to detect, identify, and quantify airborne, waterborne, and other hazards. Needed improvements include advanced standoff and point detection

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capabilities for chemical and biological threats. DoD is also working to develop and field standoff detection capabilities for explosives. Advances in standoff detection capability will improve the Department's ability to detect nuclear devices as well as weapons using explosives to disperse chemical, biological, and radioactive materials. Finally, the Department is improving medical surveillance capabilities both on installations and within surrounding communities to provide early detection and identification of CBRNE events in the workforce.

Shape. DoD characterizes CBRNE attacks by assimilating information drawn from sensors, hazard prediction models, and elsewhere to inform commanders of impending or approaching threats. The Department is improving on early CBRNE threat characterization by developing an integrated concept of operations for sensing, reporting, and warning of CBRNE attacks, and ensuring compatibility with national-level CBRNE sensor architectures, such as the Department of Homeland Security's BIOWATCH program.

Shield. The Department will continue to provide force protection in advance of a potential CBRNE attack, whether overseas or at domestic installations. Already, more than 850,000 US military personnel have been vaccinated against anthrax; more than 730,000 are vaccinated against smallpox. The Department is now focusing on the development of vaccines and other capabilities that can address new and emerging biological and chemical threats. This includes significant research on technologies for improved

chemical and biological agent detection and personal and collective protection equipment. DoD is also preparing to field capabilities that protect US forces from chemical agents that can be absorbed through the skin.

Lastly, the Department is deepening and expanding collaboration on biodefense research with the Department of Homeland Security and the Department of Health and Human Services. This includes significant new investments by these civilian agencies and the creation of a new research consortium. The construction of a National Interagency Biodefense Campus, collocated with the US Army Medical Research Institute of Infectious Diseases (USAMRIID), will significantly facilitate civil-military cooperation in this area. A revitalized and recapitalized USAMRIID, along with major Department of Homeland Security and Department of Health and Human Services investments, will provide DoD and the nation with added research capacity, additional biopharmaceutical development, increased testing and evaluation of potential biodefense medical products, and large surge lab capacity for bioterrorism incident response.

Sustain. DoD must be able to sustain operations during and after a CBRNE attack in the United States. Medical therapeutics that allow DoD personnel to continue mission-essential tasks in a CBRNE environment are of highest priority. DoD will also expand pilot programs for CBRNE installation preparedness to protect DoD personnel and facilities in the event of an attack. In addition to providing improved CBRNE defense capabilities at 200 critical

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installations in the United States and abroad through the Guardian Program, DoD will improve its capability to protect all installations through updated doctrine and guidance. The Department will examine an aggressive expansion of force protection and related programs to increase both the level of protection and the number of DoD installations it covers.

Core Capability: Preparedness and protection of defense critical infrastructure

Because resources are constrained, uniform protection of all defense critical infrastructure is not possible. **The Department must prioritize the protection of assets based on their criticality to executing the National Defense Strategy and seek to minimize the vulnerability of critical assets in accordance with integrated risk management approach.** To this end, the Department will devise a strategy to:

- Identify infrastructure critical to the accomplishment of DoD missions, based on a mission area analysis.
- Assess the potential effect of a loss or degradation of critical infrastructure on DoD operations to determine specific vulnerabilities, especially from terrorist attack.
- Manage the risk of loss, degradation, or disruption of critical assets through remediation or mitigation efforts, such as changes in tactics, techniques, and procedures; minimizing single points of service; and creating appropriate redundancies, where feasible.
- Protect infrastructure at the direction of the President or the Secretary of Defense where the nature of the threat exceeds the

capabilities of an asset owner and civilian law enforcement is insufficient.

- Enable real-time incident management operations by integrating current threat data and relevant critical infrastructure requirements.

The Military Departments, Defense Agencies, and other DoD components are now implementing the Protective Risk Management Strategy through modifications to their programs and budgets.

Core Capability: Preparedness of the Defense Industrial Base

The National Strategy for the Physical Protection of Critical Infrastructure and Key Assets (2003) notes that, **without the important contributions of the private sector, DoD cannot effectively execute core defense missions.** Private industry manufactures and provides the majority of the equipment, materials, services, and weapons for the US armed forces. The President recently designated DoD as the Sector-Specific Agency for the Defense Industrial Base (DIB). **In this role, DoD is responsible for national infrastructure protection activities for critical defense industries as set forth in Homeland Security Presidential Directive-7.**

To assure that mission critical supplies and services are available, DoD contracts are being modified to ensure that protective measures are in place at key facilities and that DoD can assess the security of the DIB. In addition, the Defense Logistics Agency and other DoD contracting activities are revising the contract process to ensure that civilian defense contractors are able to operate for the duration of a national emergency. **Defense contractors must be able to maintain**

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adequate response times, ensure supply and labor availability, and provide direct logistic support in times of crisis. DoD program managers will be held accountable for ensuring the protection of supporting infrastructure, including key suppliers. DoD base and installation commanders, and those who contract for non-DoD infrastructure services and assets, will monitor assurance activities through compliance with contract language that clearly identifies reliable service availability, priority of restoration, and asset protection.

Core Capability: Preparedness to protect designated national critical infrastructure

The Department has historically focused on preventing unauthorized personnel from gaining access to DoD installations and protecting those installations from traditional military attacks. In the post-September 11, 2001 era, DoD is expanding the traditional concept of critical asset protection to include protection from acts of transnational terrorism. Countering terrorist reconnaissance activity is central to the successful defense of critical infrastructure.

As outlined in the National Strategy for the Physical Protection of Critical Infrastructures and Key Assets (2003), DoD bears responsibility for protecting its own assets, infrastructure, and personnel. At the Department's request, domestic law enforcement may protect DoD facilities.

For non-DoD infrastructure, including private and public assets that are critical to the execution of the National Defense Strategy, DoD's protection role is more limited. The initial responsibility for protection of non-DoD infrastructure rests with asset owners.

Civilian law enforcement authorities augment and reinforce the efforts of asset owners, creating a second tier of protection.

Should protection requirements exceed the capabilities of asset owners and civilian law enforcement, state authorities provide an additional layer of defense. In addition to a Governor's authority to employ National Guard forces in a state active duty status, recent changes to Title 32 of the US Code may provide an additional, expeditious means to use National Guard forces under the control of the Governor, with the approval of the Secretary of Defense, using Federal funding to perform homeland defense activities.

To achieve critical infrastructure protection in the most serious situations, the Department of Defense maintains trained and ready combat forces for homeland defense missions.

Core Capability: Defense crisis management and DoD continuity preparedness

The Department's crisis management and continuity of operations programs are central to mission assurance. DoD must provide capabilities necessary to support senior leadership decision-making and military command and control and to perform essential DoD functions to support national-level crisis managers. DoD is working to strengthen its information management and communications capabilities to support senior leadership in crises. It is also improving the survivability and flexibility of military command and control capabilities.

A significant element of mission assurance is **continuity of operations**—maintaining the ability to carry out DoD mission essential functions in the event of a national emergency

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or terrorist attack. Fulfilling this objective in the current security environment necessitates new and innovative approaches, such as improving policies for personnel dispersion, leveraging information technology to improve crisis coordination, and improving relocation facilities. The Department recently conducted a zero-based assessment of DoD continuity capabilities. The results of this assessment detail numerous capability improvements that the Department can pursue to ensure the continuity of DoD operations in times of crisis. It will transform DoD's approach to continuity operations from a Cold War-oriented concept to one better suited to the terrorist threat.

Capabilities for CBRNE Consequence Management

Core Capability: Consequence management assistance for domestic CBRNE mass casualty attacks

The Department of Defense must be able to conduct major operations in a CBRNE environment. US military forces organize, train, and equip to operate in contaminated environments, as well as manage the consequences of CBRNE incidents, on a level unmatched by any other single domestic agency or international partner. **If directed by the President or the Secretary of Defense, the Department of Defense must be prepared to use these capabilities to assist interagency partners in the aftermath of domestic CBRNE mass casualty attacks.**

DoD's CBRNE capabilities include specialized agent detection, identification, and dispersion modeling systems as well as casualty extraction and mass decontamination abilities. DoD can also provide significant support to domestic consequence

management by providing emergency medical support, such as equipment, mobile hospitals, aeromedical evacuation, medical personnel, engineering support, and mortuary services.

Not all domestic CBRNE incidents will necessitate a Federal response; many scenarios may be well within the capabilities of state and local responders. Those incidents that do require a US Government response will be coordinated by a lead Federal agency. In most catastrophic scenarios, DoD will be called upon to provide support to the Department of Homeland Security or another Federal agency. **The Department will work closely with interagency partners – through the National Response Plan and the National Incident Management System – to ensure proficiency and interoperability in responding to multiple CBRNE incidents.**

The Department will ensure that dedicated CBRNE civil support capabilities are sized, trained, equipped, and ready for the domestic consequence management mission. Dedicated domestic CBRNE command and control is provided by the Joint Task Force-Civil Support. In addition, the National Guard WMD Civil Support Teams can operate under Federal control in times of crisis, when directed to do so by the President or Secretary of Defense. DoD is currently examining the augmentation of WMD Civil Support Teams with National Guard and other military capabilities and forces that are task-organized for this mission.

DoD will also identify, train, and equip an additional, discrete number of military forces for the potential requirements associated with multiple, simultaneous CBRNE attacks within the United States. These forces will be dual-

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mission in nature—these warfighters and support elements will not be dedicated to the civil support role but they will nevertheless be ready to perform domestic consequence management missions when required.⁴

Lastly, the Department will ensure that other elements of the Total Force—currently sized and shaped primarily for overseas missions—are identified, exercised, and ready to support CBRNE consequence management as necessary. This capability will provide added utility for overseas deployments or domestic missions. Within this Total Force context, DoD's effectiveness in responding to domestic CBRNE contingencies will be greatly improved through adjustments to Active and Reserve Component training, procedures that allow for faster mobilization of National Guard and Reserve Forces, and improved command relationships that make optimal use of the Reserve Component. This includes leveraging the National Guard's proposed Joint Force Headquarters-State organizations.

⁴ Among existing dual-use DoD assets are the US Marine Corps Chemical-Biological Incident Response Force (CBIRF); the US Army Technical Escort Unit; the US Army Chemical Biological Rapid Response Team; the Defense Threat Reduction Agency's Consequence Management Advisory Team; the US Army 52nd Ordnance Group; the US Navy Environmental and Preventive Medicine Unit; the US Naval Medical Research Center; the US Navy Defense Technical Response Group; the US Air Force Radiation Assessment Team; and the US Air Force Technical Application Center.

Improving US and International Capabilities for Homeland Defense and Homeland Security

Core Capability: Interagency planning and interoperability

Recognizing the critical importance of interoperability, DoD will share training, planning, and other appropriate resources with interagency partners to standardize operational concepts, develop technology requirements, and coordinate budget planning for homeland missions. Interagency efforts must focus on closing any remaining seams in air, land, maritime, cyberspace and space operational domains and must improve national preparedness and incident management efforts. Development of a coordinated training and exercise program is an essential step toward greater cooperation in executing homeland defense and civil support missions.

Active DoD participation in the interagency process improves planning and interoperability and will ensure that procedures for supporting civil authorities are consistent with the framework for domestic incident response outlined in the National Response Plan and the National Incident Management System.

Core Capability: Improved Federal, state, and local partnership capacity and effective domestic relationships

The Department of Defense has identified three tenets to improve defense support of civil authorities:

- Augment civil capabilities with DoD expertise where necessary;

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- Ensure the seamless operational integration of defense support capabilities with those of the civil sector;
- Assist in the civil sector's development and procurement of new technologies and equipment.

Within this civil support framework, the Department will actively seek to identify opportunities for cooperation with the civil sector. Several initiatives to strengthen civilian capabilities are already underway. Examples include:

- DoD assistance to the Department of Homeland Security to develop CBRNE victim rescue capabilities, similar to those of the US Marine Corps' Chemical Biological Incident Response Force.
- Joint DoD and Department of Homeland Security research and development on, and civilian acquisition of unmanned aerial vehicles for law enforcement and ground surveillance systems for border security.
- DoD efforts through the Interagency Counter Man-Portable Air Defense System (MANPADS) Task Force to help develop an attack prevention and recovery plan, provide technical advice and analysis to the Department of Homeland Security regarding MANPADS countermeasures, and operational assistance to stem the proliferation of MANPADS overseas.

In compliance with Section 1401 of the National Defense Authorization Act for FY 2003, DoD will continue efforts to transfer competencies between DoD and the civil sector—through technology transfer and sharing DoD's "lessons learned" from applicable exercises and program manage-

ment. **Such collaboration can increase the overall effectiveness of national capabilities and potentially reduce other agencies' dependencies on limited DoD assets.**

To succeed, the Department will need a systematic approach to ensure close coordination with the Department of Homeland Security and other interagency, state, and local partners, specifically:

- Facilitating the Department of Homeland Security's efforts to identify and provide appropriate defense technologies to state and local first responders;
- Nurturing new collaborative research, development, experimentation, test and acquisition opportunities with the Department of Homeland Security, while avoiding duplication of effort in these areas; and
- Ensuring the smooth transition of appropriate missions, technologies, and capabilities to the civil sector.

Complementing these activities will be a long-term effort with our Federal partners to identify specific, frequently requested DoD capabilities for possible transition to the civil sector.

Core Capability: Improved international partnership capacity and effective defense-to-defense relationships

Because it is the Department's first priority, homeland defense must be a central, carefully considered element of our defense relationships with key allies and friends abroad. The United States fosters strong defense relationships worldwide for many reasons of national security interest. Two such reasons are to strengthen allied military contributions to collective defense and to

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improve US capabilities through exposure to partners' expertise. Thus, DoD has an active security cooperation program that encourages mutual improvements to support coalition operations and to ensure interoperability. Clearly, our homeland defense will be substantially strengthened through the cooperation and assistance of allies. In turn, our allies can better protect their homelands if we help them build capacity for homeland defense and civil support. **We will strengthen DoD's emphasis in security cooperation on homeland defense and civil support, with particular focus on improved information sharing in defense-to-defense interactions.**

Our North American neighbors, Canada and Mexico, are vital to the protection of the US homeland and the continent. The Department also places special emphasis on cooperative homeland defense efforts with friendly nations in the Pacific and the Caribbean and with our NATO allies.

The primary mechanism for US-Canadian cooperation on homeland defense is the North American Aerospace Defense Command. Dedicated to the defense of US and Canadian airspace, NORAD has evolved from a Cold War institution to an agile 21st century counterterrorism capability reflecting an integrated, flexible bi-national approach to air defense. Over the next decade, the Department of Defense, in conjunction with the Department of State and the Department of Homeland Security, and working with our Canadian partners, will strengthen the NORAD concept by identifying mechanisms for sharing information across the air, maritime, and land operational domains — with shared awareness of the North American maritime domain as the first priority.

Given the importance of Mexico to US homeland defense, US-Mexican counterterrorism cooperation is essential. The Department will work with the Department of Homeland Security, the Department of State, and Mexico to anticipate and plan for crisis coordination and consequence management following a terrorist attack. Cooperation with Mexico on law enforcement and immigration issues is substantial, especially in counternarcotics and border control operations. Defense cooperation requires similar emphasis and must be pursued with due respect for the Mexican government's policy goals and legal constraints. Traditional security assistance tools are pivotal in developing mutually beneficial defense capabilities and arrangements.

Just as defense of the US homeland begins well beyond our geographic boundaries, so too must our cooperative efforts to improve that defense. The expansion of information and intelligence sharing with foreign partners is critical to the success of this Strategy. Friendly and allied nations often possess significant information relating to terrorism, smuggling, and other US concerns.

Beyond the information realm, some nations have significant expertise to share with the United States in combating terrorism and other mission areas related to homeland defense. The United States likewise has much to gain in increasing the homeland defense capabilities of friendly nations. The Department will therefore expand combined education, exercise, training, and experimentation initiatives related to homeland defense.



V. Implications of the Strategy

"The threats and enemies we must confront have changed, and so must our forces."

The National Security Strategy of the United States of America

September 2002

The Strategy for Homeland Defense and Civil Support requires adjustments in DoD forces and capabilities, resource allocation, and technology development. Securing the US homeland is the first among many priorities outlined in the National Defense Strategy. Given resource constraints, this Strategy's objectives must be balanced against the Department's other requirements.

Force Structure

This Strategy reflects a Total Force approach to homeland defense missions, incorporating the capabilities of Active Duty, National Guard, and Reserve forces that will be trained and equipped primarily for warfighting missions in the forward regions and approaches. Forces must also be prepared to conduct the full spectrum of domestic civil support missions when directed by the President or the Secretary of Defense to do so.

To execute this diverse range of missions effectively, DoD must ensure the Total Force, both reserve and active components, is:

- **Timely** in response and readily accessible. Homeland defense and civil support missions require a rapid response, often measured in hours, not days.
- **Trained and equipped** to achieve the highest degree of readiness in a broad array of mission sets.

- **Transformed** to meet terrorist challenges. Timely, trained, and equipped forces must be agile and interoperable, taking advantage of networked capabilities.

Focused Reliance upon the Reserve Component

Homeland defense and civil support are Total Force responsibilities. However, the nation needs to focus particular attention on better using the competencies of National Guard and Reserve Component organizations. The National Guard is particularly well suited for civil support missions. As with other Reserve components, the National Guard is forward deployed in 3,200 communities through the nation. In addition, it is readily accessible in State Active Duty and Title 32 status, routinely exercised with local law enforcement, first responders, and the remainder of the Total Force, and experienced in supporting neighboring communities in times of crisis. In addition, Reserve forces currently provide many key homeland defense and civil support capabilities, including intelligence, military police, medical expertise, and chemical decontamination. The most promising areas for employment of the National Guard and Reserve forces are:

- **Air and Missile Defense**, including surveillance and manning of ground-based defense systems.
- **Maritime Security**, including Naval Reserve augmentation of active

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component and Coast Guard capabilities for intelligence and surveillance, critical infrastructure protection, port security, and maritime intercept operations. **The Naval Reserve should continue to transform to meet 21st century terrorist threats, with an emphasis on interdicting the maritime transport of CBRNE to the United States.**

- *Land defense*, including missions requiring Quick Reaction Forces/Rapid Reaction Forces. Reserve forces, including the National Guard, Army Reserve, and Marine Corps Reserve, are capable of serving in reaction force roles when sufficiently trained and resourced. For example, **the Army is considering whether to use existing National Guard force structure to form modular reaction forces, an initiative that could provide additional capabilities for domestic land defense.**
- *CBRNE response*, including capabilities for detection, extraction, decontamination, and medical care. Army Reserve chemical companies can provide significant capabilities for CBRNE assessment as well as extraction and decontamination of mass casualties. **The National Guard WMD Civil Support Teams, which will be located in all states and territories and the District of Columbia, can be federalized, if required. The National Guard Chemical-Biological-Radiological-High Explosives Enhanced Force Packages (NGCERFPs) – task-organized from existing force structure – also could provide CBRNE response capabilities. The Reserve Component can also offer significant assistance with security, engineering, transportation, communications, medical response, and**

many other CBRNE response needs. **The effective employment of National Guard forces in state, Title 32, or Title 10 status could increase the availability of other US military forces for overseas deployments.**

- *Critical Infrastructure Protection*, including the performance of comprehensive assessments of critical infrastructure sites and utilization of Reserve component forces for quick reaction requirements, when sufficiently trained and resourced, and local security at key defense and non-defense critical infrastructure sites, when directed.

Technology

Implementation of the Strategy for Homeland Defense and Civil Support may require several new technological investments. Three areas of particular interest for further exploration are advanced information and communications technology, new generations of sensors, and non-lethal capabilities.

Advanced Information and Communications Technology

Technological and organizational improvements for homeland security and homeland defense will benefit from focused investment in advanced information technology, especially to prevent, intercept, and respond to terrorist activity. *Whether the objective is improved maritime domain awareness and operations, interception of weapons of mass destruction, response to chemical or biological attacks, or continuity of operations and government, improvement in information technology is critical to addressing current capability shortfalls. Advanced modeling and simulation techniques for*

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threat identification, pattern analysis, risk assessment, dependency analysis, and cost/benefit calculus are critical for addressing issues of data sharing, security, and interoperability. Without these tools, the return on investments in other areas, such as improved sensors, detectors, command and control, and human intelligence collection and analysis, will be insufficient.

Equally pivotal are potential advances in communications technologies, particularly those supporting ground-mobile and airborne communications. DoD must reduce the size and power requirements of mobile communications systems and be able to shield them against electromagnetic effects.

Sensors

New generations of sensors and sensor platforms will improve threat awareness by helping to close current gaps over much of the maritime domain and in domestic airspace, particularly at low altitudes. Shared sensor technology could also play an important role in improving border surveillance by civilian agencies.

The placement of sensors on high altitude platforms, including new generations of unmanned aerial vehicles, satellites, and aerostats, could allow sustained surveillance of wide areas of the earth's surface. These sensors could also strengthen defenses against low-flying cruise missiles. Some new ground sensors are expected to have an over the horizon capability with applications for homeland defense and homeland security missions.

New sensor technologies could also have utility for: maritime defense, including the non-acoustic detection of underwater vehicles, objects, and swimmers; remote

detection of concealed CBRNE weapons aboard ships; and mapping the location and extent of contamination should adversaries use these weapons. Finally, **DoD must fully integrate its sensors and others on which it relies with information networks to coordinate their use and rapidly distribute information.**

Non-Lethal Capabilities

As the terrorist attack of September 11, 2001, made it clear, we may be required to defeat attacks in major civilian population centers. Non-lethal capabilities hold some promise as an effective alternative to deadly force. The Department will therefore examine the potential operational employment of non-lethal weapons for homeland defense missions, particularly those where civilian loss of life can be effectively minimized.

Non-lethal technologies with potential application to homeland defense missions include:

- **Counter-personnel technology**, used to deny entry into a particular area, temporarily incapacitate individuals or groups, and clear facilities, structures, and areas.
- **Counter-material technology**, to disable, neutralize, or deny an area to vehicles, vessels, and aircraft, or disable particular items of equipment.
- **Counter-capability technology**, to disable or neutralize facilities, systems, and CBRNE.

The Department will expand basic research into the physiological effects of non-lethal weapons. The Department will also identify opportunities to share appropriate non-lethal

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capabilities with domestic law enforcement agencies, consistent with applicable law.

Rapid Prototyping of Emerging Capabilities

Advanced Concept Technology Demonstrations (ACTDs) are a key DoD vehicle for rapidly fielding promising technologies. The objectives of an ACTD are to conduct meaningful demonstrations of the capability, develop and test concepts of operations to optimize military effectiveness, and, if warranted, prepare to transition the capability into acquisition without loss of momentum. Currently, there are over 25 ACTDs with relevance to homeland defense and homeland security such as the Homeland Security/Homeland Defense Command and Control Advanced Concept Technology Demonstration. The Department will ensure that requirements for homeland defense and civil support are properly addressed in the ACTD process. The Department will continue working with the Department of Homeland Security and other domestic and international partners to encourage their participation in ACTDs as appropriate. **DoD will also continue to leverage innovative capabilities arising from private sector initiatives, many of which are fostered through the interagency Technical Support Working Group (TSWG).**

Funding

Proper funding and budget oversight for homeland defense and CBRNE consequence management missions is vital. Currently, the Department accounts for homeland defense activities through a variety of disparate programs and funding lines in every Military Department and combatant command and numerous initiatives under the purview of

the Office of the Secretary of Defense. Funding for homeland defense is not accounted for consistently.

Funding Implications

In developing planning and programming guidance to implement the Strategy for Homeland Defense and Civil Support, DoD must assess the fiscal implications of attaining and sustaining requisite core capabilities. Determining the relative costs and benefits of each of the following areas merit immediate attention:

- **Expanding communications infrastructure** and improving DoD's ability to share vital information while protecting the integrity of the Global Information Grid;
- **Improving intelligence assets** to improve overall threat awareness across all domains;
- Developing and procuring **advanced technologies** to maximize awareness of potential threats;
- Developing the capabilities needed to effectively conduct an active, layered **maritime defense** against transnational threats, including CBRNE attacks;
- Implementing DoD's **Defense Critical Infrastructure Protection** responsibilities;
- Furthering investments in the research, testing, and fielding of **non-lethal weapons** capabilities;
- Providing support for DoD **continuity of operations** in the event of a national emergency or catastrophe; and
- **Transforming the Reserve component** for homeland defense and civil support missions.

In the course of implementing this Strategy, the Department must not take on responsibilities and costs for homeland security missions better addressed by other Federal, state, local, or tribal authorities.

This will require close cooperation with the Department of Homeland Security and other interagency partners.

Managing Homeland Defense and Civil Support Risks

The Department's risk management strategy acknowledges the importance of an active, layered homeland defense. **An active, layered defense integrates homeland defense and forward operations conceptually and operationally.** Therefore, the Department will assess homeland defense and civil support mission risks in the context of all of the requirements outlined in the National Defense Strategy.

The Strategy for Homeland Defense and Civil Support places a premium on the Department's primary responsibility for protecting the US homeland from attack. A second priority is to meet DoD's most challenging civil support mission—CBRNE consequence management. Specifically, the Strategy's risk management approach is as follows:

Lead. The Department's key lead objectives are to achieve maximum awareness of threats, deter, intercept, and defeat threats at a safe distance, and achieve mission assurance. **DoD must not accept undue risk in its active defense of the US homeland from direct air, land, or maritime threats.** The capability and readiness of US forces to intercept and defeat

these threats must be assured. Further, because the most critical element of successfully defeating threats to the US homeland is shared situational awareness, the Department will focus special attention in this area. DoD accepts some operational risk in achieving mission assurance.

Support. Transnational terrorists have a demonstrated intent to acquire weapons of mass destruction and exploit US vulnerabilities to employ such weapons against potential domestic targets. Accordingly, the Department will reduce risk by improving its consequence management capabilities for responding to multiple, simultaneous CBRNE mass casualty attacks in the United States. **DoD will maintain a ready, capable, and agile command and control structure, along with competently trained forces, to assist civilian authorities with catastrophic incident response.** However, with the exception of a dedicated command and control element (currently the Joint Task Force-Civil Support) and the National Guard's WMD Civil Support Teams, **DoD will continue to rely on dual-capable forces for consequence management and other defense support of civil authorities.** The Department minimizes the risk that dual-capable forces may be assigned to other high priority missions by deconflicting overseas and domestic force requirements wherever possible.

Enable. **The Department aims to decrease long-term risk by improving the capabilities of our interagency and international partners.** DoD accepts some risk in achieving the "Enable" objective to address other more immediate "Lead" and "Support" objectives.



VI. Conclusion

"The battle is now joined on many fronts. We will not waver; we will not tire; we will not falter; and we will not fail. Peace and freedom will prevail."

President George W. Bush

October 7, 2001

The United States faces ruthless enemies who seek to break our will by exploiting America's fundamental freedoms. Our adversaries are eager to employ violence against Americans at home. In this environment, the Department of Defense's paramount goal will continue to be the defense of the US homeland from direct attack.

A new kind of enemy requires a new concept for defending the US homeland. **The terrorist enemy now considers the US homeland a preeminent part of the global theater of combat, and so must we.** We cannot depend on passive or reactive defenses but must seize the initiative from adversaries.

The active, layered defense articulated in this Strategy seamlessly integrates US capabilities in the forward regions of the world, the global commons, the geographic approaches to the US territory, and within the United States. Whether in a leading, supporting, or enabling role, the Department of Defense, guided by this Strategy and consistent with US law, will work with an intense focus to protect the US homeland and the American people.

When fully realized, this Strategy will transform the Department's homeland defense and civil support capabilities. The nation will have effective intelligence, surveillance, and reconnaissance capabilities for homeland defense; and information will be widely

shared with relevant decision-makers. The Department will execute homeland defense missions with well-trained and responsive forces that use improved technology and operational concepts to eliminate seams between the maritime, air, and land domains. Additionally, **the Department will achieve unity of effort with our interagency and international partners in executing homeland defense and civil support missions.**

The effectiveness of any strategy is ultimately in the hands of those charged with its implementation. The Department of Defense will carefully consider the potential implications of this Strategy for force structure, technology, and funding. It will also continually reevaluate the Strategy, adapting it as needed for the dynamic international environment and changing US policy and capabilities.

The Department of Defense must change its conceptual approach to homeland defense. The Department can no longer think in terms of the "home" game and the "away" game. There is only one game. The Strategy for Homeland Defense and Civil Support is a significant step toward this strategic transformation. Defending the US homeland—our people, property, and freedom—is our most fundamental duty. Failure is not an option.

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POSTURE STATEMENT OF
GENERAL BANTZ J. CRADDOCK, UNITED STATES ARMY
COMMANDER, UNITED STATES SOUTHERN COMMAND
BEFORE THE 109TH CONGRESS
HOUSE ARMED SERVICES COMMITTEE

9 MARCH 2005



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Mr. Chairman, Representative Skelton and distinguished Members of this Committee, I appreciate the opportunity to report to you on the posture of United States Southern Command and our efforts to combat terrorism, strengthen regional stability, and protect U.S. security interests in Latin America and the Caribbean. I would also like to thank the Members of this Committee and the Congress for your continued outstanding support to the military and civilian personnel serving in this theater.

Since assuming command on November 9, 2004, I have traveled to 12 of the 30 countries in my assigned area of responsibility (AOR), visiting Andean Ridge nations four times. This year, the men and women of this Command supported operations at the Guantánamo Detention Facility, supported Colombia's successful prosecution of its war against three U.S. Government-designated Foreign Terrorist Organizations (FTO), and deployed to lead a multinational force that included Canada, Chile, and France to reestablish security in Haiti. SOUTHCOM, through its joint interagency task force (JIATF-South), in conjunction with multinational and interagency efforts, directly contributed to the seizure of over 222 metric tons of cocaine. SOUTHCOM units and components conducted hundreds of security cooperation activities in the United States and with partner nations abroad.

Mission and Vision. U.S. Southern Command's mission is to conduct military operations and promote security cooperation to achieve US strategic objectives. Our vision is that SOUTHCOM be the recognized partner of choice and center of excellence for regional security affairs within a hemisphere of escalating importance; organized to defend the homeland and deter, dissuade, and defeat transnational threats; focused on achieving regional partnerships with nations to promote commitment to democratic

values, respect for human rights, territorial security and sovereignty, and collective regional security.

Command Priorities. To accomplish our mission, our activities are prioritized as follows: First, prosecution of the War on Terrorism (WOT), to prevent terrorist groups from using the region as a sanctuary to prepare, stage, or conduct terrorist operations against the United States or our vital interests in the region. The fight against narco-terrorism, the epicenter of which is in the Republic of Colombia, has been a significant focus of our efforts related to the War on Terror. SOUTHCOM directly supports the WOT by conducting detainee operations at Guantánamo Bay, Cuba. We commit significant time and resources to prepare for both natural and man-made contingencies. An important focus of our interaction with partner nations is to encourage a cooperative approach to regional problems. We are engaged in a process of transformation to allow us to respond to those missions more rapidly and efficiently. To maintain mission effectiveness, we work to ensure that our Soldiers, Sailors, Airmen, Marines, Coastguardsmen and civilians in Miami and in our missions abroad have the best quality of life that we can provide.

Sources of instability and insecurity in the U.S. Southern Command AOR.

Although Latin America and the Caribbean is generally free of the prospect of cross-border conventional military attacks between nations, it is the world's most violent region, with 27.5 homicides per 100,000 people. This lack of security is a major impediment to the foreign investment needed to strengthen Latin American and Caribbean economies to pull more of the population above the poverty line. To understand the sources of instability and insecurity, it is helpful to categorize them as threats; which US and partner nation security forces must actively combat in order to

protect citizens and property, challenges; which complicate our cooperative security efforts, and the underlying conditions of poverty, corruption, and inequality.

Threats. The stability and prosperity of the SOUTHCOM AOR are threatened by transnational terrorism, narcoterrorism, illicit trafficking, forgery and money laundering, kidnapping, urban gangs, radical movements, natural disasters and mass migration.

At this time, we have not detected Islamic terrorist cells in the SOUTHCOM AOR that are preparing to conduct attacks against the US, although Islamic Radicals in the region have proven their operational capability in the past. We have, however detected a number of Islamic Radical Group facilitators that continue to participate in fundraising and logistical support activities such as money laundering, document forgery, and illicit trafficking. Proceeds from these activities are supporting worldwide terrorist activities. Not only do these activities serve to support Islamic terrorist groups in the Middle East, these same activities performed by other groups make up the greater criminal network so prominent in the AOR. Illicit activities, facilitated by the AOR's permissive environment, are the backbone for criminal entities like urban gangs, narcoterrorists, Islamic terrorists, and worldwide organized crime.

Many of our partner nations in Latin America, and specifically the Andean Ridge, are threatened by regional terrorist organizations that are supported and funded by illegal drug trafficking and other forms of criminal activities. Ninety percent of the cocaine and 47% of the heroin that reaches the United States emanates from or passes through Colombia. The consumption of illicit drugs kills over 21,000 Americans annually and results in over \$160 billion worth of lost revenue. Colombia's three U.S. Government-designated Foreign Terrorist Organizations: the Revolutionary Armed Forces of

Colombia, or FARC; the National Liberation Army, or ELN; and the United Self-Defense Forces, or AUC, are Department of State-designated foreign terrorist organizations.

Although the Colombian government has made tremendous progress against these groups over the past two years, the narco-terrorist groups still exercise some level of control over 40% of the country.

Kidnapping, a problem that has reached epidemic proportions in Latin America and the Caribbean, is used by criminal and narco-terrorist organizations to raise money and fund other illicit or terrorist activities. A Council of the Americas study from 2004 ranks the top ten countries with regard to kidnapping rate. The top five are all Latin American countries. One recently published study claims that Latin America and the Caribbean account for 75% of all kidnappings worldwide, a staggering figure when one considers that the region has less than 10% of the world's population.

Especially troublesome is the growth of gangs and drug related crime across Central America, portions of the Caribbean, and in some cities in Brazil. Unemployment and poverty make Central America a spawning ground for gangs. There are estimated to be at least 70,000 gang members stretched across Central America. The level of sophistication and brutality of these gangs is without precedent. One gang in Guatemala requires the murder of a teenage girl as an initiation rite. Surges in gang violence sometimes overwhelm local law enforcement capabilities. As directed by their civilian leadership, military forces are assisting police to check this growing tide of gang violence and insecurity in Guatemala, El Salvador and Honduras. The tragic bus massacre that took place last December in Honduras claimed the lives of 28 men, women and children. This incident made international news, yet we hear little about the steady increase in

daily murders that have brought Honduras' homicide rate (45.7 per 100,000 persons) nearly to Colombia's level (47 per 100,000 persons).

There is also mounting evidence that many of those gang members have close connections with gangs in the United States, either from drug distribution networks or from immigration and deportation to their home countries. On January 14, 2005, police in Miami-Dade County, Florida arrested nine members of one of Central America's most violent gangs: Mara Salvatrucha. All of these individuals had outstanding arrest warrants for crimes ranging from larceny to murder. These arrests are just one recent example of the growing link of Central American gangs to their United States counterparts.

Challenges. While the American Servicemembers' Protection Act (ASPA) provides welcome support in our efforts to seek safeguards for our service-members from prosecution under the International Criminal Court, in my judgment, it has the unintended consequence of restricting our access to and interaction with many important partner nations. Sanctions enclosed in the ASPA statute prohibit International Military Education and Training (IMET) funds from going to certain countries that are parties to the Rome Statute of the International Criminal Court. Of the 22 nations worldwide affected by these sanctions, 11 of them are in Latin America, hampering the engagement and professional contact that is an essential element of our regional security cooperation strategy. The IMET program provides partner nation students with the opportunity to attend U.S. military training, get a first-hand view of life in the U.S., and develop long-lasting friendships with U.S. military and other partner nation classmates. Extra-hemispheric actors are filling the void left by restricted US military engagement with

partner nations. We now risk losing contact and interoperability with a generation of military classmates in many nations of the region, including several leading countries.

I am also concerned with Venezuela's influence in the AOR. The capture of senior FARC member Rodrigo Granda in Venezuela, carrying a valid Venezuelan passport and his possible connection to the kidnapping and killing of the daughter of Paraguay's former president is of concern. Granda's capture caused a significant diplomatic impasse, which was later mended by Presidents Uribe and Chavez meeting face-to-face.

SOUTHCOM supports the joint staff position to maintain military-to-military contact with the Venezuelan military in support of long-term interests in Venezuela and the region. I believe we need a broad based interagency approach to dealing with Venezuela in order to encourage functioning democratic institutions.

An increasing presence of the People's Republic of China (PRC) in the region is an emerging dynamic that must not be ignored. According to the PRC publication "People's Daily" in the period of January 2004 through November 2004, the PRC invested \$898M USD in Latin America, or 49.3 percent of their overseas investment. The PRC's growing dependence on the global economy and the necessity of protecting access to food, energy, raw materials and export markets has forced a shift in their military strategy. The PRC's 2004 Defense Strategy White Paper departs from the past and promotes a power-projection military, capable of securing strategic shipping lanes and protecting its growing economic interests abroad. In 2004, national level defense officials from the PRC made 20 visits to Latin American and Caribbean nations, while Ministers and Chiefs of Defense from nine countries in our AOR visited the PRC. Growing economic interests, presence and influence in the region are not a threat, but

they are clearly components of a condition we should recognize and consider carefully as we form our own objectives, policies and engagement in the region.

Another challenge in this AOR is the perennial problem of weak governmental institutions. Unanswered grievances and unfulfilled promises to the indigenous and marginalized segments of society have resulted in deep-rooted dissatisfaction with most partner nation governments. In Bolivia, the violent unrest that led to the resignation of President Gonzalo Sanchez de Lozada in 2003 still simmers below the surface of a deeply divided and disaffected population. Just two days ago on March 7th, President Mesa tendered his resignation to the Bolivian Congress. In Bolivia, Ecuador, and Perú distrust and loss of faith in failed institutions fuel the emergence of anti-US, anti-globalization, and anti-free trade demagogues, who, unwilling to shoulder the burden of participating in the democratic process and too impatient to undertake legitimate political action, incite violence against their own governments and their own people.

The Conditions of Poverty, Inequality and Corruption. The roots of the region's poor security environment are poverty, inequality, and corruption. Forty-four percent of Latin America and the Caribbean are mired in the hopelessness and squalor of poverty. The free market reforms and privatization of the 1990's have not delivered on the promise of prosperity for Latin America. Unequal distribution of wealth exacerbates the poverty problem. The richest one tenth of the population of Latin America and the Caribbean earn 48% of the total income, while the poorest tenth earn only 1.6%. In industrialized countries, by contrast, the top tenth receive 29.1%, while the bottom tenth earn 2.5%. Uruguay has the least economic disparity of Latin American and Caribbean countries, but its unequal income distribution is still far worse than the most unequal country in Eastern Europe and the industrialized countries. A historical climate of

corruption siphons off as much as 10 percent of the gross domestic product and discourages potential foreign investment.

These conditions are only made worse by natural disasters such as hurricanes, mudslides, floods, and earthquakes. Such disasters can strike the region at any time, resulting in thousands of dead or displaced persons. Natural or man-made catastrophes can trigger mass migration, which cause additional suffering and instability.

SOUTHCOM and Partner Nation Initiatives.

JTF-Guantánamo. This command has continued to support the War on Terrorism through detainee operations at Guantánamo Bay, Cuba, where approximately 550 enemy combatants in the Global War on Terrorism are in custody. A significant number of these enemy combatants are highly trained, dangerous members of al-Qaida, its related terrorist networks, and the former Taliban regime. More than 4,000 reports detail information provided by these detainees, much of it corroborated by other intelligence reporting. This unprecedented body of information has expanded our understanding of al-Qaida and other terrorist organizations and continues to prove valuable. Our intelligence and law enforcement communities develop leads, assessments, and intelligence products based on information detainees provide. The information delineates terrorist leadership structures, recruiting practices, funding mechanisms, relationships, and the cooperation between groups, as well as training programs, and plans for attacking the United States and other countries. Detainees have identified additional al-Qaida operatives and supporters and have expanded our understanding of the extent of their presence in Europe, the United States, and throughout the CENTCOM area of operations. Detainees have also provided information on individuals connected to al-Qaida's pursuit of chemical, biological, and nuclear weapons. Recent exchanges with

European allies have supported investigations and apprehensions of Islamic extremists in several European countries.

In performing our intelligence mission, we continue to emphasize the U.S. government's commitment to treating detainees "humanely, and to the extent appropriate and consistent with military necessity, in a manner consistent with the principles of Geneva." Along these lines, we have a good working relationship with the International Committee of the Red Cross. We take their recommendations seriously and act upon them when appropriate. All credible allegations of abuse have been investigated and appropriate disciplinary action was taken against those who have engaged in misconduct. It is important to recognize that there have been only a small number of substantiated allegations of abuse or misconduct at Guantánamo over the last three years. I recently directed an investigation into allegations of questionable conduct made by members of the FBI. That investigation is ongoing.

There are four different legal proceedings that JTF Guantánamo supports in one capacity or another: 1) habeas litigation in federal court, 2) combatant status review tribunals, 3) administrative review boards, and 4) military commissions. Let me briefly review them. Habeas litigation is the result of the U.S. Supreme Court decisions from last year that now allow civilian attorneys representing detainees to file habeas corpus petitions in federal court to challenge the basis for their detention at Guantánamo. As the habeas litigation proceeds, civilian attorneys have been given access to their clients at Guantánamo. In addition, the Deputy Secretary of Defense directed the Secretary of the Navy to conduct combatant status review tribunals (CSRTs) on each detainee; these provide each detainee a one-time opportunity to contest their status as an enemy combatant. As of 14 February of this year, 558 CSRTs have been conducted and final

action has been taken in 422 of those cases. Of these, 12 detainees have been determined to be non-enemy combatants, who have or will be released. The Deputy Secretary of Defense also directed the Secretary of the Navy to conduct administrative review boards (ARBs) on each detainee determined to be an enemy combatant; this provides annual assessments of whether detainees should be released, transferred or continue to be detained depending on their threat to the U.S. As the CSRTs wind down, the ARBs are beginning. Both require extensive logistical support and information requirements from JTF Guantánamo. And finally, military commissions of four detainees commenced last fall. These are trials of detainees who the President determined there is reason to believe are members of Al Qaida or engaged in international terrorism against the United States. However a federal court ruling recently stayed the proceedings in one of the commissions. The Department of Justice is appealing that decision. The Appointing Authority for Military Commissions, Mr. Altenburg, suspended all military commissions pending the outcome of that appeal.

Joint Interagency Coordination Group (JIACG). To counter the threat of transnational terrorism, we will continue to apply our human and material resources toward disrupting and defeating terrorist groups' illicit activities. The Joint Interagency Coordination Group is used as our forum for fusing together all elements of national power to achieve U.S. national security objectives in our AOR. Southern Command gains actionable intelligence on terrorist activities that is then used by U.S. law enforcement agencies and our partner nations to disrupt terrorist operations and their means of support. Narco-terrorists use the illegal drug trade to finance their activities. To further these efforts we enhance partner nation capabilities to control borders, eliminate safe havens, and project government presence.

Support to Colombia. The Colombian Government continues to make tremendous progress in the battle against terrorism and the restoration of security for the strengthening of its democratic institutions. Under a very courageous president, the government of Colombia has enacted the democratic security and defense policy to restore order and security while establishing a relationship of mutual trust with its citizens. In 2004, homicides decreased 16%; the lowest level since 1986. The year 2004 also saw a 25% decrease in robberies, a 46% decrease in kidnappings, and a 44% decrease in terrorist attacks nationwide. For the first time, there is a government presence in all of the municipalities in Colombia. Fundamental to this policy has been the military component of the Colombian government's Plan Colombia – Plan Patriota. SOUTHCOM is providing substantial resources to support this military campaign. U.S. training, equipment and logistical support have been vital to the success of Colombian Plan Patriota efforts to date and will continue to be needed into the future.

Military Progress in Colombia. The government's security policy has significantly diminished the FARC's ability to carry out offensive actions in a sustainable, coherent manner. Over the past two and a half years, the FARC has been reduced from 18,000 to an estimated 12,500 members. Numerous FARC leaders have been killed or captured by the Colombian military and police. Simon Trinidad is in a U.S. jail awaiting trial on drug trafficking charges. Nayibe "Sonia" Rojas, a key FARC narco-terrorist leader, was captured by the Colombian military, and the disposition of her case is pending. The Colombian military's Plan Patriota is slowly strangling the FARC's operations in southern Colombia. The ELN, with approximately 3,500 fighters, has been marginalized. The ELN struggles to survive as an organization as combat losses and leadership divisions take their toll. The AUC, with an estimated strength of 12,000

combatants, is currently negotiating peace with the Colombian government and the government has established a concentration zone to facilitate peace talks and demobilization. Over 4,600 AUC members have been demobilized to date, and the removal of these combatants from the fight represents a victory for the government. Significant issues, notably extradition to the U.S. and prison terms, remain for full demobilization of all AUC elements. Nonetheless, the Colombian government is making progress at removing combatants from the field and converting them into productive members of society. Once started, the Colombian government's demobilization program must succeed. The first combatants to demobilize are currently in the sunset phase of their demobilization and reintegration process and are ready to reintegrate themselves into Colombian society. Failure of this program will not only re-create the conditions for violence but also undermine current peace negotiations and incentive for further demobilization.

Colombian Civil Affairs Program. The Colombian government's efforts to reassert or establish governance in areas previously controlled by narco-terrorists are essential to build on recent military successes. Recognizing this and working within limitations of US law, USSOUTHCOM has worked with the Colombian Ministry of Defense to develop mechanisms to synchronize interagency planning needed to reestablish governance. To this end, the Government of Colombia established a Coordination Center for Integrated Action, which assembles representatives from 13 different ministries chaired by a board of directors that reports directly to the President of Colombia. The Center's responsibility is to develop policies and plans to ensure a coordinated and expeditious response that will re-establish government presence and services in territory reclaimed from narco-terrorists. To date, the Colombian Government

has committed over \$30 million to this effort. Related to this program, USSOUTHCOM is providing \$1.5 million in Fiscal Year 05 to develop the Colombian military's Civil Affairs capability. This capability will enable Colombian military to coordinate within their interagency, with NGOs, and integrate humanitarian assistance into military operational planning. In the departments of Arauca, Cundinamarca, Caquetá, and Guaviare, portions of which are in the former narco-terrorist controlled demilitarized zone, the Colombian military has provided basic medical care to over 30,000 civilians and has rehabilitated numerous educational and medical facilities. On 31 January 2004, the Government of Colombia announced subsidies for building 218 low-cost housing units, new projects benefiting over 530 families in the Caquetá department and the issuance of 17,000 land titles in Caquetá. Plan Colombia also has planned in this region the rebuilding of 81 houses affected by terrorism, an increase in alternative development, and \$2.5 million for small business loans. These activities build on military success to gain lasting confidence of the civilian population in the government and its institutions.

Eradication and Interdiction Gains. We have also made significant gains in attacking the illicit narcotics industry that provides nearly all of the world's supply of cocaine and about half of the US's supply of heroin. Through our close cooperation with the Government of Colombia, the eradication program in Colombia has had another record year. In 2004, over 342,000 acres of coca and over 9,500 acres of opium poppy were destroyed. Also in 2004, Colombian authorities seized 178 tons of cocaine, a 36% increase over the same period last year and over 1,500 pounds of heroin, a 67% increase.

In 2003 Colombia resumed a thoroughly vetted and robustly staffed Air Bridge Denial Program. Since then, 20 narco-trafficking aircraft have been destroyed and 6 have been impounded resulting in a total of 10.8 metric tons of seized cocaine.

Colombian Judicial Cooperation. The Colombian Judiciary and President Uribe have approved the extraditions of 154 Colombian major drug traffickers, terrorists, and corrupt legislators to the United States. Most recently, the government of Colombia extradited Simon Trinidad, a major FARC leader, to the United States to be tried. This action underscores to the global community that the FARC leaders are criminals and terrorists, not ideologically guided revolutionaries. All of these actions by the Colombian government have greatly assisted in the global struggle against illegal drug trafficking and narco-terrorism. With continued U.S. support and expanded authorities, I am confident that Colombia will win its 40-plus year battle against these narco-terrorist groups.

Colombia's War to Win. The government of Colombia understands that this is its war to win. Defense spending as a percentage of GDP rose from 3.5% to 5% in 2004. Colombia increased its tax revenue 17.4% in the first nine months of 2004, enabling the government to expand its security forces by nearly 80,000 uniformed security members in the past two and a half years. The Colombian military is a much better and more capable force in its operations against the FARC, the ELN and the AUC, nearly doubling the number of terrorists captured while also seizing the initiative on the battlefield.

Economic Indicators. Since assuming office in August 2002, President Uribe's emphasis on "Democratic Security" has aided Colombia's economic recovery. Colombia has seen growth in GDP since 2002 from 1.8% to 3.9% in 2003 and 2004. This comes after a severe economic crisis with a net GDP loss of more than 4% in 1999. The nation's unemployment rate eased from 15.1% in 2002 to 14.15% in 2003, to less than 13% in 2004. Inflation dropped from 7.1% in 2003 to 5.9% in 2004. Colombia's trade has also improved with exports outpacing imports by \$809 million in 2004

compared to \$437 million in 2003. Electrical Interconnections INC (ISA), Colombia's largest energy transport company reported a significant decrease in terrorist attacks on Colombia's utilities. Over the past five years, an average of 224 annual terrorist attacks occurred against Colombia's utilities. In 2004, thanks to government of Colombia initiatives and US government support for them, only 80 attacks occurred--down from 209 attacks in 2003 - the lowest number since 1998.

Regional Support for Colombia. The Colombian government's success has pushed the illegal armed groups to seek refuge across neighboring borders. Most of Colombia's neighbors have taken action to protect their sovereignty. The Ecuadorian military has placed many of its best troops on its northern frontier and has established cross-border communications with the Colombian military. Brazil has reinforced military presence along its border and has initiated an Airbridge Denial Program to prevent narco-trafficker use of Brazilian air space. Panamá continues to stress border cooperation due to the FARC's presence in Panamá's Darién border region. In February of 2004, Colombia, Brazil, and Perú signed a pact to improve border coordination, a superb example of regional cooperation against common threats. In April 2004, Peruvian President Toledo met with President Uribe to discuss border security and illegal drug trafficking among other topics. Among Colombia's neighbors, Venezuela's record of cooperation remains mixed. We remain concerned that Colombia's FTOs consider the areas of the Venezuelan border with Colombia a safe area to rest, transship drugs and arms, and procure logistical supplies.

Cooperative Security Locations/Forward Operating Locations (CSL/FOL) and Joint Task Force Bravo (JTF-B). El Salvador provides Southern Command the use of Comalapa Airport as a CSL/FOL for counter-drug surveillance flights throughout

Central America, the eastern Pacific, and the Western Caribbean. Joint Task Force Bravo in Honduras continues to provide a logistical support base to the humanitarian missions in the region, as well as to counter illicit trafficking operations. Ecuador continues to host one of the Southern Command's CSL/FOL's in Manta, which has been especially critical in providing aerial coverage on the eastern Pacific vector of illicit trafficking. Since the establishment of the Manta CSL in 1999, the information resulting from its operations has resulted in the seizure of 75 tons of cocaine with a street value of \$3.4 billion. Finally, Aruba and Curaçao each continue to host one of the Southern Command's CSL/FOL's.

Partner Nation actions against support for Islamic Radical Groups. In the War on Terror, we have seen countries like Paraguay and Uruguay take decisive action to disrupt or deter terrorist related activities over the past few years.

In 2002, Paraguay arrested and sentenced Assad Ahmad Barakat, an alleged Hizballah chief in the Triborder Area (TBA), for tax evasion. According to the Paraguayan chief prosecutor, Barakat's remittances to Hizballah totaled about \$50 million since 1995. Subhi Mohammad Fayad, a member of Barakat's network was also convicted of tax evasion in Paraguay. In 2004, Paraguayan agents raided a money exchange house in the TBA, which was owned by Kassen Hijazi's, a suspected Hizballah facilitator. Hijazi's money house was suspected of running an international money-laundering scheme that moved an estimated \$21 million over three years. In 2003, Said Mohkles, who was wanted by the Egyptians in connection with the 1997 Luxor terrorist attacks, was extradited to Egypt from Uruguay. We will continue to strengthen our cooperative security efforts with all countries in the AOR that may be affected by Islamic

Radical Group activity. We will also work to increase information sharing agreements and explore all possible options for security cooperation in the future.

Regionalization. U.S. Southern Command hosts four annual regional security conferences. These conferences bring together the chiefs of defense throughout the AOR to build consensus on security issues. Through these conferences, SOUTHCOM fosters and participates in frank and candid dialogue among the Chiefs of Defense in each sub region, regarding regional security threats and ways to increase regional security. In November of 2004 I co-hosted the Andean Ridge Security Conference in Lima, Peru with the Peruvian Chief of defense. It was the first Andean Ridge conference to be co-hosted within the region. Previous security conferences for the Caribbean and Central American sub regions have been held within their respective regions and this is significant as it is symbolic of the effort to solve regional problems within the region. I plan to continue this focus with the objective of assisting in the development of regional security organizations, appropriate to the constitutional limitations of each country and the needs of each region. This May, SOUTHCOM will co-host a Southern Cone Defense Conference in Buenos Aires with Argentina.

Support for Operation Iraqi Freedom. The Dominican Republic, El Salvador, Honduras, and Nicaragua sent forces to participate in Operation Iraqi Freedom. El Salvador has maintained continual presence in Iraq and sent a fourth contingent of troops last month. The Salvadoran troops have performed brilliantly in Iraq. In March 2004, Salvadoran troops saved the life of the Governorate Coordinator and five members of the Coalition Provisional Authority when they were ambushed in Al Najaf. In April, when the Salvadoran contingent was attacked during the Najaf uprising, the Salvadoran troops fought bravely against overwhelming odds. Private Natividad Méndez Ramos gave his

life that day and 10 Salvadorans were wounded. When they ran out of ammunition and were still being attacked, Corporal Toloza attacked ten enemy fighters with his knife. His actions were decisive and carried the day!

Haiti. In Haiti, the resignation and departure of former President Aristide, which resulted in a constitutional transfer of power to the interim government, presented the nations of the AOR with the opportunity to unite to help one of its neighbors. Following the passage of United Nations Security Council Resolution 1529, we established the Multinational Interim Force-Haiti (MIF-H), consisting of forces from the United States, France, Chile, and Canada. Chile deployed a force to Haiti within 48 hours of the start of the crisis and continues to have troops deployed in support of the Multinational United Nations Stabilization Force in Haiti (MINUSTAH). The rapid reaction of our troops and those of our partner nations saved the lives of innocent Haitians, prevented a mass migration during a time of rough seas, and fostered regional and international cooperation to assist a nation in need. MINUSTAH stood up in Haiti in June of 2004 and is composed mostly of Latin American countries and led by Brazil. We currently have four personnel assigned to the MINUSTAH staff. To anyone familiar with Haiti, it is obvious that more than security is needed to rehabilitate Haiti. I believe that Haiti will require a significant investment of aid for the next 10 to 15 years to get back on its feet. When a new Haitian government is elected in November, the history of predatory institutions and “winner-take-all” political environment must end, to benefit all Haitians and reestablish faith in government.

Exercises. Exercises provide unique opportunities for military-to-military interaction, enhanced interoperability, and invaluable training for both partner nations and U.S. forces. SOUTHCOM conducts three types of exercises: US-only exercises that

test our contingency plans, bilateral and multilateral exercises with partner nations, and New Horizons - humanitarian assistance exercises which provide medical, dental, and veterinary treatment to underserved populations in remote areas. Components of SOUTHCOM conducted 16 joint exercises last fiscal year involving 5,675 US and 10,320 Partner nation troops. One of the most important exercises was PANAMAX, a multinational exercise focused on maritime interdiction and security of the Panama Canal. Chile, the fourth largest user of the Panama Canal, took an active leadership role in the Southern Command sponsored PANAMAX exercise designed to protect the Panama Canal. This year's PANAMAX exercise will include 15 participating nations. In 2004, New Horizons exercises completed 30 engineer projects consisting of constructing schools, medical clinics, community centers, sanitary facilities, wells, and road construction and repair. We had 69 medical readiness deployments (MEDRETE) that treated more than 290,000 people, some of whom walked for days to be treated by qualified doctors for the first time in their lives. During these exercises, our veterinary teams treated approximately 525,000 animals in varying livestock categories, which contributed significantly to sustaining local health and economic wellbeing. New Horizons exercises improve local infrastructure, strengthen the bonds of friendship between the US and partner nations, and provide unique and rigorous training opportunities to engineer, medical, and civil affairs units. Currently, we are conducting New Horizons exercises in Haiti, El Salvador, Nicaragua, and Panama. The Haiti New Horizons will result in the construction of four wells, three schools, and a road and it will also include a Medical Readiness Training Exercise to provide needed medical care to the population in the Gonaives area – the site of devastating floods last year. The El Salvador New Horizons will construct three schools, two clinics, one well, and will conduct three

Medical Readiness Training Exercises. The New Horizons in Nicaragua will build three schools, three clinics, one well and will conduct three Medical Readiness Training Exercises. The Panamá New Horizons will construct three schools, three community centers, one well, and one road and will do three Medical Readiness Training Exercises.

Partner Nations' Support of UN Peace Operations. Many of our exercises are tailored to enhance partner nations' Peace Operations capabilities. These exercises provide real-world scenario-based training that hones the skills necessary to provide a significant contribution to United Nations and other peace operations. The success of these exercises is clear in the examples I've already mentioned; the MIF-H, MINUSTAH, and AOR nation participation in peace operations around the world. For example, a Chilean platoon, Paraguayan platoon, as well as personnel from Bolivia, Peru, and Uruguay are serving under Argentine command in the United Nations Peacekeeping Operation in Cyprus.

Central American Regionalization. Efforts toward regional integration made possible by organizations like the Conference of the Central American Armed Forces (CFAC) give me great confidence in the future of Central American regional security. An initiative of the governments of El Salvador, Guatemala, Honduras, and Nicaragua for the purpose of regionalizing their security efforts, CFAC was established in 1997, this organization has since provided collective support for flood and hurricane relief, as well as assistance in combating outbreaks of dengue that have plagued the region. CFAC was quick to show its collective solidarity post 9-11, and has since taken steps to enhance regional cooperation in the global war on terrorism. Most recently CFAC has developed a plan of action to be implemented this year to strengthen their capacity to support international peacekeeping operations.

One of the most impressive aspects of CFAC is that it is a Central American initiative that has evolved with a Central American vision. With ownership comes commitment, and these armed forces are committed to serving their civilian democratic governments and their people.

On February 1, 2005, the presidents of the Central American nations held a summit in Honduras under the umbrella of SICA, which is the Central American Integration System.

Created in 1991 to develop common policies and strategies to serve the Central American public, SICA recognizes the changing nature of the threats to national security and socio-economic development. In this most recent summit declaration the presidents agreed to take concrete steps to deal with a broad range of transnational issues in a transnational way – from health, to trade, to security. Among the elements of this declaration, they agreed to create a regional rapid reaction force to deal with narco-terrorism and other emerging threats. They agreed to implement a common arms sale and transport policy. They agreed to a regional study to better understand the theme of high-risk youth. And equally important, they are holding themselves accountable, having set a 30-day suspense to stand up a joint and combined task force to include military and police forces, to deal with these emerging threats.

Strategic Capabilities. To address the security challenges and achieve U.S. national security objectives in our AOR, the Command has five overarching strategic mission requirements:

1. An improved ability to detect and support interdiction of illegal trafficking into the United States.
2. Continued detainee operations at Guantánamo.

3. Continued ability to provide partner nation Security Forces with equipment and training.
4. Improved interoperability between our Armed Forces and those of our partner nations.
5. Improved operational reach to rapidly respond to crises in the region.

Interdiction of Illicit Trafficking. We must enhance our ability to detect and interdict illicit trafficking at its source and in transit, preventing illegal drugs, weapons, and people from reaching our borders. As we have successfully done in the past, the Command will conduct these operations in concert with our interagency partners, principally the U.S. law enforcement community, and with our partner nations, whose participation and support for these operations are indispensable. Success in this mission area will not only stem the flow of illegal narcotics on U.S. streets, but also deny a source of funding that terrorist groups may use to finance their operations.

As with virtually all of our operations in the AOR, the interdiction of illicit trafficking depends on the timely collection and distribution of accurate intelligence information. We continue to employ our limited air-, sea-, and ground-based intelligence, surveillance, and reconnaissance (ISR) assets to detect, identify, and monitor illicit activities, particularly terrorist groups, their support network, and the criminal elements that serve terrorist purposes. Given the size and geography of the region, this is a formidable task. Furthermore, with the majority of ISR assets presently at our disposal focused on operations in Colombia, the means to achieve persistent ISR presence throughout the entire AOR remains a concern.

Guantánamo Construction. I would like to thank the committee and the Congress for their support of the construction of military facilities, which has resulted in

better security, and better quality of life for the troops at JTF-GTMO. I request your support in funding two construction projects on the FY05 Supplemental request that total \$42 million. The first project is Camp 6, which represents part of the way ahead for detention operations at Guantánamo and recognizes that some of the detainees there will remain a threat to the U.S. for the foreseeable future. The Camp 6 facility will be based on prison models in the U.S. and is designed to be safer for the detainees and the guards who serve at GTMO. The second project is the security fence with sensors that is required for security around the new facilities. This security fence would be an electronic "smart fence" to detect, deter and assess potential intrusions around the perimeter of the detainee camp. Both Camp 6 and the Security Fence will provide a reduction in approximately 300 soldiers currently required to guard the detainees.

Training and Equipping our partner nation Security Forces. We must continue to provide partner nation security forces with the equipment and training they need to ensure their territorial integrity and to defeat threats such as terrorist groups operating within or transiting their borders.

The center of the fight against terrorist groups is in Colombia and because of the transnational nature of the threat, it radiates throughout the Andean Ridge. We need to maintain support in Colombia and address the spillover effect in the rest of the Andean Ridge. Our continued support will leverage the Government of Colombia's recent successes, enabling the Government of Colombia to not only defeat narco-terrorist groups, but also to establish responsible governance for all Colombians.

IMET and ASPA Sanctions. Promoting security and enabling effective security forces among our partner nations will deny terrorists the safe havens they need to prepare or conduct operations, will hinder illicit trafficking, and will prevent internal conflicts

that may lead to the destabilization of governments. SOUTHCOM fully supports immunity from ICC prosecution for U.S. service-members serving overseas. However, using IMET to encourage ICC Article 98 agreements may have negative effects on long-term U.S. security interests in the Western Hemisphere, a region where effective security cooperation via face-to-face contact is absolutely vital to U.S. interests. IMET is a low-cost, highly effective component of U.S. security cooperation that builds and expands regional security forces' professionalism and capabilities, enables a cooperative hemispheric approach to meeting transnational threats to national sovereignty, and facilitates the development of important professional and personal relationships that provide U.S. access and influence to key players in the region. Once again, IMET provides SOUTHCOM with an invaluable tool that can be used to foster positive military-to-military relations with our partner nations.

Interoperability. Fourth, we must improve the interoperability among the armed forces of the United States and our partner nations by implementing mutually beneficial security agreements, regional and sub regional security organizations, military-to-military contacts, combined training exercises, and information sharing. Only by working together can the U.S. and our partner nations effectively address the common security challenges we face in this hemisphere.

Improving the command, control, communications, and computer (C4) architecture throughout the region has been, and will remain, a top investment priority for the Command. A particular challenge is our ability to share sensitive intelligence information with our U.S. interagency partners and with partner nations in a timely manner that supports combined efforts to interdict terrorist organizations and drug traffickers. We are, however, continuing to expand our partnerships with the Department

of Defense C4 community, and with other elements of the U.S. government and industry in order to identify, secure, and maintain robust, cost-effective means to communicate information and provide efficient and effective command and control of military operations throughout the AOR. Our current C4 infrastructure, while adequate for today's tasks, lacks the robust and flexible characteristics necessary to fully implement the network-centric warfighting capabilities we need to achieve.

Operational Reach. Another significant strategic mission priority seeks to enhance our ability to rapidly conduct time-sensitive military operations and to rapidly respond to humanitarian crises that may emerge on short-notice. We continue to explore alternative solutions that will enable us to rapidly position the right forces and materiel when and where they are needed. We are also evaluating and improving ways in which interagency resources and assets might be brought to bear in response to emerging humanitarian crises, such as those resulting from the annual stream of hurricanes that carom through the Caribbean. Since 1997, U.S. Southern Command headquarters has been located in Miami, Florida – the best strategic location for the SOUTHCOM headquarters. The future location of the headquarters will depend on the outcome of the 2005 Base Realignment and Closure process. Throughout this endeavor we remain focused on properly supporting the Command's strategic requirements.

Conclusion. I have a slide in my command brief that shows which countries in the AOR were democracies in 1958, 1978, 1998, and the present. The slide depicts a very encouraging trend of governments turning from communist or authoritarian governments to democratically elected governments. Today, all 30 countries in the SOUTHCOM AOR are democracies, and SOUTHCOM has played a key role over the past 25 years in that remarkable achievement. However, if we in the US government are

honest with ourselves, we can look at the region today and see that we are not tending the fields with the same zeal we showed in planting the seeds of democracy. Too many of the democracies in our AOR are lacking some or all of the vital democratic institutions: a functional legislative body, an independent judiciary, a free press, a transparent electoral process that guarantees the rights of the people, security forces which are subordinate to civil authority and economic opportunity for the people.

Because a secure environment is a non-negotiable foundation for a functioning civil society, Southern Command is committed to building capabilities of the security forces of our region. The seeds of social and economic progress will only grow and flourish in the fertile soil of security.

We cannot afford to let Latin America and the Caribbean become a backwater of violent, inward-looking states that are cut off from the world around them by populist, authoritarian governments. We must reward and help those governments that are making difficult, disciplined choices that result in the long-term wellbeing of their people. The challenges facing Latin America and the Caribbean today are significant to our national security. We ignore them at our peril.

Your Soldiers, Sailors, Airmen, Marines, Coast Guardsmen, and Department of Defense civilians are working to promote U.S. national security interests, regionalization as well as preserve the gains made in professionalizing and democratizing Latin American and Caribbean militaries. We believe that over time this work will bring about a cooperative security community advancing regional stability and establishing an environment free from the threat of terrorism for future generations. Southern Command is a good investment of American taxpayer's dollars and trust.

Thank you for this opportunity and I look forward to responding to the Committee Members' questions.



Analysis of Stennis HRSC COBRA Report

DOD Cost and Savings Estimates for Consolidating the Human Resource Services Centers at Stennis and Philadelphia at Naval Support Activity – Philadelphia

One-Time Costs:

| | |
|------------------------|---------------------|
| HRSC-SE Stennis | \$5,855,520 |
| HRSC-NE Philadelphia | \$898,770 |
| NSA Philadelphia | \$8,632,000 |
| Combined | \$15,386,290 |

One-Time Savings:

| | |
|------------------------|--------------------|
| HRSC-SE Stennis | \$2,007,000 |
| HRSC-NE Philadelphia | \$2,224,000 |
| NSA Philadelphia | \$0 |
| Combined | \$4,231,000 |

Net One-Time Costs:

| | |
|------------------------|---------------------|
| HRSC-SE Stennis | \$3,848,520 |
| HRSC-NE Philadelphia | -\$1,325,230 |
| NSA Philadelphia | \$8,632,000 |
| Combined | \$11,155,290 |

Recurring Savings:

| | |
|------------------------|--------------------|
| HRSC-SE Stennis | \$1,145,000 |
| HRSC-NE Philadelphia | \$2,102,000 |
| NSA Philadelphia | \$0 |
| Combined | \$3,247,000 |

Recurring Costs:

| | |
|------------------------|--------------------|
| HRSC-SE Stennis | \$1,261,000 |
| HRSC-NE Philadelphia | \$0 |
| NSA Philadelphia | \$630,000 |
| Combined | \$1,891,000 |

Net Recurring Costs/Savings:

| | |
|-----------------------------------|---------------------|
| HRSC-SE Stennis | \$116,000 |
| HRSC-NE Philadelphia | -\$2,102,000 |
| NSA Philadelphia | \$630,000 |
| Combined Recurring Savings | -\$1,356,000 |

Total Net Cost Through 2010: \$10,600,000

Year In Which Total Savings Exceed Total Costs: 2018

One-time Costs at Stennis

| | |
|-----------------------------------|-------------|
| Civilian RIF | \$459,186 |
| Civilian Early Retirement | \$131,879 |
| Unemployment | \$35,608 |
| Program Overhead | \$261,888 |
| Civilian Moving | \$4,214,334 |
| Civilian Priority Placement (PPP) | \$141,984 |
| Freight | \$110,242 |
| Information Technologies | \$19,400 |
| One-Time Moving Costs | \$481,000 |

The DOD Model estimates that 91 civilians employees from Stennis will move to Philadelphia.

One-time Savings at Stennis

| | |
|--------------------------|-------------|
| One-Time Unique Savings* | \$2,007,000 |
|--------------------------|-------------|

The building is listed as “leased” space, although the footnote acknowledges that it is located on a NASA facility. The DOD treats non-DOD federal property the same as it treats private property, and has a further bias that assumes that any leased space is not compliant with Anti-Terrorism/Force Protection (ATFP) standards. It then plugs in an across-the-board estimate (from the Leased Space ATFP Cost Avoidance Model) that it would cost \$28.28 per square foot to make leased space ATFP-compliant. The HRSC building at Stennis is listed as 70,963 square feet, so DOD’s formula estimates that relocation will save the Navy 70,963 x \$28.28, which it rounds off to \$2,007,000.

In the DOD’s own military value determination, the HRSC-SE facility was scored as “Level 1” for ATFP, the highest rating and the same score as personnel centers that were located on military bases. Although Stennis is a NASA facility, it is more secure than most military bases. The building itself was constructed as part of the Mississippi Army Ammunition Plant. Stennis has a substantial military presence, including Navy and Special Operations Commands. It is probably much more secure than NSA Philadelphia.

One-Time Costs at NSA Philadelphia

| | |
|--------------------------------|-------------|
| Military Construction | \$8,297,000 |
| Information Technologies | \$325,000 |
| Environmental Mitigation Costs | \$10,000 |

According to a footnote to the table, “Former warehouse requires major renovation to be used as office space.” The warehouse is described as 70,000 square feet and in condition “Red,” which is the lowest category. A footnote also explains that the estimated cost of the military construction came from the Navy, not from the formula used by the Joint Cross-Service Working Group to estimate MilCon costs.

One-Time Costs at HRSC-Philadelphia

| | |
|--------------------------|-----------|
| Civilian RIF | \$119,372 |
| Unemployment | \$8,902 |
| Civilian PPP | \$35,496 |
| Information Technologies | \$479,000 |
| One-Time Moving Costs | \$256,000 |

One-Time Savings at HRSC-Philadelphia

| | |
|-------------------------|-------------|
| One-Time Unique Savings | \$2,224,000 |
|-------------------------|-------------|

As in the estimate at Stennis, the DOD books a huge savings for leaving a leased space by claiming it is avoiding the expense of \$28.28 per sq. ft. to make the building ATRP compliant. We do not know how accurate this might be in regard to the leased space in Philadelphia, but we can be fairly certain that the Navy would never have spent \$2.2 million on ATRP improvements there.

Recurring Savings at Stennis

| | |
|------------------------------|-------------|
| Base Operating Support (BOS) | \$14,000 |
| Civilian Salary | \$1,130,000 |

DOD estimates that the consolidation of the two offices will eliminate 17 civilian positions. This estimate does not come from a plan for the move, but from an estimate that consolidation eliminates 12.5% of jobs. So, of the 138 positions in the Stennis baseline, 121 would be transferred to Philadelphia and 17 would end. The cost estimate does not come from actual payroll figures. Instead, all civilian DOD jobs anywhere in the U.S. are treated by the COBRA formula as jobs paying \$59,959.18. With payroll taxes and government share of benefits, the average civilian DOD job is estimated to be worth approximately \$66,500. Multiplying \$66,500 x 17 gets the \$1.13 million estimate for annual payroll saved by the consolidation. The BOS estimate also is derived by multiplying a DOD across-the-board figure by the number of civilian positions.

Recurring Costs at Stennis

| | |
|-------------------------|-------------|
| Miscellaneous Recurring | \$1,261,000 |
|-------------------------|-------------|

This is exaggerated and, unfortunately, is not really a recurring cost.

The Headquarters and Support JCSG recommendation projects that the cost of continuing to lease the facility at would be \$1,261,000 per year in 2005 dollars. They did not use the actual cost of the lease in 2005, which is quite a bit less than that. Instead, the JCSG Leased Space Savings Model used a formula to arrive at a cost of \$17.77 per Gross Square Foot and then multiply that times 70,963 GSF to arrive at a rounded off figure of \$1,261,000. This was intended to be listed as an annual savings from avoiding the cost of leasing the facility at Stennis, but the figure was mistakenly entered as a recurring cost, not a savings, in the COBRA Report.

Recurring Savings at HRSC-NE

| | |
|-------------------------|-------------|
| Civilian Salary | \$276,000 |
| Miscellaneous Recurring | \$1,826,000 |

The Navy estimates that four of the Philadelphia positions would be eliminated by the consolidation. The recurring savings is an estimate of the cost avoidance from no longer leasing the Philadelphia property. The DOD formula, not the actual lease, estimates a cost of \$23.22 per GSF. The building is listed at 78,626 GSF.

Recurring Costs at NSA-Philadelphia

| | |
|---------------------------|-----------|
| Recapitalization | \$73,000 |
| Base Operating Cost (BOS) | \$237,000 |
| Civilian Salary | \$321,000 |

These figures are derived by formula. I believe that the increase in civilian salary costs reflects the higher locality pay in Philadelphia for the 121 jobs that were relocated from Stennis.

Concluding Note

Some of the estimates are obviously wrong, especially the phantom savings of \$2 million from avoiding the cost of making the Stennis facility ATFP compliant. Other estimates are obviously exaggerated, such as estimate of the lease costs that would be avoided by leaving the Stennis facility and the estimate of the payroll costs that would be avoided by the elimination of 17 of the jobs at Stennis. Even with the questionable value of the DOD estimates, the figures show sizeable up-front costs for construction and relocation of personnel. It should be easy to show that consolidating the two offices at Stennis would work much better in almost every way imaginable.

