SEP 3 0 2009

PERSONNEL AND
READINESS

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Section 1674(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 requires the Department to provide Congress with a plan for the provision of health care for military beneficiaries and their dependents in the National Capital Region (NCR).

On 14 May 2009, the Department submitted its milestone schedule, as required by the section 2721(d) of the NDAA for FY09, detailing the design and construction of Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) as well as the relocation of operations at Walter Reed Army Medical Center (WRAMC) to the WRNMMC and FBCH.

The attached report provides the previously submitted milestone schedule in addition to the requirements mandated by section 1674(a) of the NDAA for FY08 such as details on the manner in which patients, staff, bed capacity, and functions will move from WRAMC to WRNMMC and FBCH; a timeline, including milestones, for such moves; projected budgets, including planned budget transfers, for Military Treatment Facilities (MTFs) within the region; the management or disposition of real property of MTFs within the region; and staffing projections for the region. It includes the Department's Master Transition Plan for the realignment of healthcare in the NCR as well.

The Department expresses its gratitude to Congress for its unwavering support and interest in the transformational efforts the Department is undertaking in the NCR to provide world-class medical care. Congressional oversight and support have made immeasurable contributions to this process and the entire Military Health System (MHS) to ensure Service Members, retirees and all MHS beneficiaries receive the finest healthcare available. Next to the war itself our nation's wounded warfighters remain the Department's top priority.

Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable John McCain
Ranking Member
Enclosure:
As stated

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

SEP 30 2009

PERSONNEL AND
READINESS

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Section 1674(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 requires the Department to provide Congress with a plan for the provision of health care for military beneficiaries and their dependents in the National Capital Region (NCR).

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Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable Lindsey O. Graham
Ranking Member
Enclosure:
As stated

SEP 3 0 2009

PERSONNEL AND
READINESS

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Section 1674(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 requires the Department to provide Congress with a plan for the provision of health care for military beneficiaries and their dependents in the National Capital Region (NCR).

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Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member
Enclosure:
As stated

3 0

PERSONNEL AND
READINESS

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House or Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
   Under Secretary of Defense
   (Personnel and Readiness)

cc:
The Honorable Joe Wilson
Ranking Member
Enclosure:
As stated

PERSONNEL AND
READINESS

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable Thad Cochran
Ranking Member
Enclosure:
As stated

SEP 3 0 2009

PERSONNEL AND
READINESS

The Honorable David Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable Jerry Lewis
Ranking Member
Enclosure:
As stated

PERSONNEL AND
READINESS

SEP 3 0 2009

The Honorable John Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

Gail H. McGinn
Deputy Undersecretary of Defense (Plans)
Performing the Duties of the
    Under Secretary of Defense
    (Personnel and Readiness)

cc:
The Honorable C.W. Bill Young
Ranking Member
Enclosure:
As stated

Guaranteed Funding of Walter Reed Army Medical Center, District of Columbia

Report to Congress

Executive Summary

The Final Report of the 2005 Defense Base Realignment and Closure (BRAC) Commission contained recommendations that will significantly alter the landscape of military healthcare facilities in the National Capital Region (NCR). At the conclusion of the BRAC implementation, Walter Reed Army Medical Center (WRAMC) will cease operations when all of its components have been relocated by September 15, 2011, resulting in two inpatient facilities in the NCR: Walter Reed National Military Medical Center (WRNMMC), Bethesda, Maryland; and Fort Belvoir Community Hospital (FBCH), Ft. Belvoir, Virginia. Malcolm Grow Medical Center (MGMC) at Andrews Air Force Base, Maryland, will transition to an ambulatory care center.

Section 1674(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 requires that the amount of funds available for the commander of WRAMC for a fiscal year shall be not less than the amount expended by the commander of WRAMC in FY 2006 ($368,707,400) until the first fiscal year beginning after the date on which the Department submits to the congressional defense committees a plan for the provision of health care for military beneficiaries and their dependents in the National Capital Region. Congress mandated that the plan shall include the manner in which patients, staff, bed capacity, and functions will move from the WRAMC to expanded facilities (WRNMMC/FBCH); a timeline, including milestones, for such moves; projected budgets, including planned budget transfers, for military treatment facilities within the region; the management or disposition of real property of military treatment facilities within the region; and staffing projections for the region.

On 14 May 2009, the Department submitted its milestone schedule, as required by the section 2721(d) of the Duncan Hunter NDAA for FY 2009, detailing the design and construction of Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) as well as the relocation of operations at Walter Reed Army Medical Center (WRAMC) to the WRNMMC and FBCH.

This report provides the previously submitted milestone schedule in addition to the requirements mandated by section 1674(a) of the NDAA for FY 2008 such as the manner in which patients, staff, bed capacity, and functions will move from the WRAMC to expanded facilities (WRNMMC/FBCH); a timeline, including milestones, for such moves; projected budgets, including planned budget transfers, for military treatment facilities within the region; the management or disposition of real property of military treatment facilities within the region; and staffing projections for the region.   It includes the Department's Master Transition Plan for the realignment of healthcare in the NCR as well.

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Introduction

1. Purpose

This report is in response to Section 1674(a) of the National Defense Authorization Act (NDAA) for FY 2008, "Guaranteed Funding of Walter Reed Army Medical Center, District of Columbia."

2. Background

On May 13, 2005, the Department of Defense announced its recommendations for the latest round of Base Realignments and Closures (BRAC). The 2005 Defense Base Closure and Realignment Commission reviewed the work of the Department and made its recommendations to the President on September 8, 2005. The recommendations became binding on the Department in November 2005. The BRAC recommendations provide for major changes for military medicine in the Washington, DC area.

The BRAC recommendations contained a significant change affecting the landscape of military hospitals in the area. Currently, there are four inpatient facilities in use: National Naval Medical Center (NNMC), Bethesda, Maryland; Walter Reed Army Medical Center (WRAMC), Washington, District of Columbia; Malcolm Grow Medical Center (MGMC), Andrews Air Force Base, Maryland; and DeWitt Army Community Hospital (DACH), Fort Belvoir, Virginia. Upon completion of the 2005 BRAC implementation, WRAMC in Washington, D.C. will cease operations when all of its components have been relocated by September 15, 2011. As a result, there will be two inpatient facilities in use: Walter Reed National Military Medical Center (WRNMMC) Bethesda, Maryland; and Fort Belvoir Community Hospital (FBCH), Ft. Belvoir, Virginia. MGMC at Andrews Air Force Base, Maryland, will transition to an ambulatory care center facility.

In September 2007, the Department established the Joint Task Force National Capital Region Medical (JTF CAPMED) as a fully functional Standing JTF to oversee these efforts as well as pioneer the integration of military healthcare delivery in the NCR.

Walter Reed
National Military Medical Center

345 Inpatient Beds
Square Footage:
Addition: 637,000
Alteration: 321,000
Support Facilities: 590,000

The new WRNMMC will consist of new inpatient and outpatient building additions, predominantly for patient care. Building A will include mostly ambulatory care, primary and specialty care. Building B will include imaging, diagnostics and critical care beds. Other inpatient and surgical service renovations will occur in Buildings 9 and 10.

WRNMMC will also provide several enhancements for wounded warrior care including new Warrior Support Facilities. Services will include a Warrior Clinic, a Warrior Housing Complex and non-medical support including a fitness center and parking garage. The Department is working diligently to design these support services for wounded warriors while maintaining the command and control equities that the Services see as essential.

Fort Belvoir Community Hospital

120 inpatient beds
1.275 M GSF Hospital Complex

The new Fort Belvoir Community Hospital will be a 120 bed inpatient community hospital (Building C) with four attached clinic buildings, an attached utility plant, helipad and two parking garages.

The Department anticipates the design for both WRNMMC and FBCH will be completed during 2009. The Department expects construction and renovations to be completed between the beginning of 2010 and August 2011. The completion of the project is scheduled to meet the deadlines imposed by the Defense Base Realignment and Closure Act of 1990, as amended. **APPENDIX B** provides the construction and transition schedule and a list of clinics that will be at WRNMMC and FBCH.

3. Military Health System Mission

The Department will effectively continue the following missions as the recommendations of BRAC 2005 are implemented:

- Provide casualty care;
- Provide health services in support of our nation's military mission;
- Be prepared to respond anytime, anywhere with comprehensive medical capability to military operations, natural disasters and humanitarian crises around the globe;

- Ensure delivery of world-class healthcare to all Department of Defense service members, retirees, and their families;
- Promote a fit, healthy and protected force by reducing non-combat losses, optimizing healthy behavior and physical performance; and
- Be a source of innovative education, medical training, research, technology and policy, striving to provide a bridge to peace.

4. Plan and Certification to Congress

Section 1674 of the NDAA for FY 2008 addressed minimum funding and the plan for the provision of healthcare for military beneficiaries and their dependents in the National Capital Region (NCR) under Section 1674(a) as follows:

MINIMUM FUNDING.—The amount of funds available for the commander of Walter Reed Army Medical Center, District of Columbia, for a fiscal year shall be not less than the amount expended by the commander of Walter Reed Army Medical Center in fiscal year 2006 until the first year beginning after the date on which the Secretary of Defense submits to the congressional defense committees a plan for the provision of health care for military beneficiaries and their dependents in the National Capital Region.

Section 1674 of the NDAA for FY 2008 provided requirements for the plan for healthcare for military beneficiaries and their dependents in the NCR under Section 1674(b) as follows:

MATTERS COVERED.—The plan under subsection (a) shall at a minimum include—

Section 1674 (b)(1): *The manner in which patients, staff, bed capacity, and functions will move from the Walter Reed Army Medical Center to expanded facilities;*

Section 1674 (b)(2): *A timeline, including milestones, for such moves;*

Section 1674 (b)(3): *Projected budgets, including planned budget transfers, for military treatment facilities within the region;*

Section 1674 (b)(4): *The management or disposition of real property of military treatment facilities within the region;*

Section 1674 (b)(5): *Staffing projections within the region.*

Section 1674 of the NDAA for FY 2008 addressed certification in Section 1674(c) as follows:

CERTIFICATION.—After submission of the plan under subsection (a) to the congressional defense committees, the Secretary shall certify to such committees on a quarterly basis that—

Section 1674 (c): *patients, staff, bed capacity, functions, or parts of functions at Walter Reed Army Medical Center have not been moved or disestablished until the expanded facilities at the National Naval Medical Center, Bethesda, Maryland, and DeWitt Army*

Community Hospital, Fort Belvoir, Virginia, are completed, equipped, and staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at Walter Reed Army Medical Center during fiscal year 2006.

5. Update on Congressional Requirement for Provision of Care Plan and Quarterly Certifications
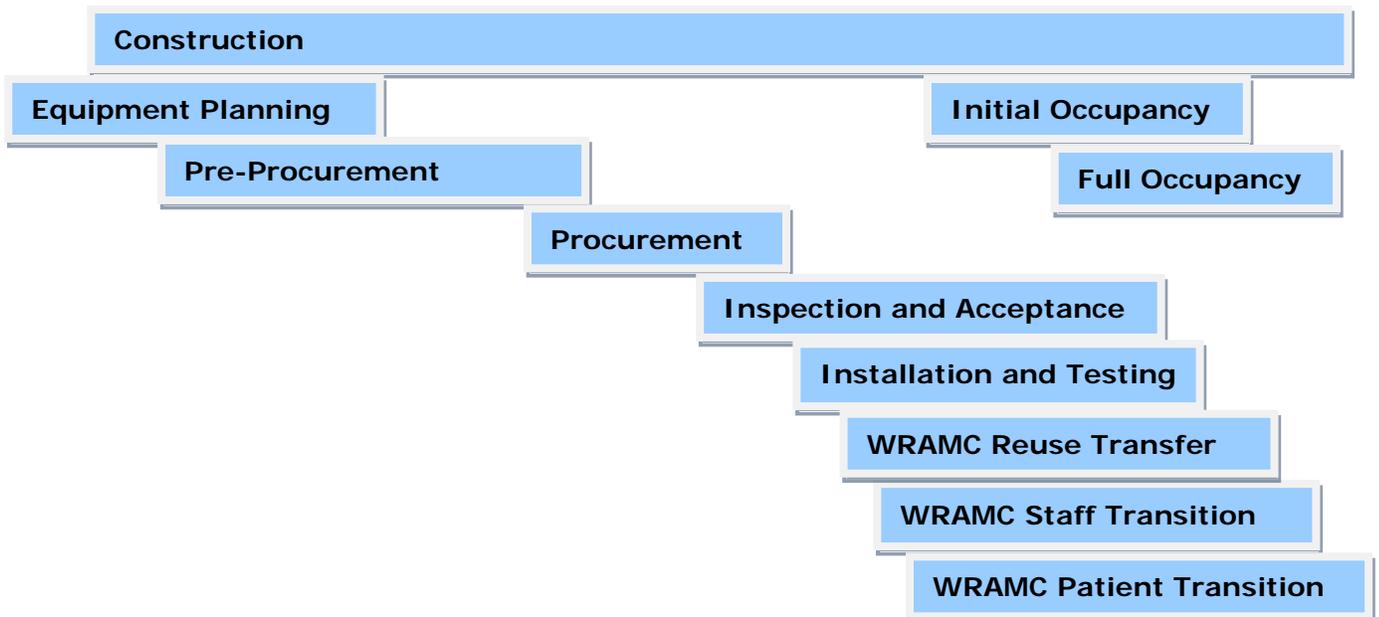
The Department is focused on establishing world-class care at WRNMMC and FBCH while closing operations at WRAMC and transitioning from inpatient to ambulatory surgery operations at MGMC. The transition planning for this effort is complex and requires planning at both the facility and regional levels as well as integrating the planning into the Department's overall military healthcare system requirements.

One of the specified missions of JTF CAPMED is to oversee BRAC implementation planning and related medical military construction projects in the NCR. This involves coordinating the scheduling and funding of clinical and non-clinical work with the Military Services, Military Health System (MHS) BRAC Program Integration Office, US Army Corps of Engineers (USACE), and Naval Facilities Engineering Command (NAVFAC). Accomplishment of this extremely complex mission requires a cogent systematic approach to ensure integration and coordination of the many interdependent systems throughout the entire life cycle of the BRAC transition. To do this in a coherent fashion, JTF CAPMED developed an adaptive Joint NCR Master Transition Plan (MTP) that has been included as an **APPENDIX A** to this report. This multi-faceted approach is critical to meeting this specific JTF CAPMED mission and essential to meeting congressional reporting requirements.

Transition Planning Process and Execution

WRNMMC and FBCH Outfitting and Transition Process Mock-up

See below for the order of major outfitting and transition milestones:

Construction
Equipment Planning
Pre-Procurement
Procurement
Inspection and Acceptance
Installation and Testing
WRAMC Reuse Transfer
WRAMC Staff Transition
WRAMC Patient Transition
Initial Occupancy
Full Occupancy

The execution of BRAC oversight responsibilities requires JTF CAPMED to focus the transition process at three different levels: tactical, operational, and strategic.

- A tactical focus concentrates on the transition effort at each of the specific BRAC sites, i.e. WRAMC, NMMC, and FBCH. At a tactical level construction timelines are merged with manpower, equipment and space requirements. This informs individual work tasks, or lines of operation, that must be accomplished along the BRAC timeline to allow for the orderly and precise movement of medical capability from one facility to its transitional counterpart. In other words, this tactical approach informs JTF CAPMED of what needs to be done at each site to execute the BRAC business plan.

- An operational focus takes these tactical lines of operation for each site and consolidates them to identify interdependencies among all BRAC sites throughout the Joint Operating Area (JOA). This gives JTF CAPMED a common site picture of all projects and assists in the identification of problematic areas and critical pathways.

- A strategic focus allows for the development of the BRAC NCR Master Transition Plan (MTP). The MTP is the capstone document regarding the execution of JTF CAPMED's mission of BRAC oversight. The MTP is an adaptive document derived from the Integrated Master Schedule (IMS) and allows JTF CAPMED integration and transition personnel to monitor and proactively analyze the execution of BRAC and the maintenance of critical medical capability during the process. Critical nodes and pathways can be studied well in advance of their occurrence to exercise mitigation strategies designed to avoid possible "service delivery troughs" caused by transitional movements of administrative and clinical capability packages from one facility to another.

Methodologically, JTF CAPMED blends these three perspectives into a proactive, analytical process to orchestrate the myriad of activities necessary to establish WRNMMC and FBCH and transition medical capabilities from WRAMC while maintaining the same level of care and access throughout the JOA as was available to patients prior to the start of the BRAC process. The Department, through JTF CAPMED, utilized this multi-faceted approach to answer its reporting obligations under Section 1674(a) of FY 2008 NDAA. The Department will ensure patients, staff, bed capacity, functions, or parts of functions at WRAMC have not been moved or disestablished until the expanded facilities at Bethesda, Maryland and Fort Belvoir, Virginia, are completed, equipped, and ready to be staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at WRAMC during FY 2006.

The Department, through integrated program and project management, has set in place a comprehensive planning effort to develop detailed milestone schedules and a transition of operations plan as required by both the Section 1674(a) of the FY 2008 NDAA and Section 2721(d) of the FY 2009 NDAA. The planning effort culminates in the production of the MTP, **APPENDIX A** to this report, and covers all aspects of the transition from WRAMC to WRNMMC and FBCH. It lays out the sequence and timing of all service moves (clinical and others) from WRAMC to WRNMMC and FBCH. It details all of the individual actions required to ensure success at each step of the

transition. The plan is dynamic in nature and will be regularly updated as it continues to evolve across the duration of the BRAC execution timeline. Later iterations of the MTP will also be used as the foundation to answer the Department's quarterly certification obligations under Section 1674(c) of the FY 2008 NDAA. The schedules provided in this report represent the Department's best and current understanding of the critical milestones.

Major elements of the MTP include, but are not limited to:

- Transition Management Organization
- Relocation Planning Process
- Civilian Human Resource Plans
- The 2009 Joint Table of Distribution Methodology
- Staff Education and Training Plans
- Resource Management
- Process Integration Plans
- IM/IT Infrastructure Transition Plans

Section 1674 (b)(1): *The manner in which patients, staff, bed capacity, and functions will move from the Walter Reed Army Medical Center to expanded facilities.*

Patients, staff, bed capacity and functions will move from WRAMC to expanded facilities at WRNMMC and FBCH over a relatively compressed timeframe. Any significant transition out of WRAMC is dependent on the delivery of new space at FBCH and WRNMMC. Thus, the WRAMC transition requires the completion of FBCH, the new additions at WRNMMC and construction of other supporting services (i.e. administration and parking at Bethesda). Also several other key trigger activities at Bethesda (e.g. staff training, attrition of inpatient census at WRAMC) must occur.

Central to the development, completion and oversight of the detailed plan in which operations will move from WRAMC to the replacement facilities is the JTF CAPMED Integrated Master Schedule (IMS), provided in **APPENDIX A** as part of the MTP. The IMS delineates the key activities, targeted completion dates and critical transition milestones.

The IMS provides JTF CAPMED, WRAMC and NNMC leadership, as well as the various other participants in this process (such as USACE and NAVFAC), an understanding and appreciation of the interdependency and relationships between various location tasks as well as an indication of progress against those tasks. An example of an interdependency would be that prior to WRAMC initiating the move of a clinical function from WRAMC to FBCH, all of the required construction and outfitting tasks assigned to the gaining location (FBCH) would need to be completed. Therefore in the IMS there is an established requirement that the move not occur until all of those tasks are completed and there is a linkage of milestones at the two locations. Conversely, there are a number of tasks that must be completed by the clinic at WRAMC before they can move to FBCH. In the WRAMC schedule these tasks are linked to each other, and to any other tasks at WRAMC that might require association (such as this clinic cannot move until another clinic has moved), but not to any other location schedule. The final task is the beginning of "Clinical Transition".

JTF CAPMED recently completed briefing each staff at the three geographic locations (WRAMC, NNMC and DACH) on the IMS. JTF CAPMED IMS personnel have been placed at each of the geographic locations to work with the organizations present (such as NAVFAC) to develop the five project schedules. JTF CAPMED has developed a template for the IMS which will provide status/progress information with drill-down capability to the clinical level (e.g. Internal Medicine). The IMS contains approximately 15,000 tasks and is updated on a monthly cycle.

<h2 style="text-align:center">INITIAL OUTFITTING AND TRANSITION STRATEGY (IO&T)</h2>

A critical preparatory activity is the planning and execution of the Initial Outfitting and Transition Strategy (IO&T). IO&T consists of three key elements:

- a central performance based service contract,

- procurement contracts for long lead items, and

- contracts to support the reuse of current assets from WRAMC and DACH.

Highlights of these elements are described below:

Central Performance Based Service Contract

The purpose in pursuing a central performance based contract for purchasing equipment and services for both MILCON projects is to achieve: unity of effort, patient safety, economies of scale (i.e. cost savings through quantity purchases and maintenance contracts), interoperability, and standardization of equipment across the NCA MILCON projects. This contract will provide transition services (planning and execution) as well as provision equipment, hardware, materiel and supplies to outfit each of the buildings. Support for establishing this central performance based service contract is being provided by two DoD contracting organizations – the U.S. Army Medical Research Acquisition Activity (USAMRAA) and the TRICARE Management Activity (TMA) Acquisition Team. The required pre-procurement documents for the contract are being developed by the JTF CAPMED Program Manager and the JTF CAPMED/JOA Acquisition Team Members. This contract is intended to support the Walter Reed National Military Medical Center (WRNMMC) Request for Proposal 1 (RFP1) Medical Facilities and the Fort Belvoir Community Hospital (FBCH) MILCON projects. Deadlines associated with developing required pre-procurement documentation that have been met for this contract are:

- USAMRAA/TMA submit Draft Acquisition Plan for Approval – Completed

- NNMC/DACH submit performance based service contract requirements – Completed

- USAMRAA/TMA submit Final Acquisition Plan for Approval – Completed

- Acquisition Team submits final procurement documents to USAMRAA/TMA – Completed

- Contact award– Targeted for January 2010

For purposes of the contract, the equipment requirements are divided into four categories: medical, non-medical, IM/IT, and furniture and furnishings. As discussed below, long lead items and efforts to support the reuse of equipment from WRAMC and DACH were not included in this central contract.

Long Lead Items

Long lead items are generally defined as medical equipment items costing over $100K which require more than 6 – 8 months to procure. To mitigate risk to the central performance based service contract, the long lead items were removed and are being procured via other contracting vehicles indicated below. Additionally, this assures the medical equipment items critically linked to building design and construction are available when needed. The long lead items consist of equipment such as linear accelerators, diagnostic imaging equipment, pharmacy equipment and robotics, laboratory equipment, ophthalmic lasers, 3-D applications equipment, and surgical robotics. Contracting agencies to support long lead items were selected based on agency contracting mission, available capacity, and experience in contracting for capital expense equipment items. Therefore the requirements for long lead items are being supported by several contracting offices. The MILCON funded long lead items for the FBCH are being procured by the U.S. Army Corps of Engineers. The majority of long lead items for FBCH and WRNMMC are being supported by the Defense Supply Center Philadelphia (DSCP). Equipment that is not within the scope of the DSCP mission will be supported by the Naval Medical Logistics Command (NAVMEDLOGCOM). One unique requirement is the Da Vinci Surgical Robotic System required at both MILCON sites. Since NAVMEDLOGCOM has purchased this item recently, they will support this item for both projects. Deadlines associated with the long lead items procurement that have been met are:

- DSCP identifies long lead items they can support – Completed

- FBCH coordinates and finalizes long lead items with U.S. Army Corps of Engineers – Completed

- Long lead reuse and standardization decision – Completed

- NAVMEDLOGCOM assigns all other long lead items to a contracting activity – In progress

- Contract awards (multiple)–FY 2010-FY2011

Reuse Items from WRAMC and DACH

The MILCON project teams are exercising due diligence to reuse major investment equipment items ($100K and above) as well as other expense equipment (below $100K).

From 10 March – 3 April 2008, the Joint Technology Assessment and Requirements Analysis (JTARA) Team conducted assessments of current equipment and technology used at Walter Reed Army Medical Center (WRAMC), DeWitt Army Community Hospital (DACH), National Naval Medical Center (NNMC), and Malcolm Grow Medical Center (MGMC) in the areas of diagnostic imaging, pharmacy, laboratory, monitoring systems, and central materiel service. In a final report released in September, 2008, the JTARA Team recommended that certain items, systems and technologies be considered for reuse. Since the release of this report, the two MILCON project teams have assessed the JTARA recommended items for reuse.

As both new MILCON projects reach 100% design and the MILCON project for WRNMMC renovations nears 100% design, the decisions regarding reuse of these JTARA items will be finalized. This should occur not later than October 2009. Reuse of items is also balanced and coordinated with constructions schedules, equipment standardization objectives, and clinical transition plans. Reuse of the major equipment items and systems requires contracts to de-install, move, reinstall, test, and in some cases recertify the equipment's installation and operation. NAVMEDLOGCOM has routinely supported such service contract efforts and will support contracts for equipment reuse that require these services. A Diagnostic/Ancillary Services Group was created to drive the final reuse decisions and to obtain the joint approvals and coordination actions needed for the reuse items.

Equipment and systems under $100K were not evaluated by the JTARA Team, but assets under $100K at WRAMC and DACH are being reviewed by JTF CAPMED, Army and Navy for reuse at both sites.

Section 1674 (b)(2): *A timeline, including milestones, for such moves.*

The Department will utilize a compressed timeframe during August and early September of 2011 to move patients, staff, bed capacity and functions from WRAMC to expanded facilities at WRNMMC and FBCH. Any significant transition out of WRAMC based on the compressed timeframe is dependent on the delivery of new space at FBCH and WRNMMC. Thus, the WRAMC transition requires the completion of FBCH, the new additions at WRNMMC and construction of other supporting services (i.e. administration and parking at Bethesda). Also several other key trigger activities at Bethesda (e.g. staff training, attrition of inpatient census at WRAMC) must occur.

The Department evaluated multiple courses of action in developing a milestone schedule for the relocation of operations to the replacement facilities, which will constitute a major part of the MTP. Several interdependent lanes of transition were analyzed: DACH to new FBCH, NNMC to the expanded WRNMMC and WRAMC to FBCH and WRNMMC.

Current State vs. Future State of Healthcare Delivery in NCR

Current State: Two Large Medical Centers, Two Hospitals; Service Specific Staffing

National Naval Medical Center — *Large Medical Center*

Walter Reed Army Medical Center — *Large Medical Center*

DeWitt Army Community Hospital — *Hospital*

Malcolm Grow Medical Center — *Medical Center*

Merge and Expand

Merge and Expand

Remove Inpatient Capacity

Walter Reed National Military Medical Center (Bethesda, MD) — *Joint Military Medical Center*

Fort Belvoir Community Hospital — *Large Joint Hospital Expanded Inpatient*

Malcolm Grow Clinic — *Air Force (AF) Clinic No Inpatient*

Key — Navy / Arm / Air Force / Joint Staffing

Future State: One Large Medical Center, One Large Hospital, One Clinic; Joint Staffing

Other Medical Treatment Facilities (MTFs) were assessed that could temporarily or permanently provide additional capacity for WRAMC inpatient and/or outpatient care, including healthcare facilities at Andrews AFB and Fort Meade, Maryland. Key assumptions and issues related to each of these transitions are provided below.

Existing Dewitt Hospital to new FBCH

The DACH transition to the new FBCH is relatively uncomplicated. When the FBCH is completed, services from DACH can readily move in. Some services could potentially transition in advance as individual buildings and/or floors become available; however, this approach will not provide great benefits. As described below (under WRAMC to FBCH), Building C, the main hospital (including ER, ancillary support and inpatient beds) will be the last building to be completed at FBCH. It is estimated that the existing DACH to FBCH transition will occur between April and June of 2011. Outpatient services would come on line in April while the inpatient tower is readied for occupancy. Inpatients would then move over in June. See below.

FBCH Internal Move Schedule (Major Moves Only)

2nd Qtr
CY 2011

2th Qtr '11 (April)

Allergy & Immunology
Audiology & Speech
Pathology
Behavioral Health
Cardiology
Community Health Nursing
Dermatology
Endocrinology
ENT
Family Practice
General Surgery
GI & Virtual Colonoscopy
Internal Medicine
Occupational Health
Occupational Therapy
Ophthalmology
Optometry Services
Orthopedics & Podiatry
Orthotics & Prosthetics
Pediatrics
Physical Medicine and Rehab
Physical Therapy
Sports Medicine
Urology

2th Qtr '11 (June)

Anesthesia
Blood Donor Center
Breast Care Center
Central Sterile
Clinical Pharmacy
Emergency Amb. Services
Environmental Health
GME
Health Physics & Radiation Safety
Industrial Hygiene
Main OR
Main Radiology Suite
Nuclear Medicine
Nursery
OB/GYN
Obstetrics
Pharmacy
Radiology
Surgical
Transfusion & Pheresis Services

NNMC to new WRNMMC

At Bethesda, the internal transition plan is also fairly basic. As each clinical and/or administrative area is completed (in either new or renovated space), the respective NNMC function will move in. Many clinics will vacate their space and move to temporary space to allow for renovations in the clinical vacated space. Thus, the NNMC transition to WRNMMC is governed by the construction schedule below.

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NNMC to WRNNMC Move Schedule (Major Moves Only)

1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr
CY 2009				CY 2010				CY 2011		

3th Qtr '09
General Surgery

1st Qtr '10
Ophthalmology

2nd Qtr '10
3D Modeling
Endo/Infertility
OB/GYN
Uro/Gynecology

3rd Qtr '10
Dental Readiness

4th Qtr '10
Allergy Immunology
Anesthesia Service
BH – Adolescent Psych
Breast Care Center
Cardiac Cath
CT Surgery
Dermatology
Early Intervention
ED/ER
Endocrinology
Family Health Center
ICU
Internal Medicine
Outpatient Pharmacy
PACU
Partial Hospitalization
Pathology, Blood
Radiation oncology
Radiographic procedures
Rheumatology
Satellite Radiology

1st Qtr '11
Adolescent Medicine
Adult Inpatient Psychiatry
APU
BH – Adult Outpatient
Cardiology
Chiropractic
Diagnostic radiology
ENT
Exceptional Family
Hematology Oncology
Infectious Disease
MOR
Neurology
Occupational Therapy
Optometry
Orthopedics
Orthotics
Pediatrics Primary Care
Pediatrics Subspecialty
Podiatry
Urology

3rd Qtr '11 (August)
Administrative Building
Adult Med-Surg Inpatient
Anesthesia Pain Clinic
Audiology Speech
Cardiac Rehab
Clinical Inv. (Pharm)
GME
GYN Oncology
Health Physics
Infectious Disease (Lab)
Neuro Sleep Lab
Neurosurgery
Oral Max Facial
Pediatric Sedation
Pediatrics Inpatient
Physical Therapy
Plastic surgery
Preventive Psychology
PT Inpatient
Pulmonary
Staff Parking Garage
Vascular surgery
Warrior Transition Unit
Women's Invitro

Clinical moves to final locations following renovations and new construction.
Schedule as of Nov 2008 (CBB Dept Move Schedule)

WRNMMC Services - August 2011 Scheduled Completion

Inpatient Unit Care
Medical/Surgical Unit – Floor Three
Medical/Surgical Unit – Floor Four
Pediatric Inpatient
Pediatric Sedation and Procedure Unit
Inpatient Physical Therapy
Secure Inpatient Unit

Clinical Services
Neurosurgery
Neurological Sleep Lab
Cardiac Rehabilitation
Transplant
Plastic Surgery
Vascular Surgery
Women's Invitro Procedural Unit
Nephrology
Pulmonary Clinic
Pain Clinic
Integrated Cardiac Health Project
Dental Clinic Expansion

Clinical Support Services
Preventative & Consultative Services
Investigative Research Pharmacy
Infectious Disease Lab
Duty Rooms
GME ON Call Rooms
Medical Duty Rooms
Command Duty Rooms

Warriors-in-Transition Support
Warriors-in-Transition Dorms
Warriors-in-Transition Mess Hall
Warriors-in-Transition Support Center (over 50,000 sq. ft.)

Gymnasium
Courts and Pool
Fitness Center
Wellness Center
Integrated Cardiac Health Project

Administration
~120,000 sq. ft. of Administrative Functions
Potential Renovation of Buildings 3 & 5

The Department anticipates beginning outpatient health care service delivery at the new FBCH by April of 2011 and inpatient care by June 2011. The respective WRAMC elements of these services will not be moved until August-September 2011. The new space at Bethesda, Buildings A and B, should be available for care in part or in total between November of 2010 and February 2011. This window of time is dependent upon resolution of the later stage renovations which subsequently will affect the duration of transition time. Ideally, five months of unfettered transition time would be available; however, the realities of the schedule's critical path may require overlapping transition activities across the end stage ("red zone") of construction.

Wargame Analysis

In February of 2009, JTF CAPMED sponsored a structured transformational gaming exercise to evaluate the merits and risks of the various WRAMC transition strategies. The goal of the wargame was to mobilize WRAMC transition stakeholders to evaluate various strategies to transition existing services at WRAMC to their final location. The wargame was designed to meet the following objectives:

- Explore strengths, weaknesses and gaps of potential courses of action (COA) for moving patients, staff and equipment
- Identify and analyze levers that may impact various timelines
- Identify stakeholders' concerns – obstacles and derailers – with potential COAs, suggestions, and next steps
- Identify a preferred COA to best ensure access to medical services in the NCR

More than 130 stakeholders participated, representing a mix of component clinicians (e.g., WRAMC, DACH, and NNMC), command staff, JTF CAPMED, administrators, logisticians, equipment planners, facility and construction experts, patients and patient family members. Throughout the four days, stakeholders were assigned to one of five teams (inpatient, outpatient, diagnostic and ancillary services, administration, and patients) and were tasked with examining each COA and responding to specific questions.

A particular concern was meeting the intent of the FY 2008 NDAA Section 1674 (c), which requires that "patients, staff, bed capacity, functions, or parts of functions at WRAMC have not been moved or disestablished until the expanded facilities at the NNMC, Bethesda, Maryland, and DeWitt Army Community Hospital, Fort Belvoir, Virginia, are completed, equipped, and staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at WRAMC during fiscal year 2006."

Wargame participants evaluated three COAs, which varied primarily in the duration of the planned move—ranging from an extended move of various services from as early as November 2010 and extending to August 2011 to moving all at once over the course of a relatively compressed timeframe in August 2011. A summary of the three COAs follows:

COA One – represents a multi-phased approach that spreads the transition from WRAMC over a 6-8 month period. The "multi-phased" move requires completed construction and outfitting of all of FBCH and Buildings A and B at Bethesda. This option would occur in April of 2011.

COA One expedites the relocation of services and staff into these new facilities, while ensuring essential services are retained at WRAMC as long as necessary to accommodate any remaining lines of patient care. However, since the new home for the list of services mentioned on page 15 will not be fully available until August of 2011, this option would entail a second wave of transitions in August/September of 2011 following the delivery and outfitting of all remaining facility elements at the new WRNMMC.

COA Two – seeks to concentrate the transition in June of 2011 in order to accommodate the Services PCS cycle and the Graduate Medical Education (GME) cycle (ending June 30, 2011) and take advantage of a traditionally low inpatient census period.

COA Two begins the first transition wave into Bethesda in June of 2011. The strategy minimizes the timeframe between the first transition wave and the end of transition, while aiming to transition as many services as possible prior to the end of June. The driving feature of this scenario is the desire to best facilitate the Services summer PCS cycle and the GME cycle by having all GME providers in place by July of 2011. Additionally, this option takes advantage of the typical trough in inpatient census across the month of June.

COA Three – is the reverse strategy of COA one, end-loading the transition in the final month or so of the BRAC period. This "end-load" approach would occur in the August/September timeframe of 2011.

COA Three transitions most WRAMC elements coming to Bethesda in the final weeks of the BRAC timeframe. By waiting until August 2011 to begin moves, the Department avoids leaving a small complement of services at WRAMC across the last five-and-a-half months of the BRAC timeline. Virtually all functions move at once. By deciding to wait until August of 2011 to migrate the bulk of operations transitioning from WRAMC to the new WRNMMC, the construction congestion can be avoided. This would also help ensure that a critical mass of services remains at WRAMC until all functions can be transferred. Moving virtually all functions at once has the effect of being the most patient centered approach. Patient safety, access and convenience are maintained to a greater degree. Industry best-practices support this approach.

An August of 2011 move of functions from WRAMC to WRNMMC would allow for focus on "internal" campus moves from old to new space (from DACH to FBCH and from NNMC to WRNMMC). These internal moves must occur before functions from WRAMC can move to WRNMMC and FBCH. This also mitigates the challenges of

merging the staffs of multiple facilities are not overlaid upon the challenges of solving the new space and systems problems.
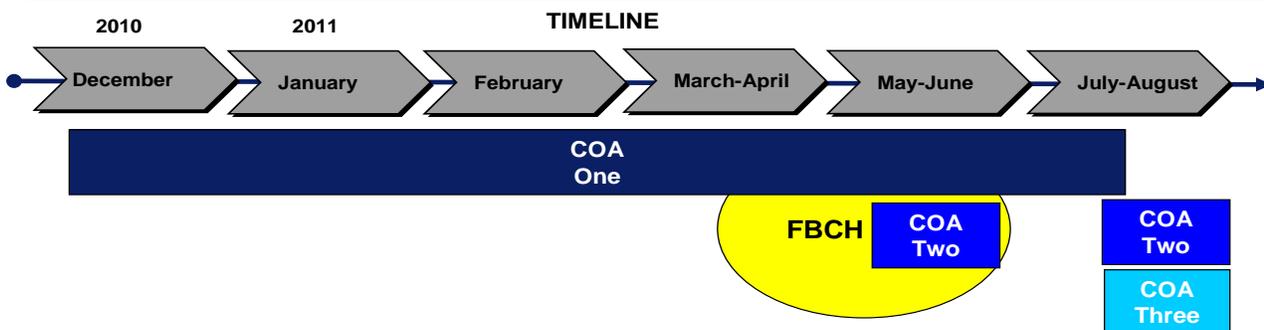
Once WRNMMC is completed, all equipment installed in the new facilities, all problems resolved in the new additions, and all training is accomplished by August 2011, then all WRAMC services should be able to transition in one coordinated wave over in a compressed timeframe.

Wargame Transition COAs and Timeframes

In all of the options discussed above, the search for a best transition alternative is clearly dependent upon the construction at WRNNMC. There will be more flexibility in the transfer of services designated for FBCH. To the extent that inpatient care can be transferred from WRAMC upon the opening of FBCH, outpatient and ancillary care should be able to transition proportionately. We analyzed this relationship in our transformational gaming exercise. In all options, on 15 September 2011, all patient services will be transitioned out of WRAMC and the transfer of the WRAMC main post property can occur.

All courses of action operate within a set of planning assumptions:

- *Continuity of care will be 100 percent assured throughout the transition with minimum interruption in health service delivery.* While consideration may be given to sending patients out to the network, on an as-needed basis, this practice will be the exception, not the rule. The goal is to maintain the care of all WRAMC primary beneficiaries within the NCR to the greatest extent possible.

- *Internal moves at Bethesda and Fort Belvoir will occur as the space is made available at both campuses.* At Fort Belvoir, the transition will not occur until Building C, comprising the inpatient, surgical and most ancillary diagnostic services is available. Given that the NNMC is already a fully functioning hospital, at Bethesda the transition will occur as each clinic/service is completed.

- *WRNMMC and FBCH will be governed and operated as joint integrated facilities.* The Deputy Secretary of Defense signed a Memo on January 15, 2009 approved a recommendation that will continue JTF CAPMED as a joint military command and establishing WRNMMC and FBCH as joint subordinate commands.

- *All certification, equipment testing, equipment training, and support system setup will be completed before the first patient day.* All activities relating to the installation, setup, and operation of both fixed and moveable equipment will occur in advance of any major patient moves from WRAMC.

- *Accreditation will be maintained or achieved.* The JTF will work with accrediting bodies, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Council for Graduate Medical Education (ACGME), ensuring that the WRAMC transition does not impede or negatively impact accreditation.

- *All staff training, including conducting "day-in-the-life" exercises (as necessary), will have been completed before the first patient day.* Day-in-the-life and other staff training will be conducted months prior to the first patient day, ensuring that staff has full knowledge and understanding of the "new" facility's layout, equipment, processes, etc.

- *A strategic communication plan will be executed.* A comprehensive strategic communication plan will be developed and executed, with appropriate messaging for all stakeholders impacted by the WRAMC move, including WRAMC patients, their families, personnel, and the community.

- *Transition moves occur during times that minimize patient and staffing disruptions.* The physical movement of patients will occur ideally over a long weekend and/or at times to leverage a low patient census.

- *Resources ensuring the viability of the preferred course of action will be provided.* Funding supporting a compressed timeframe move during the transition, e.g., extra shuttle services for patients, etc will be provided to support the smooth efficient transition of patients.

- *All WRAMC primary beneficiaries will be accommodated in their final healthcare "home" by the BRAC deadline.* Beneficiaries who previously had been enrolled with a primary care manager at WRAMC will be enrolled with a new primary care manager.

To inform the transition process, each stakeholder team reviewed and analyzed data, including the following:

- The Fort Belvoir and Bethesda construction completion schedules for each service
- Construction staging diagrams
- A list of major equipment requiring a long lead time
- A list of services showing interdependencies
- Warrior care diagnoses data

This data review validated the following constraints significantly impeding the ability to move patients out of WRAMC any earlier than April 2011:

- Due to the construction completion schedule, the new FBCH outpatient care can begin no earlier than April 4, 2011
- FBCH inpatient services cannot operate until June 2011
- WRNMMC expanded capacity for inpatient services will not be operational until August 2011
- The Warrior Transition barracks, staff parking, and new Walter Reed administrative offices will not come online until August 2011

In any scenario, Warriors-in-Transition receiving only primary and secondary care should be relocated to Fort Belvoir (pending scheduled March of 2011 completion of the Warriors-in-Transition Center adjacent to FBCH) and Fort Meade (pending provision of similar support facilities at Fort Meade) as soon as facilities are made available to accommodate them. However, Warriors-in-Transition requiring tertiary services may need to remain at WRAMC until their consolidated Warrior Transition Center (dorms, dining, and support facilities) are opened at the end of the summer of 2011. Likewise, services accessed by Warriors-in-Transition may need to be maintained at WRAMC until the Warriors are transferred to WRNMMC. Essential Warriors-in-Transition services include all physical and behavioral care modalities along with surgical and ancillary services. The Department is fully committed to maintaining sufficient clinical, administrative, and support capabilities at WRAMC to care for Warriors-in-Transition until the replacement facilities or other locations are ready to assume their care. This level of support and clinical activity may affect transition actions at WRNMMC and FBCH.
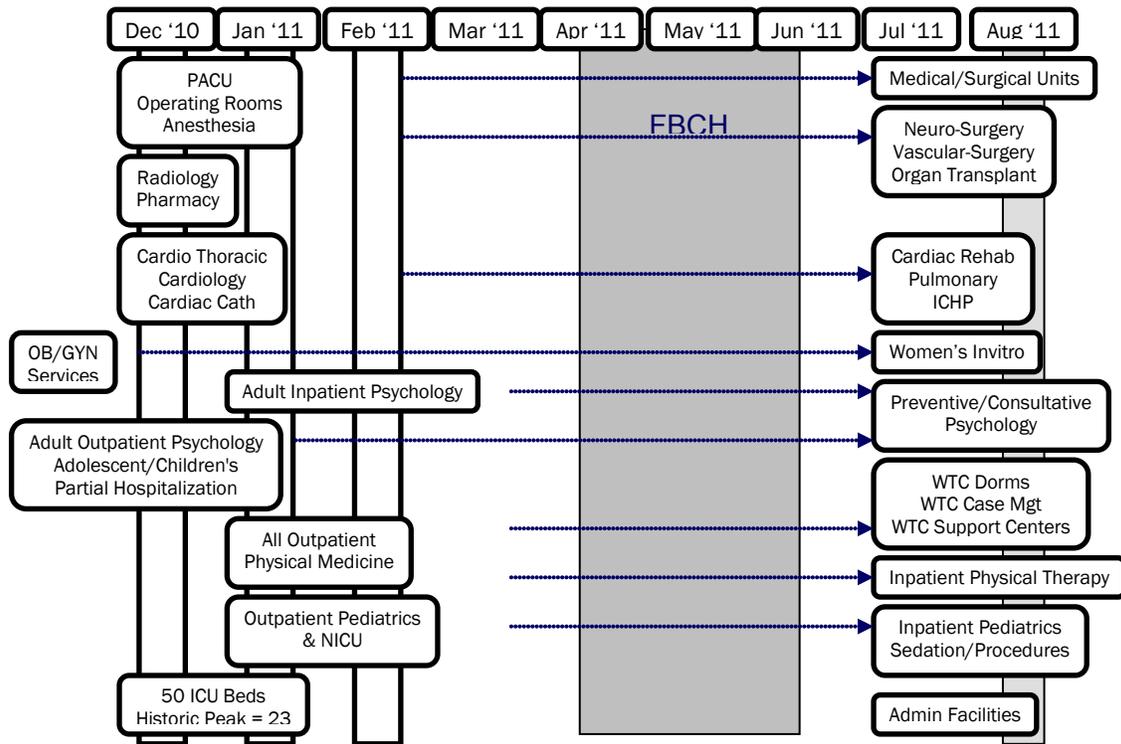
Armed with this information, the stakeholder groups discussed the strengths and challenges of each COA, in detail, considering the following criteria shown below.

Transition Course of Action Criteria

Criterion	Definition
Maintain Patient Safety and Quality of Care	▪ Provide quality healthcare that is free from accidental injury due to medical care or medical errors ▪ Remain compliant with the Patient Safety and Quality Improvement Act of 2005 ▪ Maintain and utilize qualified staff ▪ Promote an environment that maintains patient confidentiality ▪ Develop and implement activities that will improve patient safety and the quality of healthcare delivery
Provide Full Access to Services Throughout	▪ Provide a full range of services to all patients (ability and capacity), which may include, but is not limited to, specialty services, diagnostic testing, and substance abuse treatment
Minimize Impact on Graduate Medical Education/Health Professions Education	▪ Maintain quality education and training programs for interns, residents, and fellows ▪ Remain compliant with all policies and procedures with the Accreditation Council for Graduate Medical Education's (ACGME) Institutional and Program Requirements
Promote Patient Satisfaction	▪ Provide a patient-centered environment that exudes trust, professionalism, responsiveness, and quality care
Promote Transition	▪ Minimize disruptions and adverse impact on staff ▪ Meet all targeted dates and construction deadlines

Much of the wargame discussion focused on challenges associated with moving services in a phased approach. While some services such as the OR and cardiology *could* move as early as January of 2010, related and interdependent services such as the inpatient medical surgical services, and cardiac rehab will not be constructed and outfitted until August of 2011. Examples of such interdependencies are depicted in the chart below.

WRAMC to WRNMMC Challenges

Dec '10	Jan '11	Feb '11	Mar '11	Apr '11	May '11	Jun '11	Jul '11	Aug '11

PACU / Operating Rooms / Anesthesia ·····► **Medical/Surgical Units**

FBCH

Radiology / Pharmacy ·····► **Neuro-Surgery / Vascular-Surgery / Organ Transplant**

Cardio Thoracic / Cardiology / Cardiac Cath ·····► **Cardiac Rehab / Pulmonary / ICHP**

OB/GYN Services ·····► **Women's Invitro**

Adult Inpatient Psychology ·····► **Preventive/Consultative Psychology**

Adult Outpatient Psychology / Adolescent/Children's Partial Hospitalization

All Outpatient Physical Medicine ·····► **WTC Dorms / WTC Case Mgt / WTC Support Centers**

·····► **Inpatient Physical Therapy**

Outpatient Pediatrics & NICU ·····► **Inpatient Pediatrics Sedation/Procedures**

50 ICU Beds / Historic Peak = 23 **Admin Facilities**

Various risks and mitigation efforts surrounding an incremental move were discussed during the wargame, which informed strategic thought and critical planning needs. Discussion included the risk of losing Residency Review Committee (RRC) accreditation due to the loss of procedural volume, loss of staff supervision, and the loss of interdependencies at WRAMC. The longer the transition, the more the risk. A coordinated and synchronized clinical transition plan that ensures consideration of interdependencies could mitigate such risk. Another mitigating effort includes incorporating input from the RRCs into the "staff" plan to make certain that accreditation requirements are being met.

Similarly, another risk with an incremental move is the risk of losing clinical accreditations (e.g., blood bank, radiology, The Joint Commission, etc.). Again, the consensus was that the longer the transition, the more risk is involved with losing accreditation. In addition to involving accrediting agencies in the "staff" transition plan, another mitigation effort would be to have a single governance for the two MTFs. This solution would help in standardizing communication and developing common NCR-wide policies and procedures.

A protracted move spreads out the "inconvenience factor" for access to clinical services over a five-month period. This transition spread has the potential of decreasing patient satisfaction, decreasing the continuity of care, and increasing patient loss to civilian providers. Mitigation efforts for the inconvenience of a spread-out transition include

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developing a central appointing system and implementing effective strategic communication (STRATCOM) messages to both internal and external community stakeholders (a longer move would require more STRATCOM messages to be sent out).

After four days, the consensus among all stakeholder groups was the following:

▪ Belvoir and Bethesda internal moves should occur as new and renovated space comes online
  – For Bethesda, that movement occurs from spring 2009 through August of 2011
  – For Belvoir, patients move from DACH to FBCH in April 2011 for outpatient services and diagnostic care and in June 2011 for inpatient care

▪ WRAMC functions transition to Belvoir and Bethesda over a compressed timeframe in late August/Early September, following completion of several key trigger activities at Bethesda including:
  – Parking garages, Warrior Transition Center Complex, inpatient renovations, administrative complex
  – Equipment installation, certification, testing, training
  – Support system setups and commissioning
  – Building systems commissioning
  – Staff training, including "day-in-the-life" exercises
  – All critical Joint lines of operation are resolved and in place
  – Mitigation Strategies
  – Attrition of inpatient census.

Following the four-day wargame, the principle directors of the Clinical Transition War Game Exercise met with senior leaders in the National Capital Area having joint oversight of the WRAMC transition. Attendees discussed the results of the War Game Exercise and debated the way forward. Group consensus was that, other than by exception, services should not transition from WRAMC to WRNMMC and FBCH until critical trigger activities are completed at the Bethesda campus and/or mitigation strategies are leveraged. A key trigger activity is ensuring that essential clinical and supporting services are in place and fully functional. Several facilities including staff parking garages and the Warrior Transition Center Complex are not expected to be ready for occupancy until late summer 2011. The consensus of the group was that it would require risk to attempt to transition patients and staff with construction contractors still spread across the Bethesda installation and inadequate staff parking available.

Following completion of critical trigger activities, delivery of a "quick" transition is desired. While advantageous to shift services in phases over a longer period of time, the group discussed the identified industry standard to transition whole services all at once, i.e. over a compressed timeframe. Commander, JTF CAPMED, VADM John Mateczun concurred in the concept and directed the transition team to provide supporting case studies and develop a detailed execution plan, the MTP in **APPENDIX A**, for all

precedent activities and mitigation strategies required to facilitate a coordinated transition.

The wargame participants believed that the chosen option best matched their knowledge of the hospital industry's approach to transition. To verify this, the JTF CAPMED conducted a study of recent high-profile facility moves, with a goal of extracting a common set of lessons learned and best practices in merging and moving hospitals. Hospitals and health systems selected for the study were chosen for their similarity to WRNMMC/FBCH's situation. Most selected hospitals represented major, tertiary care facilities, whose move involved the relocation of a large number of patients, furniture and equipment to a renovated or replacement facility; some institutions involved the consolidation of multiple sites into one, and several had robust teaching programs.

Of the key study findings, nearly all administrators underscored the importance of minimizing the length of the patient move to a one to two day window, with an initial "soft" move of non-clinical administrative and support areas occurring two to three weeks prior to the move. According to those interviewed, extending the patient move any longer multiplies the potential for risk to patients, as the degree of concentration and synchronization needed to successfully move inpatients is not sustainable for an extended period of time. Even for outpatient services, there is value in an all at once "first patient day". The staff is prepared, energized and motivated, and patients are excited about being in a newly opened/renovated environment.

In a few of these case studies the move was virtually "across the street." Thus, it might appear that the NCR is in a more difficult position requiring a move "across town." Yet, on closer examination, these examples are equally compelling in favor of an "all at once move." In cases where a major medical center has built its replacement facility "across the street," and moved over a weekend, that action, in itself, demonstrates that there is little or no advantage to transitioning services early or in a piecemeal fashion because otherwise that entity would have done so—being located "across the street." Patients and staff could walk back and forth for complementary services and yet these institutions did not exercise that option.

Other findings supported the importance of carefully sequencing inpatients during the physical move, the benefits of hosting strategically-planned orientations and walkthroughs, the necessity of developing a robust move plan including contingency plans, and suggestions for how to effectively structure a Transition Team to promote efficiency. Finally, administrators reported a common set of challenges, including ensuring that all department heads faithfully execute their individual move plans, maintaining patient-centered care in the existing facility, securing patient and family buy-in to the move, and managing the media's involvement with the move.

While wargame participants strongly recommended that the physical move of patients and staff occur over a brief period, wargame participants identified essential predecessor activities that **must** be planned and executed a minimum of six to nine-months prior to

the WRAMC transitioning of patients and staff. These activities are identified in the critical milestone chart within the MTP **(APPENDIX A)**.

Section 1674 (b)(3): *Projected budgets, including planned budget transfers, for military treatment facilities within the region.*

Funding Flow
The flow of Operations and Maintenance (O&M) funding to MTFs within the NCR will be discussed in reference to fiscal years and by Military Medical Department. The Department operates on a fiscal year budget cycle beginning 1 October and ending 30 September.

The Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA) receives funding in Defense Health Program (DHP) appropriation for medical operations in the Department. Funding levels are established and concurred with by the DHP Resource Management Steering Committee (RMSC) and then approved by Military Health System (MHS) senior leadership. These amounts are reflected on Funding Authorization Documents (FADs). FAD amounts are the obligation authorities subject to the provisions of 31 U.S.C. §1517 and DoD Directive 7200.1. Funding is executed in accordance with applicable provisions of the DoD Appropriations Act and all other laws, regulations, procedures and policies necessary to support the DHP appropriation.

The U.S Army Medical Department (USAMEDCOM) receives funds from OASD/HA. USAMEDCOM allocates the funds to the Army MTFs. The Army MTFs in the NCR are under the control of the North Atlantic Regional Medical Command (NARMC). The Commanding General of Walter Reed Army Medical Center (WRAMC) also serves as Commander of the North Atlantic Regional Medical Command. The region covers 21 of the northeastern States plus the District of Columbia.

The Navy Bureau of Medicine and Surgery (BUMED) receives funds from OASD/HA. BUMED allocates the funds to Regional Medical Commands. The Navy MTFs in the NCR receive funding from and are under the control of Navy Medicine National Capital Area (NCA). The Regional Commander, Navy Medicine NCA also serves as the Commander of National Naval Medical Center, Bethesda MD.

The Air Force Surgeon General's Office of Resource Management (AF SGY) receives funds from OASD/HA. AF SGY allocates the funds through Air Force District of Washington to the Air Force MTFs in the NCR.

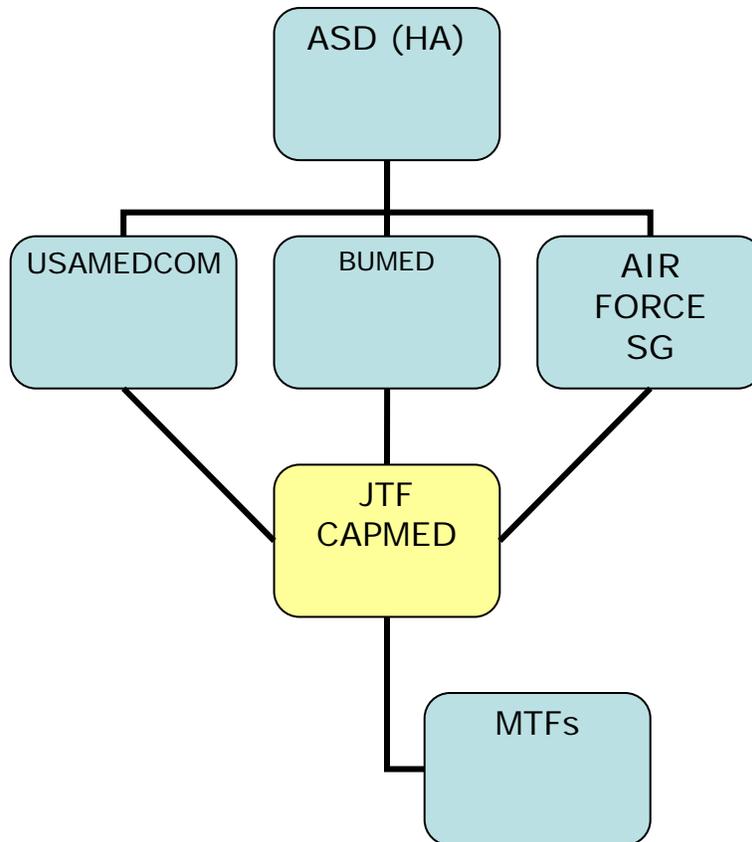In FY 2009, military medical facilities in the NCR will be funded as they have been in the past. Budget figures can be found below. MTFs will continue to receive funds from their respective Service through their unique, Service specific means. As per section 1674(a) of the FY 2008 NDAA, WRAMC will continue to be funded at FY 2006 levels until the new hospitals at Bethesda, MD and Fort Belvoir, VA are ready.

National Capital Region FY 2010 Projected Budgets
(in thousands of dollars)

Medical Treatment Facility	FY 2008	FY2009	FY2010
Walter Reed Army Medical Center and Garrison	$ 378,794	$ 387,319	$ 400,044
Dewitt Army Community Hospital at Fort Belvoir, VA	$ 155,761	$ 164,565	$ 171,183
Kimbrough Army Community Hospital at Fort Meade, MD	$ 72,453	$ 76,932	$ 79,410
National Naval Medical Center at Bethesda, MD	$ 371,558	$ 333,613	$ 363,637
Naval Health Clinic Annapolis, MD	$ 14,234	$ 12,918	$ 14,081
Naval Health Clinic Quantico, VA	$ 22,535	$ 21,336	$ 23,256
Naval Health Clinic Patuxent River, MD	$ 14,027	$ 11,853	$ 12,801
Malcolm Grow Medical Center at Andrews Air Force Base, MD	$ 72,000	$ 62,000	$ 62,119
Total NCR Medical	**$ 1,101,362**	**$ 1,070,536**	**$ 1,126,531**

NOTE: Projected Budget amounts comprise O&M, RDT&E and baseline procurement funding only and does not include OCO (other Contingency Operations used to be GWOT); MERHCF (DoD Medical Eligible Retiree Health Care Fund); Congressional Special interest items and any centrally funded equipment from the Medical Service Headquarters. In FY 2008, execution for Medical Treatment Facilities in the NCR was approximately $1.3B.

In FY 2010 and FY 2011, the three Service medical department headquarters will receive funds from OASD/HA and determine appropriate program amounts for their respective group of NCR MTFs. The Services will then coordinate with JTF CAPMED for the distribution of funds to individual MTFs. This financial structure was concurred upon by the DHP Resources Management Steering Committee (RMSC). See figure below.

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Proposed budget Transfers

The financial structure for FY 2012 and beyond has not been determined as yet. Once this has been determined, JTF CAPMED Comptroller will work with RMSC members to determine the budget transfers. A major challenge, however, will be the determination of an equitable baseline to be transferred.

Section 1674 (b)(4): *The management or disposition of real property of military treatment facilities within the region*

In January-February 2006, the U.S. General Services Administration and the Department of State made application for the Walter Reed Army Medical Center Main Post real property in response to the Secretary of the Army report of excess for the 113 acres associated with Main Post resulting from BRAC 2005. The applications were approved by the U.S. Army and the plans are to complete a federal to federal transfer upon completion of the Walter Reed Army Medical Center clinical mission. The Department of State will receive the remainder of the property.

Section 1674 (b)(5): *Staffing projections within the region.*

During the past 18 months, the JTF CAPMED has worked to consolidate and realign medical manpower resources within the NCR. The strategy builds upon the initial analyses of the NCR Multi-Service Market Office (MSMO), incorporates key elements of resultant Programs for Design (PFD), and refines requirements through an iterative, spiral development processes. Supporting analyses project workload figures, benchmark military/civilian production standards and incorporate expert user input. The resultant Joint medical manpower allocation reflects the unique mission requirements of JTF CAPMED and captures efficiencies gained using integrated plans, interoperable assets and standardized systems/processes.

Most recently, JTF CAPMED completed Phase IV of a four-phased spiral development process, included in the MTP located in **APPENDIX A**. A pre-decisional draft of the Joint Table of Distribution (JTD) for both WRNMMC and FBCH has been completed and forwarded to the Assistant Secretary of Defense (Health Affairs), the Military Services, and the Joint Chiefs of Staff (JCS) for review. The objective is to complete the review and formal documentation by early 2010. Completion of these actions will support effective, timely military assignment and civilian human resource management activities prior to the 15 September 2011, opening of the new facilities.

At this time, manpower requirements (nearly 10,000 individuals across WRNMMC and FBCH) are distributed according to the new facilities' organizational structures and include occupational skill, personnel category, military Service, and military/ civilian grade level details. The draft laydown is intended to operate within the existing pool of manpower resources. It strives to ensure 1) that current Readiness missions supported by the NCR are sustained in the future, 2) the impact of deployments and contingencies are balanced across medical facilities -- sustaining the continuity of world-class casualty and beneficiary care, and 3) civilian workforces experience minimal dislocation during the transition. Graduate Medical Education (GME) faculty and support staff figures are incorporated in the manning document. Consistent with past practice, GME resident requirements are determined and managed by the military Services. Resident figures are projected to remain at current levels. Critical faculty requirements are identified to ensure that medical training programs are sustained. Finally, the laydown incorporates contributions by Army, Navy and Air Force services within the NCR. As previously noted, a pre-decisional version has recently been forwarded to principal stakeholders for review.

Conclusion

The Department of Defense is fully committed to providing the finest casualty care to its Wounded Warriors and to prepare to respond anytime, anywhere with comprehensive medical capability to military operations, natural disasters and humanitarian crises around the globe. The Department also strives to ensure delivery of the highest quality healthcare to all its service members, retirees, and their family members. Toward those ends, the Department is working vigorously with its many partners to ensure the manner

in which patients, staff, bed capacity and functions will move from WRAMC to the new WRNMMC and FBCH

The Department is grateful to Congress for its unwavering support and interest in the transformational efforts the Department is undertaking in the NCR to provide world-class medical facilities and an Integrated Delivery System. Congressional oversight and support have made immeasurable contributions to this process and the entire Military Health System (MHS) to ensure Service Members, retirees and all MHS beneficiaries receive the finest healthcare available.

APPENDICES

A.) Master Transition Plan for movement of operations from Walter Reed Army Medical Center to Walter Reed National Military Medical Center and Fort Belvoir Community Hospital

B.) Construction and transition schedule and a list of clinics that will be at WRNMMC and FBCH
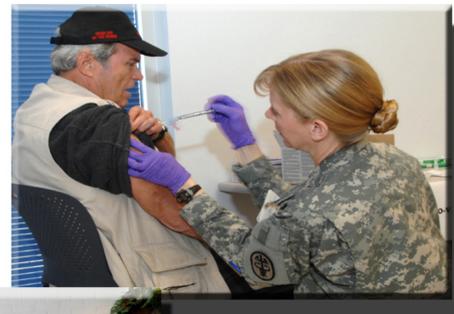
JOINT TASK FORCE
NATIONAL CAPITAL REGION MEDICAL

MASTER TRANSITION PLAN

WALTER REED NATIONAL
MILITARY MEDICAL CENTER

FORT BELVOIR
COMMUNITY HOSPITAL

MTP

15 July 2009 v.1.1

Master Transition Plan

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Message from the Commander

Joint Task Force National Capital Region Medical

It is my pleasure to present the Joint Task Force's Master Transition Plan. This comprehensive document will guide the military medical commands of National Naval Medical Center, Walter Reed Army Medical Center, DeWitt Army Community Hospital and the 79th Medical Wing during the next two years as we transition into the Walter Reed National Military Medical Command and Fort Belvoir Community Hospital. This unprecedented transformation of the Department of Defense's military medical capabilities within the National Capital Region will result in the establishment of two joint facilities serving as lynchpins of an integrated regional health care network in the Nation's Capital.

During this transition period we will leverage the best practices of each military Service in order to integrate 13,000 military and government staff and more than 75 clinical and administrative services; all while we build two state-of-the-art medical facilities to ensure our 600,000 eligible beneficiaries receive superior healthcare. The National Capital Region is the primary receiving site for combat wounded warriors and our number one priority is ensuring these heroes receive world-class medical, surgical, and psychological health care. Our second priority is ensuring the successful integration of our staffs into cohesive, joint medical teams to provide advanced, evidenced-based patient care, while ensuring we "Care for the Caregivers" as we continue nearly a decade of support for sustained combat operations.

In response to the challenges of planning the largest military medical construction project in the United State's history and developing the first joint Military Medical Treatment Facilities, we have designed a comprehensive plan that focuses on the four key components of this project: people (our greatest resource), unified processes, advanced technology and physical infrastructure. To ensure this project is managed with a focus on the complex interdependencies of transitioning four service-based medical facilities into two joint medical facilities, we developed an Integrated Master Schedule which includes a critical milestone chart and detailed action plans. This dynamic plan will be updated and published quarterly to ensure we incorporate the principles of adaptive planning and should be seen as a living document – flexible and adaptive.

I look forward to collaborating with our patients and staff as we adapt and execute this JTF CAPMED's Medical Master Transition Plan.

JOHN M. MATECZUN
VADM, MC, USN
Commander, Joint Task Force
National Capital Region Medical

Preface

The MTP describes the transformation of the Department of Defense's military medical capabilities within the National Capital Region. Its audience includes the Executive Branch; Congress; Office of the Secretary of Defense; Joint Staff; combatant commanders; officers, noncommissioned officers, civilians, and enlisted personnel of all services.

The MTP is prepared under the direction of the Commander, Joint Task Force National Capital Region Medical (JTF CAPMED) and it delineates how the JTF CAPMED will transition medical healthcare services in the National Capital Region from four Service specific military treatment facilities to two joint facilities as required by the Deputy Secretary of Defense (DEPSECDEF) on 14 September 2007. This plan applies to the all Medical Facilities within the Joint Task Force National Capital Region Medical Joint Operations Area.

The Joint Task Force National Capital Region Medical is the proponent for this publication. The preparing organization is the J5 Plans and Policy Directorate, Joint Task Force National Capital Region Medical. Users are encouraged to send comments and suggested improvements on Department of the Army (DA) Form 2028 (Recommended Changes to Publications and Blank Forms), by memorandum to CJTF National Capital Region—Medical, J5 Plans and Policy, 8901 Wisconsin Ave, Bethesda MD 20889 or through the MTP update link on the JTF CAPMED BRAC Portal at http://a58.aetc.af.mil:8080/saio/jtfcapmed

Record of Changes.

CHANGE NUMBER	COPY NUMBER	DATE ENTERED	POSTED BY

Executive Summary

The Final Report of the 2005 Defense Base Closure and Realignment Commission (BRAC) contained recommendations that will significantly transform the medical capabilities offered throughout the National Capital Region (NCR). The four major military medical treatment facilities of National Naval Medical Center (NNMC) in Bethesda, Maryland, Walter Reed Army Medical Center (WRAMC), DeWitt Army Community Hospital (DACH) and Malcolm Grow Air Force Medical Center will combine into two inpatient bedded-facilities: Walter Reed National Military Medical Center (WRNMMC) Bethesda, Maryland and a newly constructed, Fort Belvoir Community Hospital (FBCH), Fort Belvoir, Virginia. The two facilities currently named Walter Reed Army Medical Center (WRAMC) and DeWitt Army Community Hospital (DACH) will cease operations when all their components have relocated to either WRNMMC or FBCH. The facility currently known as NNMC will expand significantly and incorporate all tertiary care for the National Capital Region. When this project is completed in September 2011, NNMC will cease operations and will become WRNMMC, a joint medical facility assigned to Joint Task Force National Capital Region Medical (JTF CAPMED). Malcolm Grow Medical Center (MGMC) at Andrews Air Force Base, Maryland will transition from a bedded inpatient hospital to an outpatient ambulatory care center.

The 2006 Quadrennial Defense Review provided strategies to improve the management, performance, and efficiency of the Military Health System (MHS). These strategies included elimination of redundant command structures, alignment of resource streams, and provision of clear lines of authority and responsibility for local decision making.

As a result, on 14 September 2007, the Deputy Secretary of Defense (DEPSECDEF) established JTF CAPMED with the dual mission of ensuring the effective and efficient delivery of world-class military healthcare within the NCR, overseeing the consolidation and realignment of military healthcare within the NCR and conducting such other missions as may be assigned to improve the management, performance, and efficiency of the MHS. On 1 October 2007, JTF CAPMED, under the command of military medical Flag Officer, achieved Initial Operating Capability and one year later, Full Operational Capability.

On 15 January 2009, the action memorandum, "Civilian and Military Personnel Management Structures for the JTF CAPMED" was signed by DEPSECDEF, directing that WRNMMC and FBCH be subordinate joint military commands to JTF CAPMED. The transformation from four service-specific to two joint medical treatment facilities (MTF) is a complex mission requiring the relocation of more than 9,000 military and civilian staff, consolidation of more than 60 medical services and the largest military medical construction project in United States' history.

Master Transition Plan

JTF CAPMED's Master Transition Plan (MTP) guides the workforce in the JTF's Joint Operations Area (JOA) in executing the 2005 BRAC Commission directives. The MTP contains two primary sections: a Transition section based on a Critical Milestone Chart and the Campaign Plan.

Section one, Transition, focuses on the key impact areas of the BRAC process, specifically the People (wounded warriors, patients, and staff), Processes (clinical, administrative, and personnel), Technology (evidenced-based technology, digital imagery and advanced telecommunications to enhance patient care) and Physical Infrastructure (environmentally friendly building design and high-tech equipment). Section two, Campaign, highlights the mission shift interdependencies (four hospitals to two) and the cultural integration efforts necessary to merge three Service-centric medical cultures into an effective and efficient joint medical infrastructure. The Master Transition Plan (MTP) serves as the capstone document which guides JTF CAPMED and subordinate unit planning efforts throughout the 2+ year transition

process. MTP version 1.0 was developed using a detailed analytical process focusing on the three levels of joint planning: tactical, operational and strategic.

Tactical planning emphasizes the transition effort at each of the specific BRAC sites, i.e. WRAMC, Bethesda, MGMC and Fort Belvoir. There, construction timelines are merged with manpower, equipment, and space requirements revealing individual lines of operations that must be accomplished to ensure the precise shift of medical capabilities.

Operational planning takes tactical lines of operation and uses them to identify planning interdependencies from each BRAC-site throughout the JOA. These interdependencies then provide planners with a common site picture over all phases of project planning. Strategic planning assures the full development of the MTP. The MTP covers all aspects of transition. Ultimately, it maps the sequence and timing of all service moves (clinical, support, etc.) from WRAMC to WRNMMC and FBCH. It will detail the individual actions required to ensure success at each step of the transition. The plan will be dynamic in nature and updated quarterly (or more frequently if necessary) so as to evolve across the duration of the BRAC execution timeline. Critical nodes and pathways can be analyzed well in advance of their occurrence to exercise mitigation strategies designed to avoid possible "service delivery troughs" caused by transitional movements of administrative and clinical capability packages from one facility to another.

JTF CAPMED is actively engaged in all activities necessary to effectively transition from four service-specific military medical facilities to two joint facilities by September, 2011. JTF transition strategy focuses on four interrelated planning factors – people, process, physical infrastructure, and technology.

People, (patients, staff, and strategic partners), are the greatest resource within the JOA and meeting their needs is a top priority of the JTF commander. During the next two years many will experience some inconvenience associated with move-related planning such as construction of facilities, temporary internal movements of medical services to accommodate construction, uncertainty about final placement of staff, and the process of tri-Service integration into a Joint unit structure. To mitigate the impact on our people, JTF CAPMED will publish a Strategic Communication Plan in September 2009.

The Process factor addresses the actions necessary to shift people and missions from current to post-BRAC commission directed end state.

JTF CAPMED directed the development of unified processes for example:

- Relocation of patients, staffs, and services
- Transition management
- Determination of clinical and administrative operation concepts
- Preparation for and conducting of accreditation surveys and inspections
- Staff and Services integration
- Multi-Service cultural assimilation
- Equipment
- Healthcare Business Rules

Physical infrastructure addresses the buildings and equipment necessary to support and enable people and processes

Technology is comprised of equipment, software, and technicians necessary to manage the data, information, and communication necessary to support the infrastructure, processes, and people that will combine to make the Military Healthcare System in the National Capital Region one of the finest in the world.

Campaign Plan

To synchronize and carry out the MTP and critical milestones, JTF CAPMED developed an overarching strategy of campaigns. The strategic framework for this transition strategy includes three separate campaigns[1].

- Campaign I begins at the present day to October 2012, and its goal is to "Operationalize JTF CAPMED Forces" by realigning and transforming the JOA to implement BRAC requirements.
- Campaign II spans the period of October 2012 to October 2017 with a goal to "Demonstrate JTF CAPMED Capabilities."
- Campaign III is JTF CAPMED's vision to 2023 with a goal to "Lead Strategic Change."

Why a Campaign Plan? According to Joint Publication 1.0, a campaign plan is "a joint operation plan for a series of related major operations aimed at achieving strategic or operational objectives within a given time and space." The transition that the NCR is undertaking in the next two years is the largest transformation of military medical assets in United States history. To perform this transformation, the DoD must carefully orchestrate and execute a multitude of tasks, including the relocation and integration of medical staff and capabilities.

Campaign Plan I is the strategy for successful implementation of the BRAC requirements, mandated by the U.S. Congress to transform the NCR. See the Campaign section of the MTP for the detailed campaign plan covering the present to 1 October 2012.

Quarterly action plans will detail specific objectives and tasks to guide the JTF and its subordinate commands (WRAMC, NNMC, FBCH, and the 79th Medical Wing) through the process of transitioning from four Service-specific military treatment facilities to two joint facilities.

The end state for Campaign Plan I is the same as the Near-Term End State. The Near-Term End State reflects the patients and staff perception of the WRNMMC and FBCH, and how the JTF postures itself for the next stage of JTF CAPMED maturation. By 1 October 2012, one year past the requirement for transformation, JTF CAPMED will have established:

- Interoperable systems that not only interact with each other, but provide a foundation for future joint systems, exportable to any geographic location
- Integrated healthcare delivery systems that ensure a patient's continuity of care throughout the continuum of healthcare
- The Walter Reed National Military Medical Center on the Bethesda, Maryland installation
- The Fort Belvoir Community Hospital on Fort Belvoir, Virginia
- A JTF CAPMED culture committed towards the pursuit of quality care to our beneficiaries and an unmistakable pride in our healthcare system
- Assured primary care access throughout and after the transition of personnel and equipment between the following locations: Walter Reed Army Medical Center, National Naval Medical Center, Malcolm Grow Medical Center, Fort Belvoir, and nearly 40 other military medical treatments facilities throughout the JOA

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[1] This document will only address Campaign I

On 13 May 2005, the Department of Defense (DoD) announced its recommendations for the latest round of Base Realignments and Closures (BRAC). The 2005 Defense Base Closure and Realignment Commission reviewed the work of the DoD and made its recommendations to the President on 8 September 2005. The recommendations became law in November 2005, law that contained a significant change affecting the landscape of military hospitals in the National Capital Region (NCR). Currently, there are four inpatient military hospitals within the NCR:

US Navy	National Naval Medical Center (NNMC), Bethesda, Maryland
US Army	Walter Reed Army Medical Center (WRAMC), Washington, District of Columbia
US Air Force	Malcolm Grow Medical Center (MGMC), Andrews Air Force Base, Maryland
US Army	DeWitt Army Community Hospital (DACH), Fort Belvoir, Virginia.

Upon completion of the 2005 BRAC implementation, the NNMC and the WRAMC will merge to form the Walter Reed National Military Medical Center (WRNMMC) on the existing grounds of the NNMC in Bethesda, Maryland. As a result, WRAMC will cease operations by 15 September 2011. DACH will also close, and a new, expanded facility, the Fort Belvoir Community Hospital (FBCH), at the same site will significantly increase the medical capabilities available to beneficiaries in the southern portion of the NCR. MGMC at Andrews Air Force Base, Maryland, will transition to an outpatient-only facility.

History of JTF CAPMED

The 2006 Quadrennial Defense Review articulates strategies for improving the management, performance, and efficiency of the military health system (MHS). These strategies include elimination of redundant command structures, alignment of resource streams, and provision of clear lines of authority and responsibility for local decision making. In this vein, the Deputy Secretary of Defense (DEPSECDEF) established JTF CAPMED on 14 September 1997. JTF CAPMED is a standing, fully functional, joint task force reporting directly to the Secretary of Defense through the DEPSECDEF. It was assigned specific forces representing the Army, Navy, and Air Force, and its Joint Operations Area (JOA) covers the assigned forces attendant TRICARE catchment areas. Under the command of an O-9 medical department officer, JTF CAPMED was charged with three primary responsibilities: ensuring effective and efficient delivery of world-class military healthcare within the JOA using all available military healthcare resources from its assigned forces; overseeing the consolidation and realignment of military healthcare within the JOA in accordance with BRAC recommendations; and conducting other missions to improve the management, performance, and efficiency of the MHS. Initial Operational Capability (IOC) was reached on 1 October 2007, and Full Operational Capability (FOC) was achieved on 30 September 2008.

JTF CAPMED Commander's Guidance

- **Purpose:** Provide guidance for and direction to forces assigned to JTF CAPMED to achieve unity of effort in the accomplishment of its assigned mission
- **Mission:** Deliver integrated healthcare in the NCR, ensure readiness, and execute the BRAC business plans to achieve the vision

- o Healthcare delivery in the NCR: Regional healthcare delivery, readiness and disaster preparedness
        - o BRAC: Construction projects/relocations, create a world-class medical center
- **Vision:** A world-class medical center at the hub of the nation's premier regional healthcare system serving our military and our nation
- **Intent:** The Commander JTF CAPMED serves as the senior medical officer in the JOA with responsibility for the effective and efficient delivery of world-class military healthcare in the NCR. This guidance will help assigned forces carry out the mission of the JTF by:
        - o Stating the vision and mission of the JTF
        - o Establishing guiding principles and priorities to achieve mission success

JTF CAPMED Commander's Priorities

- **Casualty Care:** As America's primary reception site for returning casualties, our number 1 priority is casualty care. We will answer our nation's call to care for its casualties without fail.
- **Caring for the Caregivers:** Our people are called to provide healthcare for all we serve, often under trying circumstances, and we have a covenant leadership responsibility to care for them.
- **Be Ready Now:** The lessons of near constant engagement for more than 8 years reaffirm the importance of constant preparedness at home and abroad. Without planning and training, we will not be able to answer the call.
- **Regional Healthcare Delivery:** Integrated planning for the efficient and effective delivery of services on a regional basis is the key to quality and to mission success. We cannot afford to optimize operations at any single facility at the expense of sub-optimizing operations in the entire region.
- **Common Standards and Processes:** Achieving common business and clinical processes will be necessary to maximize regional potential. Differences that could impact patient safety and outcomes as our people work in different facilities across the region on a day–to-day basis cannot be tolerated.

JTF CAPMED Commander's Guiding Principles

Mission Focus: We are at war and must focus on our responsibilities to provide healthcare services while we prepare and train for deployments and contingencies

Serving Our People: Our success depends on the contributions of our active, reserve, civilian, and contract personnel and their families. Personal and family readiness is key to mission success. Developing and fostering, individual, family, and community resilience is necessary for readiness

Leadership: Leadership is key to service. Everyone is responsible for developing their own leadership potential to be ready to lead when necessary. All leaders are accountable for ensuring someone is being prepared to replace them if the need arises. We must take advantage of the leadership advantage of our young leaders, many of whom have extensive combat experience.

Accountability: We take full accountability for our decisions and actions. We have high standards and will meet our responsibilities with integrity and honor. We will be good stewards of the resources we receive to accomplish our mission

Interoperability: The future of the military health system lies in interoperability and cooperation among the Services. Each Service brings unique and critical capabilities but they can only be as effective as the contribution they make to the overall mission. We require:

- Alignment*: The degree to which resources and processes support the mission, vision, and priorities. If efforts do not support the mission vision and priorities, then they are not aligned. Authority necessary to carry out the mission must be aligned with accountability for mission success.
- Commitment to Change**: Mission success demands that we continue to adapt the way we think and operate. It requires leaders to set the right expectations, minimizing the uncertainty caused by change through constant dialogue and free flow of information
- Teamwork**: Giving our best for something larger than ourselves is a core value of service and it means putting aside personal ambition, ego, and pride.

Strategic Communications

JTF CAPMED's strategic communication element oversees strategic communication (STRATCOMM) objectives in support of the JTF's primary BRAC and integrated healthcare delivery mission. STRATCOMM facilitates the accurate, timely, and transparent communication of the JTF's goals, actions, and tasks associated with the medical transition in the NCR.

Strategic communication efforts are directed at multiple audiences with the intent to better inform them on the changes and opportunities created from the transition. These audiences may include the following:

- DoD military personnel and their eligible family members
- Military retirees and their eligible family members
- DoD health professions personnel assigned to WRAMC, NNMC, DACH, the Andrews AFB 79th Medical Wing (79 MDW), and other units throughout the NCR
- Senior military and government leaders who visit MTFs in the NCR
- Military and veterans support organizations
- Health professional organizations
- Health educators
- Private nonprofit organizations that support wounded warrior care programs
- Washington DC, Northern Virginia, and Maryland hospital associations
- Members of the U.S. Congress and their staff.

The JTF STRATCOMM element is closely aligned with the Public Affairs and STRATCOMM personnel of the NCR's four affected military inpatient hospitals in order to:

- Develop a strategic communication strategy
- Author strategic communication plans focused on specific events related to JTF milestones
- Monitor and track media activities related to BRAC and medical transition activities
- Shape public perception and acceptance of the medical transition process.

Key elements of the STRATCOMM plan include marketing, legislative liaison, and public affairs. Each of these elements will provide the basis for the development of plans to reach specified audiences and key stakeholders, thus creating awareness of the medical transition process. Through these efforts, the JTF expects to maintain the support of its key audiences while reducing transition obstacles.

Using multiple forms of communications, STRATCOMM clearly informs target audiences on the intent and progress of the BRAC transition. As BRAC law dictates the standup of the new WRNMMC and FMCH, STRATCOMM will provide current updates on all efforts necessary to complete the BRAC-directed transition.

JTF CAPMED Media Strategy

- Development of a Joint Strategic Communication Plan
- Websites for Joint Task Force and Sub-Elements
- Social media marketing and public engagement
- Joint-themed newsletter/online newspaper
- DOD-HA-moderated media
- Development of a joint closing and reopening events list and engagement plan
- Individual employee and beneficiary testimonials to demonstrate the positive impact on individuals

JTF Enduring Messages

- *Provision of "World-class", high quality, comprehensive healthcare*
- *Enhancement of the quality of care and access to care for all eligible beneficiaries in the region*
- *The continuance of fully accredited, integrated Graduate Medical Education and clinical research programs*
- *A well organized, well planned transition process and a smooth occupation of the new facilities with no interruption in, or degradation of, patient care*
- *A transparent transition process with patients, staff and stakeholders notified as each milestone is approached and reached*

Without a complete and well-executed approach to STRATCOMM, the JTF will risk losing the support necessary for a seamless transition and alienating our key audiences, including military medical personnel, Component services, and political leadership. STRACOMM is an essential element in the medical transition process, serving as the communication hub for all JTF BRAC-related activities. Its team consists of skilled, dedicated professionals highly qualified in executing their missions.

At an operational level, the individual MTFs in the JOA are conducting robust STRATCOMM plans using monthly town hall meetings open to patients, staff, and community members and informative news articles in local base papers. These forums have addressed issues ranging from the physical designs of the new facilities to cultural integration. The NNMC command has also built a dynamic display in the BRAC Journey room highlighting past integration milestones and delineating future milestones.

JTF CAPMED Master Transition Plan Development Process

The DOD, through the Joint Task Force National Capital Region Medical (JTF CAPMED), is carrying out the BRAC Commission's recommendations of closing WRAMC, renovating and building the replacement facilities, and transferring operations from WRAMC to the replacement facilities.

The execution of BRAC recommendations requires JTF CAPMED to focus the transition process at three different levels of *Tactical*, *Operational*, and *Strategic* and to align execution functions along enabling dimensions of *People*, *Process*, *Technology* and *Physical Infrastructure*.

Methodologically, this organizational matrix ensures a proactive, analytical process orchestrating the myriad of activities necessary to establish WRNMMC and FBCH, transition medical capabilities from WRAMC, and do so while maintaining a consistent level of care and access throughout the JOA as was available to patients prior to the start of the BRAC process.

Levels of Focus – Tactical, Operational, and Strategic

The *Tactical Focus* concentrates on the transition effort at each of the specific BRAC sites, i.e., WRAMC, Bethesda, and Fort Belvoir. Within this focus, construction timelines are merged with manpower, equipment, and space requirements to reveal individual work tasks, or lines of operations, that must be accomplished according to the BRAC timeline to ensure the orderly and precise movement of medical capability from one facility to its transitional counterpart. This tactical approach informs JTF CAPMED of what needs to be done at each site to carry out the BRAC recommendations.

The *Operational Focus* consolidates these tactical lines of operation for each site to identify interdependencies among all BRAC sites throughout the JOA. This focus provides JTF CAPMED with a common site picture of all projects and assists in the identification of problematic areas and critical pathways.

The *Strategic Focus* directs the development of the BRAC NCR Master Transition Plan (MTP). The MTP, as the capstone planning document, describes how JTF will effect a successful BRAC-directed transition.

The MTP covers all aspects of the transition from WRAMC to WRNMMC and FBCH. It lays out the sequence and timing of all service moves (clinical and other) from WRAMC to WRNMMC and FBCH. It details all of the individual actions required to ensure success at each step of the transition. The plan is dynamic in nature and will continue to evolve during the duration of the BRAC execution timeline; it will be updated, at a minimum, quarterly to document the evolution.

 The MTP, because it is derived from the Integrated Master Schedule (IMS), allows JTF CAPMED integration and transition personnel to monitor and proactively analyze the execution and maintenance of critical medical capability during the process. Critical nodes and pathways can be studied well in advance of their occurrence so that mitigation strategies can be designed to avoid possible "service delivery troughs" caused by transitional movements of administrative and clinical capability packages from one facility to another.

JTF CAPMED Planning Process
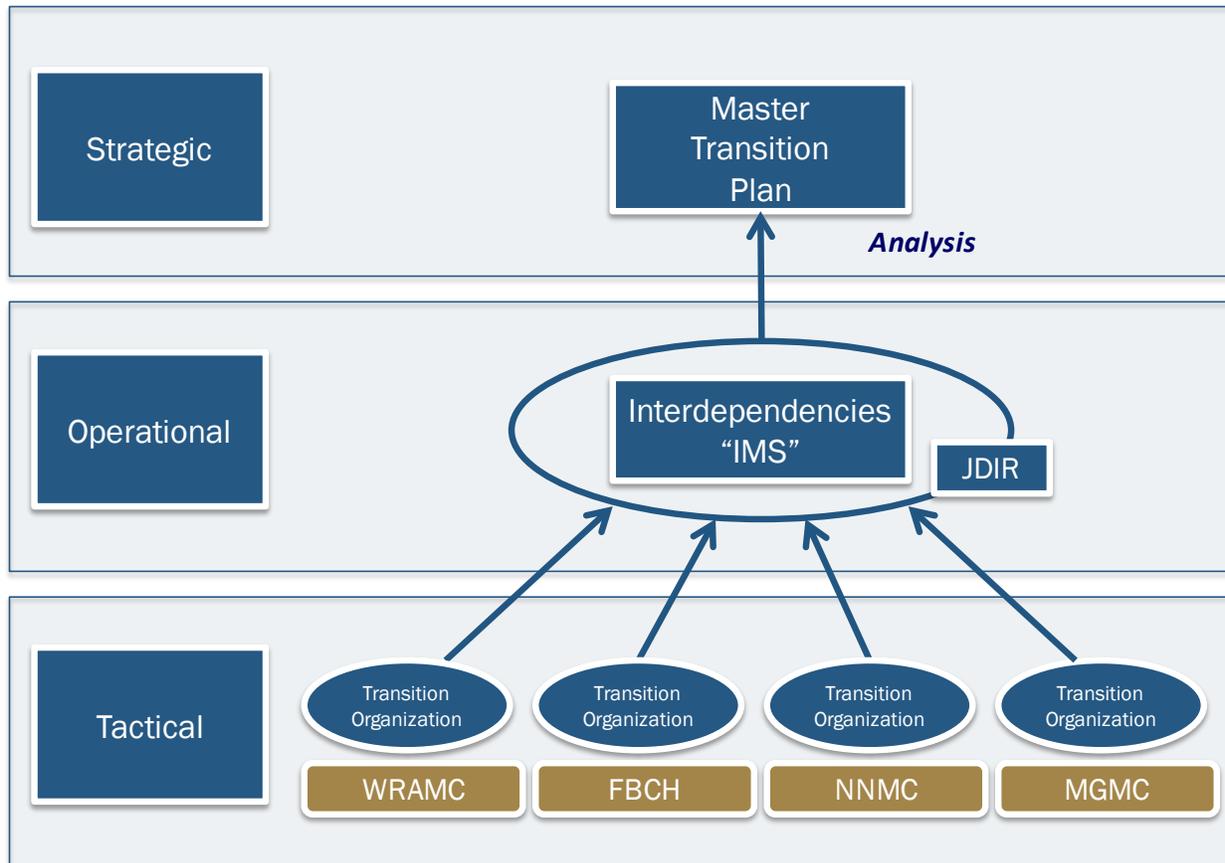
FIGURE 1 - JTF CAPMED PLANNING PROCESS

People, Process, Technology and Physical Infrastructure Dimensions

The development of the MTP will employ the adaptive planning process, which is a cyclic process of planning, executing, reevaluating, and carrying out follow-on planning. The first version of the MTP is from a global perspective and focuses on the JTF CAPMED functional divisions "setting the conditions" for the detailed planning of transition and relocation. Follow-on MTP updates will be published quarterly and will include detailed plans for all aspect of the transition of patients, staff, and functions across the JOA. Planning will focus on the enabling change dimensions that are interdependent:

- **People** – The organizational structure and human capital management to support world-class medical care for our patients
- **Processes** – The business activities in the JOA that result in integrated patient care (e.g., rules, standard procedures, data analysis, metrics information)
- **Technology** – The data, applications, and technical infrastructure that supports the delivery of world-class medical care
- **Physical Infrastructure** – The places and environments where the enterprise workforce (e.g., military, civilians, contractors, mission partners) perform

Figure 2 - The TLC Framework depicts Booz Allen Hamilton's Transformation Life Cycle (TLC), which provides a holistic, integrated approach for developing new or improved capabilities; it simultaneously addresses the four dimensions of change.
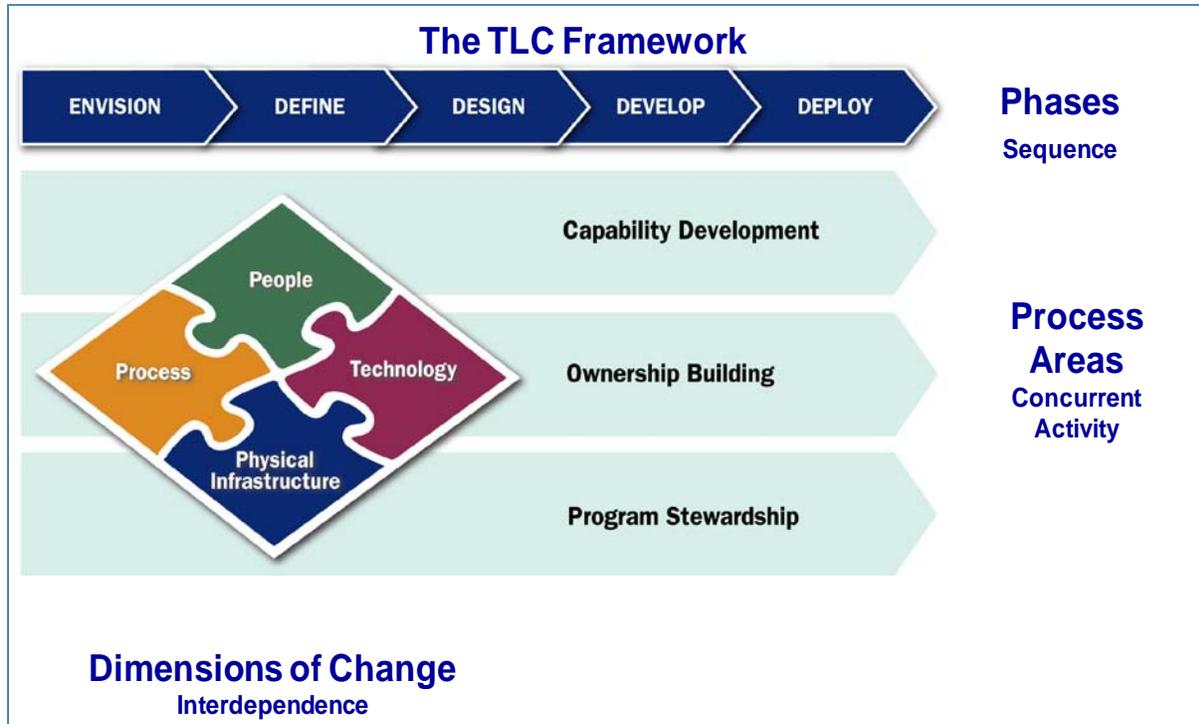
FIGURE 2 - THE TLC FRAMEWORK

JTF CAPMED Critical Milestones

As the capstone document describing how JTF CAPMED will affect a successful BRAC directed transition, the MTP will describe critical milestones that must be executed along a specific timeline concluding in September 2011. To develop the MTP and accompanying Campaign Plans to transition from four Service-specific MTFs to two joint, integrated MTFs, schedules will be used. Data used to develop individual schedules and the IMS is depicted in Figure 3 - Schedule Framework.
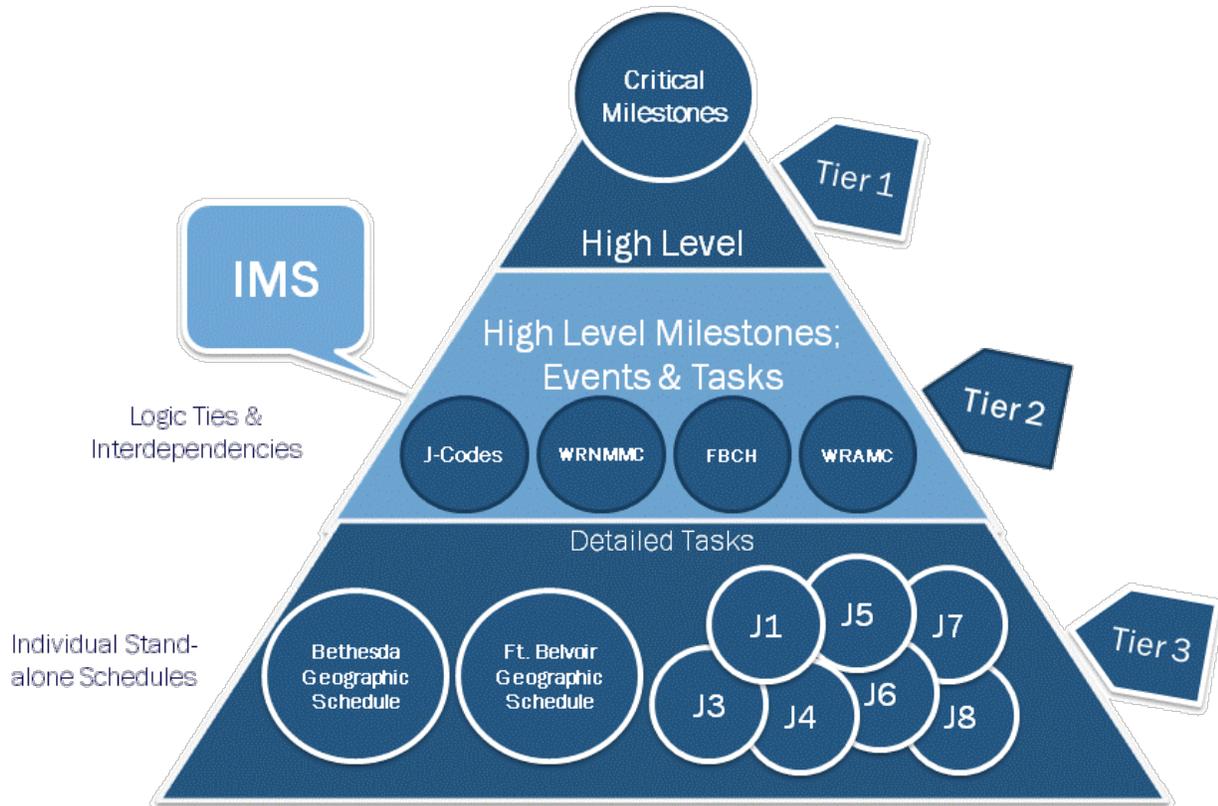
FIGURE 3 - SCHEDULE FRAMEWORK

The JTF CAPMED Critical Milestones were identified using the following documents:

- The Commander's Guidance Memorandum dated 17 October 2007
- Commander's Information Memorandum to the DEPSECDEF dated 21 January 2009, which directs the 2009 major objectives for the JTF
- The JTF Transition Wargame Report and Decision Brief dated 5 February 2009
- CJTF Action Memorandum for the Transformation of four Service-specific hospitals to two joint commands dated 16 April 2009
- The Integrated Master Schedule (IMS) – the Microsoft Project indentifying inter-dependencies within and across each JTF J-code.

According to industry standards, critical milestones are defined as the end of a stage that marks the completion of a work package or phase, typically marked by a high-level event such as completion, endorsement, or signing of a deliverable, document or a high-level review meeting. In addition to signaling the completion of a key deliverable, a milestone may also signify an important decision or the derivation of a critical piece of information, which outlines or affects the future of a project. In this sense, a milestone not only signifies distance traveled (key stages in a project), but also indicates the direction of travel as key decisions made at milestones may alter the route through the _project plan_. In most cases, a milestone is used as a project checkpoint to validate how the project is progressing and to revalidate work. Milestones are used as high-level snapshots for leadership/management to validate the progress of the project; in many cases, there is a decision to be made at a milestone.

A JTF CAPMED Critical Milestone Chart (See Figure 4) was created to represent Tier 1 milestone level data along a timeline.

Critical Milestones are:

- a measure of progress
- visible to senior managers
- help communication outside of the project team
- focus project attention on results
- provide manageable stages of work
- enable responsibilities to be assigned at a high level.

The critical milestones chart also delineates those interdependencies, or connections, between two related milestones, tasks, or activities.

Critical Milestone Chart Legend

The Critical Milestone Chart graphically depicts the key events that need to occur for a successful transition of the three Services to one joint command at both WRNMMC and FBCH, while closing WRAMC. These milestones were selected based upon analysis of the detailed schedules developed within JTF CAPMED, numerous interviews with J-Code Directors and Staff, as well as a collaborative working Summit held in May 2009. Each milestone indicates a specific point in time for this key event. Tasks and sub-tasks within more detailed tiers of the Integrated Master Schedule (not pictured here) exist to further define these actions.

Each milestone is shown as a colored diamond within a grouping/ category and timeframe, and is further annotated to represent which JTF CAPMED J-Code has the lead for this milestone. This is denoted by a color coding mechanism as seen below:

◇ CoS Lead	◇ J6 Lead
◆ J1 Lead	◆ J7 Lead
◇ J3 Lead	◇ J8 Lead
◆ J4 Lead	◇ CHR Lead
◆ J5 Lead	
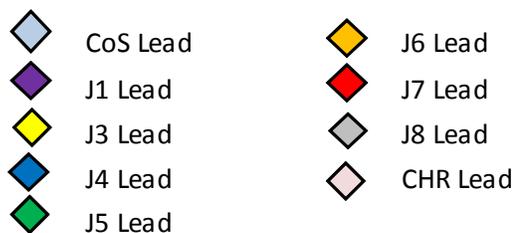
The milestone grouping /category, is represented within lanes horizontally across the page. These are further defined below. The milestones are also depicted within the timeframe they are expected to occur. This is illustrated by alignment with the Calendar Year, Fiscal Year & quarter and month, as shown in the timeline along the top and bottom of the chart.

The grouping/category of milestones is based upon their functional thrust and includes:

- Anchors – End state events which cannot move in time.

- People – Milestones which impact the organizational structure and human capital management

- Process – Milestones which impact the business activities performed by the enterprise.

- Infrastructure – Milestones which impact the places and environments where the enterprise workforce performs work.

- Technology – Milestones which impact the data, applications, and technical infrastructure.

It is important to note that although the milestone is being led by a specific J-Code, the tasks associated with these milestones are the responsibility of many J-Codes. These inter-dependencies are represented graphically with asterisks as follows:

✿	J1 Inter-Dependency	✿	J6 Inter-Dependency
✿	J3 Inter-Dependency	✿	J7 Inter-Dependency
✿	J4 Inter-Dependency	✿	J8 Inter-Dependency
✿	J5 Inter-Dependency	◈	Inter-Dependency with all J-Codes

The following symbol represents when a building at FBCH or WRNMMC will be ready for equipment installation.

Anchors are lines shown vertically up and down the height of the chart, and are labeled according to the event they represent.
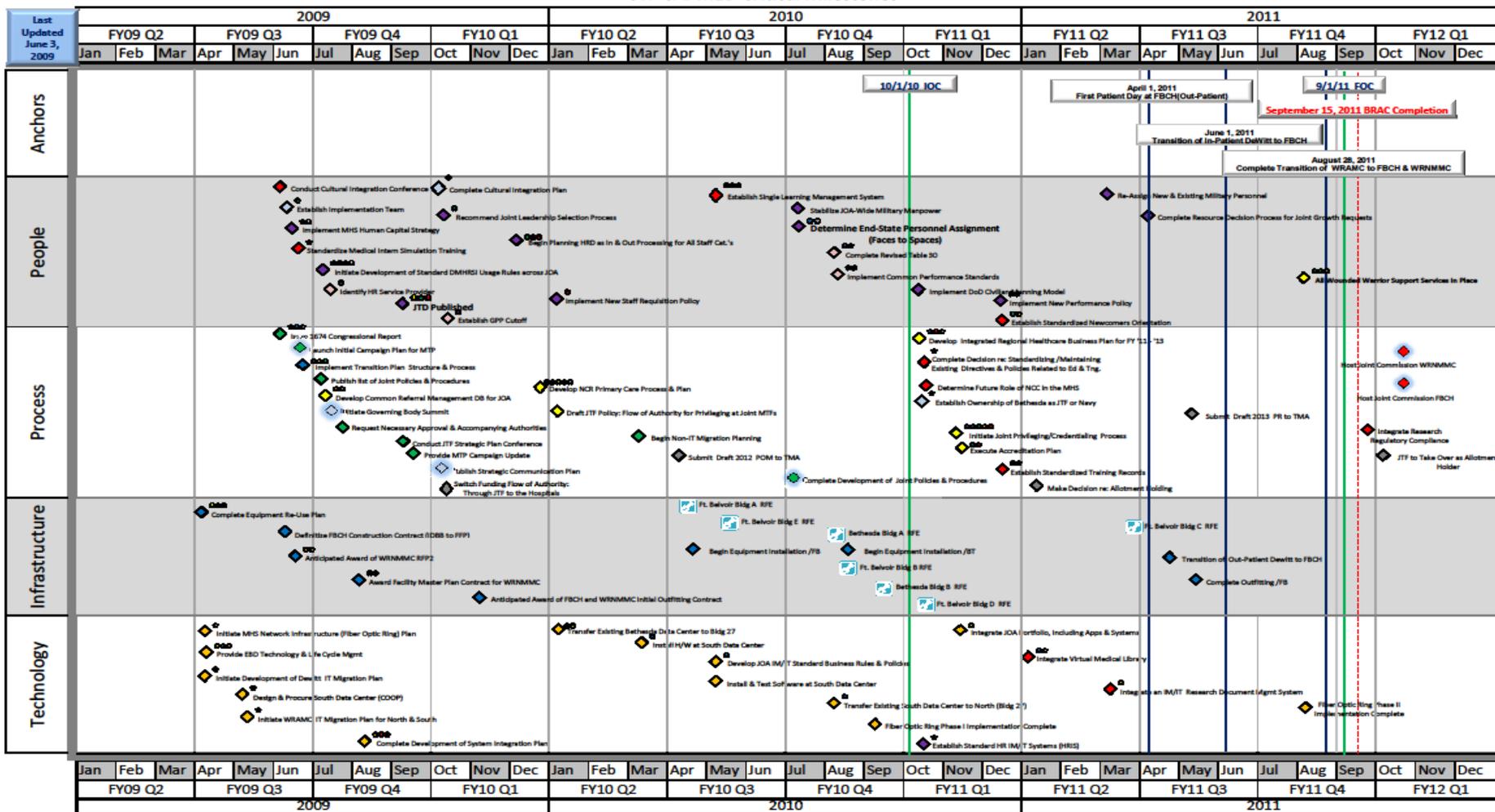
FIGURE 4 - JTF CAPMED CRITICAL MILESTONES

Master Transition Plan Facts

The following facts guide this transition plan:

- By law, WRAMC will cease patient care operations by 15 September 2011.
- The March 2008 Final Environmental Impact Statement for Activities to Implement 2005 Base Realignment and Closure Actions at National Naval Medical Center Bethesda, Maryland states that after the transition to the WRNMMC, the Bethesda Naval Base will have no more than 2,500 additional staff each weekday.
- On 15 January 2009, the DEPSECDEF approved action memorandum "Civilian and Military Personnel Management Structures for the Joint Task Force National Capital Region – Medical," which recommended the following:
    - Development of a DoD civilian model for NCR medical facilities that realigns civilian personnel authorizations and delegates civilian personnel authorities to the Commander of CJTF CAPMED
    - Incorporation of the policy of "guaranteed" placement of current civilian employees in the future CAPMED organization; guaranteed placement means best efforts within applicable regulations to achieve placement in new positions within the NCR
    - The establishment of Joint Commands at WRNNMC and FBCH, which will continue JTF CAPMED as a joint military command establishing subordinate joint commands and establishing all billets at both commands as joint.
- Continuity of care will be 100 percent assured throughout the transition with minimum interruption in healthcare service delivery. While consideration may be given to sending patients to the network on an as-needed basis, this practice will be the exception, not the rule. The goal is to maintain the care of all WRAMC primary beneficiaries with the NRC to the greatest extent possible.
- Based on recommendations from the JTF Transition War Game in February 2009, the Commander, JTF CAPMED approved that the WRAMC to WRNMMC transition will occur during a consolidated time frame prior to September 2011.

Master Transition Plan Assumptions

The development of the MTP occurs within a set of planning assumptions for the JOA during this regional transformation:

- Construction will be completed on time for WRNMMC, the Joint War Transition Unit, and FBCH to facilitate the transition of patients (including wounded warriors) and staff from WRAMC to WRNMMC/FBCH by 15 September 2011.
- All certification, equipment testing, equipment training, and support system setup will be completed before the first day of patient care within the new MTFs.
- All activities related to the installation, setup, and operation of both fixed and movable equipment will occur in advance of any major patient moves from WRAMC.
- Accreditation will be maintained or achieved. The JTF will work with accrediting bodies, including The Joint Commission and the Accreditation Council for Graduate Medical Education (ACGME), to ensure that the WRAMC transition does not impede or negatively impact accreditation at either the WRNMMC or FBCH.

- All staff training, including conducting "day-in-the-life" exercises (as necessary), will have been completed before the first patient care day.
- Day-in-the-life and other staff training will be conducted months prior to the first patient day, ensuring that staff has full knowledge and understanding of the "new" facility's layout, equipment, processes, etc.
- A STRATCOMM plan will be executed. A comprehensive strategic communication plan will be developed and executed, with appropriate messaging for all stakeholders affected by the WRAMC move, including WRAMC patients, their families, personnel, and the community.
- NNMC will continue to execute the internal moves based on space availability/readiness and will complete all internal moves prior to deadline to move WRAMC.
- All WRAMC primary beneficiaries will be accommodated in their final healthcare "home" by the BRAC deadline.
- JTF CAPMED will allocate funds to Walter Reed National Military Medical Center and Fort Belvoir Community Hospital.
- JTF CAPMED will oversee programming, budgeting, and execution.
- JTF CAPMED will use all available resources from its assigned forces.

Stakeholders

Key stakeholders for the successful transition of the NCR's medical facilities include the following:

- Our beneficiaries– 600,000 active duty, reserve, retirees, and their eligible family members
- Our staff – more than 13,000 active duty, reserve, and civilian personnel
- Our communities – Montgomery County, Northwest Washington, DC, Alexandria, Virginia, and any other areas where our beneficiaries reside
- U.S. Congress
- DoD and the individual Services: U.S. Army, U.S. Air Force, U.S. Marine Corps, and U.S. Navy
- Combatant Commanders
- JTF NCR
- TRICARE Management Activity
- Interagency partners, who include but are not limited to, the following:
  - Department of State
  - Federal Emergency Management Agency
  - National Institutes of Health
  - Department of Homeland Security
  - Department of Health and Human Services
  - Department of Veterans Affairs
- Uniformed Services University of the Health Sciences (USU)
- Federal entities such as the National Institutes of Health, National Cancer Institute, National Intrepid Center of Excellence for Traumatic Brain Injury, and Psychological Health
- Military and veterans support organizations
- Private nonprofit organizations that help wounded warriors
- DC, Northern Virginia, and Maryland hospital associations.

Campaign Plan

To synchronize and carry out the MTP and critical milestones, JTF CAPMED developed an overarching strategy of campaigns. The strategic framework for this transition strategy includes three separate campaigns[2].

- Campaign I begins at the present day to October 2012, and its goal is to "Operationalize JTF CAPMED Forces" by realigning and transforming the JOA to implement BRAC requirements.
- Campaign II spans the period of October 2012 to October 2017 with a goal to "Demonstrate JTF CAPMED Capabilities."
- Campaign III is JTF CAPMED's vision to 2023 with a goal to "Lead Strategic Change."

Why a Campaign Plan? According to Joint Publication 1.0, a campaign plan is "a joint operation plan for a series of related major operations aimed at achieving strategic or operational objectives within a given time and space." The transition that the NCR is undertaking in the next two years is the largest transformation of military medical assets in United States history. To perform this transformation, the DoD must carefully orchestrate and execute a multitude of tasks, including the relocation and integration of medical staff and capabilities.

Campaign Plan I is the strategy for successful implementation of the BRAC requirements, mandated by the U.S. Congress to transform the NCR. See the Campaign section of the MTP for the detailed campaign plan covering the present to 1 October 2012.

Quarterly action plans will detail specific objectives and tasks to guide the JTF and its subordinate commands (WRAMC, NNMC, FBCH, and the 79th Medical Wing) through the process of transitioning from four Service-specific military treatment facilities to two joint facilities.

Measures of Performance

Each objective in the campaign identifies a measure of performance (MOP), which is a criterion used to assess actions tied to measuring task accomplishment, e.g., decision made, a policy promulgated, etc. These measures serve as a qualitative basis to track mission accomplishment. The measures of performance must be relevant and measureable to ensure that targeted objectives are accomplished successfully.

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[2] This document will only address Campaign I

Measures of Effectiveness

From the inception of the JTF, it has been a top priority that no discernible degradation of patient care will occur during the transition period. To this end, it will be imperative that disciplined tracking of metrics surrounding patient and staff satisfaction, clinical quality, and operational efficiency occur throughout the transition and integration process. The goal is to provide both JTF and MTF leaders with a tangible set of metrics on the effectiveness of the transition and allow for targeted process redesign should a performance "dip" emerge. The foundation of these metrics is the following Defense Health Program (DHP) performance metrics:

- Beneficiary satisfaction with health plan
- Inpatient production target
- Outpatient production target
- Primary care productivity
- Medical cost per member per year.

Additional measures of effectiveness for those critical pathways contained within the campaign are being defined using industry standards and the Services' best business practices. For example, to improve quality, access to care, and patient satisfaction, adopting the WRAMC Data Warehouse and Business Intelligence program, instituting JOA-wide the implementation of the Air Force Referral Management System Tracking Reports (RMSTR) as a model for access to care, and implementing the Disability Evaluation System pilot program to track additional patient satisfaction are all courses of actions currently being studied. Subsequent versions of the MTP will further delineate these measures of effectiveness.

Change Dimensions

Transition is defined in Webster's as the "passage or change from one state to another." JTF CAPMED is actively engaged in all of the activities required to effectively transition from four Service-specific military Medical Treatment Facilities to two joint facilities by 15 September 2011. To accomplish this end state, JTF CAPMED is focused on four dimensions of change that are key enablers to facilitate mission accomplishment—*PEOPLE, PEOPLE, PROCESS, TECHNOLOGY AND PHYSICAL INFRASTRUCTURE*. As key enablers, below is an explanation of how these dimensions of change work together to ensure JTF CAPMED's priorities are achieved by capability development, ownership building and program stewardship.

PEOPLE will perhaps undergo the most profound change of all of these dimensions over the course of the next two years. Wounded and ill warriors, DoD service members, retirees and their families; JOA human capital to include military, civilian and contractor staff members; stakeholders across the JOA to include internal and external entities and stakeholders outside of the JOA who are potentially affected by the transformation; as well as leaders of the new joint commands are all representative of the people involved in this transformation. Whether the change signals positive enhancement to healthcare delivery and research capabilities or it creates stress, it is change nonetheless and requires diligent consideration and planning. To mitigate the impact of this transition on our *people*, JTF CAPMED is developing a Strategic Communication Plan that is scheduled for publication in September 2009.

The *PROCESS* dimension of change includes all of the activities that occur within the JOA to ensure that the needs of our *people* are being met by the creation of efficient JTF CAPMED operations. Within the *process* dimension, standardized processes and use of various tools such as the IMS and MTP for such activities as relocating patients, staffs, and services; managing transition; determining concepts of clinical and administrative operations; preparing for and conducting inspections; integrating staffs and services; assimilating cultures; and conducting the myriad other activities can be orchestrated effectively to reach FOC by 15 September 2011.

TECHNOLOGY represents a change dimension that sustains the *process* dimension and is intricately linked and is essential to the support of the *people* dimension. Data, applications and technical infrastructure is addressed in this dimension and it is here that the NCR as well as MHS performance will be influenced. Along with equipment and software applications, the technical expertise necessary to manage the data, information, and communication reside in this dimension.

PHYSICAL INFRASTRUCTURE as a change dimension is especially critical during this transformation as it is highly complex and intersects with all the other change dimensions. As the oversight authority, JTF CAPMED demands program stewardship in areas of governance and program management that drives, integrates and coordinates the BRAC transition and the transformation to an integrated regional healthcare delivery system.

People

PEOPLE will perhaps undergo the most profound change of all of these dimensions over the course of the next two years. Wounded and ill warriors, DoD service members, retirees and their families; JOA human capital to include military, civilian and contractor staff members; stakeholders across the JOA to include internal and external entities and stakeholders outside of the JOA who are potentially affected by the transformation; as well as and leaders of the new joint commands are all representative of the people involved in this transformation.

Wounded Warrior Care

Since 2001, more than 15,000 casualties from Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom in Iraq have flowed through the Nation's primary casualty reception site—the NCR. These wounded warriors are moved from Andrews Air Force Base to either WRAMC or NNMC to receive triage, surgical, tertiary and appropriate rehabilitation care. When possible, wounded warriors are transferred to military MTFs closer to their homes. However, many stay within the NCR for a year or longer. JTF CAPMED's approach to wounded warrior services is to provide care for these seriously wounded and ill warriors in condition-appropriate settings, while ensuring coordination, communication, and integration at all levels.

Developing transition plans to support the relocation of wounded warriors from WRAMC to WRNMMC and FBCH is one overarching priority of JTF CAPMED. On 26 September 2007, the NCR Overarching Integrated Product Team (OIPT), on behalf of the DEPSECDEF, approved a plan to move a projected 350 wounded warriors, 176 staff members, and 150 families (e.g., non-medical attendants) from WRAMC to WRNMMC. Current CONOPs include housing wounded warriors requiring tertiary care at WRNMMC. Those patients requiring non-tertiary levels of care will be housed at other MTFs, as regulated by their respective Services. FBCH construction plans include a warrior transition unit to accommodate 400 wounded warriors and a 288 bed Warrior in Transition (WT) Complex to house and care for some of those warriors not requiring tertiary care. After construction is completed, the lodging capacity, including Fisher Houses, barracks, and the Navy Lodge, will support a total of 1,370 wounded warriors and family members in WRNMMC Warrior Transition Plans.

The plans for Warriors in Transition on the WRNMMC campus include the following requirements:

- Lodging for 350 patients (includes all Services' severely wounded)
- Primary care space – 5,000 square feet (SF)
- Warrior in Transition services support staff (176 personnel)
- Support services for family members (150)
- Administrative space – 41,000 SF
- Messing (dining areas) – 21,000 SF
- Gym – 64,000 SF.

JTF CAPMED Warriors in Transition Plans

The JTF CAPMED HQ Director of Warriors in Transition has chartered three working groups to develop transition plans for the WRNMMC site. The following working groups consist of Service representatives, subject matter experts (SMEs) on Wounded Warrior issues, and patients:

- Warrior Transition Center Working Group – Integrates service for wounded, ill, and injured warriors throughout the JOA who are healing as they transition back to military duty or civilian life.
- Warrior Family Assistance Center Work Group – Identifies the full spectrum of common-level services needed to support wounded warriors and their family members, recommending changes and enhancement for the transition of wounded, ill, and injured warriors and their families to WRNMMC.
- Child Activity Room Working Group – Identifies total requirements for providing child care to wounded warriors and their family members, focusing on MTF child care during all

hospital shift work, hourly child care, and child care for Warriors in the Child Activity Room of the Warrior Family Assistance Center (WFAC).

Warriors in Transition Working Group's Current Activities:

- Identifying requirements for personnel, administrative space, warrior and non-medical lodging, warrior clinics, and common levels of service
- Working to facilitate the transition activities for Warriors in Transition throughout the JOA, including Warriors in Transition, WFAC, and child care
- Establishing a pre-decisional staffing model for the Warrior Transition Unit (WTU) that received approval from the Deputy Commander, JTF CAPMED (DCJTF)
- Developing a patient tracking model to support real time tracking and location of warriors in the NCR. It will be instrumental in managing patient surge in the NCR and ensuring that the most seriously injured warriors receive care at the right place at the right time.

Current Challenges for Wounded Warrior Care:

- Identifying installation resources available to meet WT requirements determined in the National Defense Authorization Act (NDAA) 2008, 1650
- Executing transition of current monthly WRAMC population of approximately 743 warriors to WRNMMC, FBCH, and Fort Meade by 2011
- Average length of stay is around 210 days in a WTU
- Dealing with issues caused by the removal of Congressional funding for the WRNMMC Fitness Center. This resulted in a delay of the initial timeframe for approval of RFP #2 and a possible delay in the building of the Fitness Center.

Plans are being developed to determine the common operating picture for wounded warrior services required on the WRNMMC campus and will be included in the future versions of the MTP.

Joint Commands and Leadership

The first step in transforming the NCR from four Service-specific operated hospitals to two joint commands is establishing joint leadership over the command elements of WRNMMC and FBCH. On 5 May 2009, Commander, JTF CAPMED (CJTF CAPMED) signed Decision Memorandum #0001 directing the establishment of Initial Operating Capability (IOC) of WRNMMC and FBCH command elements no later than 1 October 2010. The objective of the two joint commands is to enhance unity of command and effort, focus the JTF and its actions to catalyze transformation from the current four bedded facilities into two joint commands, standardize processes to achieve joint interoperable systems, and achieve integrated healthcare delivery in the JOA.

To ensure that appropriate, timely, and joint-focused decisions are made for the new WRNMMC and FBCH, the JTF established a Joint Commands Implementation Team (JCIT) consisting of members from the JTF and the four affected MTFs. The goal of the JCIT is to create a bridging strategy to accelerate the transition process for establishing the two joint medical facilities. The JCIT will develop a plan not later than 1 August 2009 that will set the conditions for IOC. An Operation Order (OPORD) directing staff and unit tasks required to implement and execute the transformation plan will be published not later than 31 October 2009. The OPORD will describe when to execute the commander's plan, define the internal actions necessary to set conditions, and establish "no later than" dates for JTF CAPMED staff and

Service component action. The plan will also require JTF CAPMED staff and units to periodically update the DCJTF on transformational activities.

These incremental actions are required to incrementally align the JTF CAPMED functions, facilities, and people to the future JTF CAPMED end state in fiscal year (FY) 2012. Establishing command leadership elements is the pivotal step in aligning responsibility for the future healthcare delivery process for the JTF CAPMED JOA to the accountable commands, WRNMMC and FBCH. The transfer of appropriate authority (Operational Control), once granted to JTF CAPMED, will complete the necessary requirements to fully control the future action and direction of the integrated healthcare delivery network in the JOA.

The command structure for the future WRNMMC is an innovative blend of traditional Army, Navy, and Air Force medical organization structures and will result in a joint command element. FBCH's command structure is similar in function and like WRNMMC is also joint. Figure 5 - WRNMMC Command Structure organizational chart represents the WRNMMC's future organization chart.

Efforts to integrate staff at NNMC and WRAMC began with the assignment of two full-time Deputy Commanders for Integration (DCIs). The mission of the DCIs is to facilitate the integration of NNMC and WRAMC into a singular "world-class" healthcare facility by maximizing sustainable, and projectable complex patient care. To continue the integration of staff at WRAMC and NNMC, a process was developed to establish Chiefs of Integrated Departments (CIDs) and Chiefs of Integrated Services (CISs). These Integrated Chiefs oversee clinical care and clinical staff simultaneously at both MTFs, ensuring a logical chain of command and reasonable span of control within the combined departments. As of June 2009, all 15 CIDs and 53 CISs were selected.

WRNMMC Command Structure
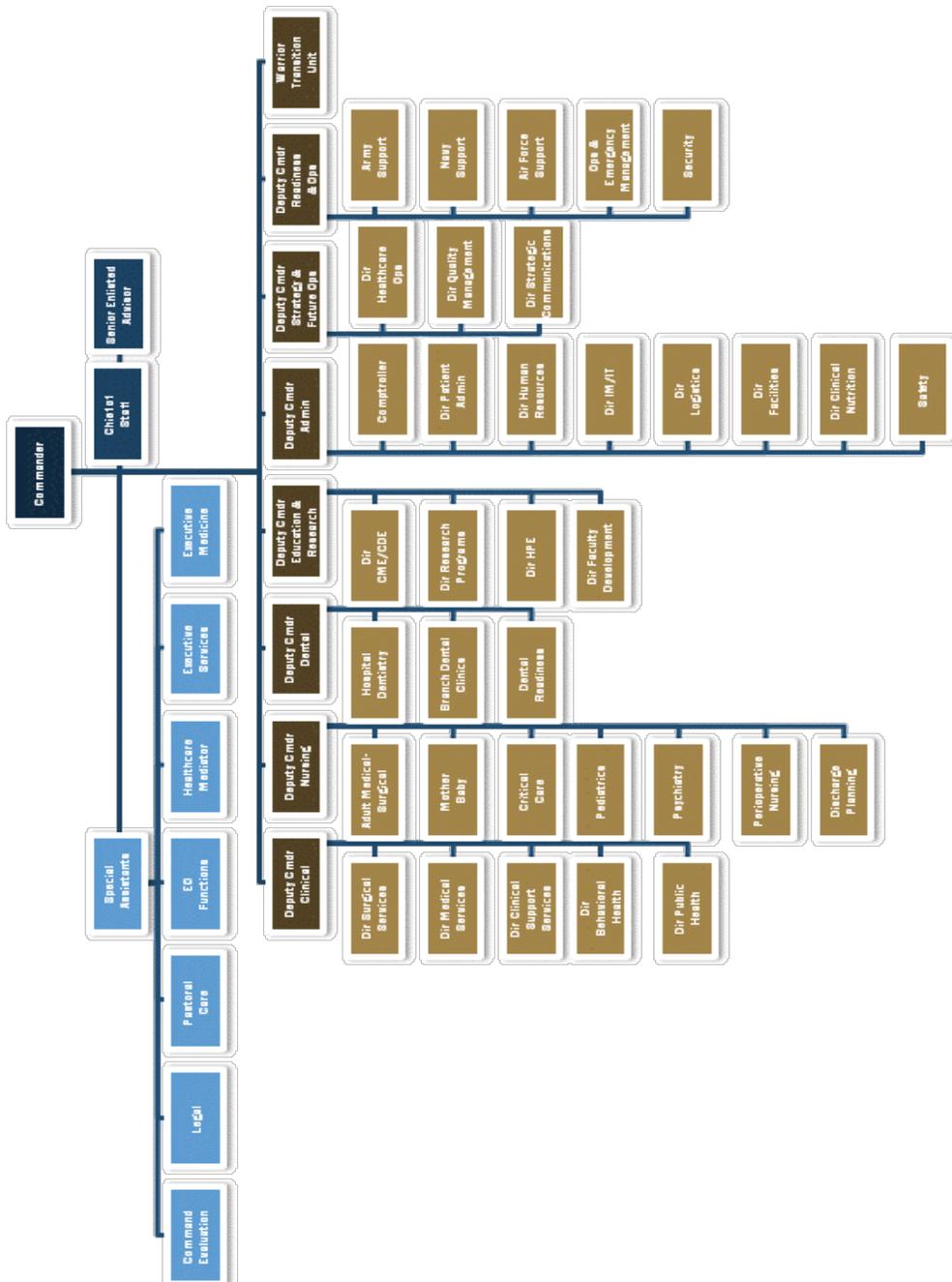
FIGURE 5 - WRNMMC COMMAND STRUCTURE ORGANIZATIONAL CHART

Error! Reference source not found., Figure 6 and Figure 7depict the WRNMMC's future Deputy Commander for Clinical Services' organization charts with the CIDs and CISs identified. These CIDs and CISs will play an integral role in the development of detailed transition plans, including clinic phasing strategies and clinic activation plans, which will be included in future versions of the MTP.

WRNMMC Deputy Commander Clinical

(Continued)

Deputy Commander Clinical

Dir Medical Services
- Emergency
- Primary Care
  - Family Practice
- Medicine
  - Allergy/Immunology
  - Internal Medicine
  - Critical Care
  - Optometry
  - Hematology Oncology
  - Dermatology
  - Infectious Disease
  - Cardiology
  - Rheumatology
  - Nephrology
  - Endocrinology
  - Pulmonary
  - Gastro-enterology
- Pediatrics
  - Primary Care
  - Adolescent Medicine
  - Neonatology
  - Hematology Oncology
  - Neuro-development
- Neurology

Dir Surgical Services
- Surgery
  - Organ Transplant
  - Audiology Speech
  - Urology
  - Neurosurgery
  - OMFS
  - General Surgery
  - Vascular Surgery
  - Ophthalmology
  - ENT
  - Anesthesia
  - CT Surgery
  - Trauma
  - Plastic Surgery
- OB/GYN
  - General OB/GYN
  - GYN ONC
  - Rep. Endo. & Infertility
  - Urogynecology
  - Maternal Fetal Medicine
- Orthopedics Rehabilitation Medicine
  - Orthopedics
  - Physical Therapy
  - Occupational Therapy
  - Amputee Care
  - Orthotics
  - PMR

FIGURE 6 - WRNMMC DEPUTY COMMANDER CLINICAL ORGANIZATION CHART

WRNMMC Deputy Commander Clinical

(Continued)

Deputy Commander Clinical

Dir Public Health (Branch Clinics)
- Preventive Medicine
  - Occupational Health

Dir Behavioral Health
- Psychology
- Social Work
- Behavioral Health
  - Adult Inpatient Psychiatry
  - Behavioral Health Consultation
  - Tele-Behavioral Health
  - Child & Family Services
  - Adult Outpatient Behavioral Health
- Substance Abuse Prevention

Dir Clinical Support Services
- Pharmacy
  - Inpatient Pharmacy
  - Outpatient Pharmacy
- Radiology
  - Nuclear Medicine
  - 3-D Medical Applications
  - Radiation Oncology
  - Diagnostic Radiology
  - Radiographic Procedures
- Pathology

FIGURE 7 – DEPUTY COMMANDER CLINICAL ORGANIZATION CHART (CONTINUED)

Military Personnel

The 2005 BRAC recommendations will close WRAMC, integrate its military workforce of more than 1,700 personnel with the NNMC military workforce of nearly 2,000 personnel, and establish the new WRNMMC. Another facility affected by the BRAC recommendations, DACH in Fort Belvoir, Virginia, is expected to integrate military personnel from WRAMC and NNMC, augmenting its 324 military workforce to support the newly built FBCH. The challenge of migrating more than 4,000 military personnel from their current billets in Bethesda, at WRAMC, at DACH, and at Andrews AFB and shifting them to their new billets at the new WRNMMC and FBCH is significant. Additionally, the number of military personnel disrupted by this relocation is expected to increase as the Air Force expands its support of the newly established NCR joint medical command with what is expected to exceed 400; military workforce at MGMC will also shift to either WRNMMC or FBCH.

The military personnel necessary to support readiness requirements for all Services will be redistributed to support the integration of WRAMC and NNMC into the new WRNMMC. On the north side of the NCR, WRNMMC will provide primary, subspecialty, complex, and tertiary medical services. On the south side of the NCR, FBCH will expand from a 60-bed hospital to a 120-bed hospital that delivers primary and subspecialty care to nearly 600,000 NCR beneficiaries. These new medical facilities will report to the JTF CAPMED. As joint medical hospitals, they will be staffed with a mix of military and civilian medical professionals currently serving in similar capacities for the Army, Navy, and Air Force medical services. The manning documents for the hospitals will be Joint Table of Distribution (JTD).

Manpower Planning

JTF CAPMED chartered the Joint Manpower and Personnel (J1) Joint Planning Group (JPG) to oversee the transition of military personnel, contract issues, and manpower of critical functions to ensure sustained healthcare at the current facilities and, once transition is complete, at the new facilities as well. The members of the group consist of human resources representatives from the Air Force Medical Service (AFMS), Bureau of Medicine and Surgery (BUMED), WRAMC, NNMC, and DACH. These representatives provide advice and analysis of the Human Resources (HR) functions within each facility and how best to integrate those functions in a joint facility.

Program Areas

Joint Table of Distribution

During the past 18 months, the JTF CAPMED J1 Manpower and Personnel Directorate has worked to consolidate and realign medical manpower resources within the NCR to effectively continue missions outlined in the 169 BRAC Business Plan. The strategy builds on the initial analyses of the NCR Multi-Service Market Office (MSMO), incorporates key elements of resultant Programs for Design (PFD), and refines requirements using an iterative, spiral development process. Supporting analyses project workload figures, benchmark military/civilian production standards, and incorporate expert user input. The resultant joint medical manpower allocation reflects the unique mission requirements of JTF CAPMED and captures efficiencies gained using integrated plans, interoperable assets, and standardized systems/processes.

Most recently, JTF CAPMED completed Phase IVb of a four-phased spiral development process (see Appendix A). A pre-decisional draft version 2.0 of the Joint Table of Distribution (JTD) for both WRNMMC and FBCH has been completed and made available to OASD/HA, TRICARE Management Activity (TMA), the military Services, and the Joint Chiefs of Staff (JCS) for review. The objective is to complete the review, refine the version 2.0 document, and make the necessary programming adjustments by 15 August 2009. Completion of these actions will support effective, timely military assignment and civilian HR management activities prior to the 15 September 2011, opening of the new facilities.

As of June 2009, manpower requirements in the draft JTD are distributed according to the new facilities' organizational structures and include occupational skill, personnel category, military service, and military/civilian grade-level details. The JTD draft assumes operation within the existing pool of manpower resources. It strives to ensure (1) that current readiness missions the NCR supports are sustained in the future, (2) that the impact of deployments and contingencies are balanced across medical facilities, sustaining the continuity of world-class casualty and beneficiary care, and (3) that civilian work forces experience minimal dislocation during the transition. Graduate Medical Education (GME) faculty and support staff figures are incorporated in the manning document. Consistent with past practices, GME resident requirements are being determined and managed by the military services. Resident figures are projected to remain at current levels. Key faculty requirements are also identified to ensure that medical training programs are sustained. Finally, the JTD draft incorporates contributions by Army, Navy, and Air Force services within the NCR. As previously noted, a pre-decisional version has recently been forwarded to principal stakeholders for review.

The Environmental Impact Statement for the Walter Reed National Military Medical Center caps the total number of personnel in the MTF at a given time at 5932. The JTF applied conservative availability factors to the requirement of both facilities to meet the day to day mission of this medical treatment facility. Not all military authorizations are filled at 100% for a variety of reasons. There are shortages within the service medical department for specific occupations such as individuals not available for assignment due to full time training and transit between duty stations. A military fill rate was applied to account for these types of shortfalls. Like the military, not all civilian positions are filled 100% of the time. Facilities in the national capital region historically run a 10% vacancy rate. Civilian positions are vacant due to individual leaving their position for better employment, family needs, retirement and other reasons. In addition, civilian positions are also vacant due to recruitment actions such as the hiring for new and existing positions. Finally, the availability factor includes individuals are not available to work each day due to vacation, temporary additional duty, illness, and professional development. Each of the services applied a manpower availability factor in their requirements determination process.

In May 2009, manpower listings in the pre-decisional draft were updated to include projected healthcare services at other locations (i.e., Andrews AFB, Pentagon Clinic, Tri-Service Dental Clinic at the Pentagon, and a primary care clinic at Forest Glen). Requirements for operations at Andrews AFB are nearly complete. Analyses of operations at the Pentagon and Forest Glen are still being developed; estimates were taken from existing manning documents and serve as placeholders for future refinement. Operating locations at Andrews AFB and the Pentagon are additives to initial requirement projections as they represent workload that was not projected for the two main facilities. The proposal to locate primary care services at Forest Glen is not an additive. These services were previously planned for WRNMMC and, therefore, will be supported by resources that had been designated for that facility. In each instance, requirements will be refined in future updated JTDs and supported by existing resources.

Staffing

The MHS Human Capital Strategic Plan (see Appendix B) is the primary document for the strategic alignment of JTF manpower resources necessary, which will ensure the provision of highly qualified manpower and personnel support to the HR staff at WRNMMC, FBCH, and the JTF CAPMED headquarters. This alignment will be accomplished by selecting highly qualified military and civilian personnel with extensive backgrounds in HR. As a joint activity, the selection of military personnel must include all Service Components to adequately support and reflect the JOA. The JTF is currently implementing the MHS Human Capital Strategy, and future versions of the MTP will contain more detailed plans.

Defense Medical Human Resources System Internet

The JTF unanimously selected the Defense Medical Human Resources System internet (DMHRSi) as the personnel system to use in the Human Resources Department to support the JOA. After a demonstration of DMHRSi, the JTF Commander was impressed with the benefits associated with having a single, integrated HR management system and fully supported its implementation. Because this system will provide visibility, standardized information, accurate reporting, and cost analysis capabilities, DMHRSi will be implemented throughout the NCR JOA.

Standard Operating Procedures

Each medical facility in the NCR has its own standard operating procedures (SOPs) that govern operations. Most of these SOPs are Service Component-centric. As joint facilities, development of joint SOPs and best business practices must be identified, approved, and disseminated throughout the JOA by September 2010.

Assignment of Military Personnel

The JTF will coordinate the realignment of military personnel by retaining personnel currently living in the north for assignment at WRNMMC and those residing in the south for assignment at FBCH. With the buildup of the FBCH, some military personnel living in the north may be reassigned to the south due to their occupational code and the needs of the facility. To prevent disruption and maintain continuity in the organizations, ideally military personnel who report to the JOA by FY 2010 will not be considered for reassignment until after the successful integration of the new facilities.

Personnel Services Division

The Personnel Services Division (PSD) provides management of military personnel programs, including assignments and reassignments, management of organizational structure, functional assignments, and manpower authorizations for the JTF and its subordinate commands. The new medical facilities integrated into the JTF CAPMED will contain joint PSDs that provide support to all military members regardless of Service. The PSDs will have a staff trained in all aspects of military personnel functions that is able to assist all assigned Airman, Soldiers, and Sailors. The PSDs will interface with the Component detachments and the J1 JTF CAPMED for the assignment and reassignments of military personnel. The PSD is currently an agency on the installation that supports the NNMC, WRAMC, and DACH. The J1 JPG recommends modifying the memorandum of understanding (MOU) to continue the PSD support at the installations where WRNMMC and FBCH will reside.

Human Resources Department

Both WRNMMC and FBCH will have a Human Resources Department (HRD) function with representation from each Service Component to support individual service needs for military personnel in a joint environment. Services will include in/out processing of personnel, command sponsorship programs, position management, end strength management, personal contract management, military pay, special pay for physicians and allied professionals, personnel actions, civilian payroll, civilian personnel actions, reserve liaison, The Joint Commission HR standards, screening for military personnel with an overseas assignment, military leave/liberty program recruitment, and retention.

Personnel Awards and Military Evaluations

At NNMC, the function of managing personal awards and military evaluations currently resides in the Secretariat. The J1 JPG recommends that this function, along with its staff, be moved to HRD to handle the increased volume of military and civilian personnel awards and evaluations. The HRD at WRNMMC and FBCH will manage the functions of personnel awards and military evaluations.

Civilian Drug Screening

Civilian Drug Screening (CDS) is a function of the Civilian HR division. With the realignment of civilian personnel in the HRD, the J1 JPG recommends that CDS remain in HRD.

Personal Contracts

The J1 JPG recommends that Personal Contracts be managed within the HRD. The rationale for this decision is based on the accountability of contractors in the workplace and the ability to evaluate the appropriateness of request for contractors in the event of military deployments or shortfalls in staffing.

Joint Human Resources Policy Committee

An HR Policy Committee, which will include Service representatives, will develop a list of standardized HR polices across the JOA. Once the policies are reviewed and best practices are identified, the committee will present to the J1 Joint Planning Group (JPG) for concurrence and approval. Once approved, the policies will be disseminated across the JOA by October 2010.

Reassignment and Personnel Actions

Military personnel currently assigned to NNMC, WRAMC, and DACH will be identified for reassignment to WRNMMC and FBCH in July 2010. Orders will be generated in concert with their respective Component. Incoming military personnel to NNMC, WRAMC, and DACH in 2010 may be stabilized until after the integration of the new facilities to prevent disruption of the staff as they transfer to WRNMMC and FBCH.

The establishment of the JTF is a mandate from the Secretary of the Defense for a "world-class region, anchored by a world-class Medical Center." According to BRAC law, WRAMC will close in September 2011, and its mission, along with its support staff, will relocate to the WRNMMC or FBCH; the population growth in the South led to a decision to expand DACH from a 60-bed to a 120-bed hospital and to rename it FBCH. Yet, if the transition plans for the military personnel functions were suspended or discontinued, the mandate of the Secretary of Defense and BRAC law would not be met. At the same time, if military personnel orders are not identified early, there may be a significant impact on quality of life issues for

those personnel and their family members when assignments are transferred from WRAMC to either WRNMMC or FBCH, which is 60–90 minutes south.

Civilian Personnel

The civilian workforce is a key resource for military medical facilities throughout the NCR, as it provides continuity of care and corporate knowledge while sustaining and enhancing surge capability during periods of military deployments. From now until September 2011, civilian employees, like their military counterparts, will experience uncertainty and potentially some turbulence during the relocation to the newly constructed WRNMMC and FBCH. Most of the more than 2,000 Army civilians at the current WRAMC campus will transfer either to WRNMMC or FBCH, nearly 600 Army civilians at DACH will transfer to the newly constructed FBCH and, after undergoing 4 years of transformative construction and internal moves, the 1,400 civilians at NNMC will integrate with WRAMC's displaced force. All of these Army and Navy civilian employees, acculturated to the military service where many have worked for their entire careers, will become DoD civilians (versus Service-centric employees) with an as yet undefined culture in 2011. Yet, throughout this challenging time, the nearly 600,000 beneficiaries the JTF supports will need the expertise and empathy of these caregivers and support personnel who are experiencing their own significant personal transitions. JTF leadership anticipated this need, and the DEPSECDEF responded.

Two precedential DEPSECDEF decisions—the Guaranteed Placement Program (GPP) commitment and the decision to convert to DoD civilians in the new joint facilities—have created unique challenges and opportunities in connection with the transition of MHS civilians in the NCR to joint medical facilities in 2011. Under past BRAC practice, the closure of WRAMC might have resulted in a large-scale reduction-in-force of WRAMC employees with their subsequent placement in positions at the newly expanded WRNMMC and DACH facilities through the Priority Placement Program (PPP). For many DoD employees displaced by BRAC decisions, the PPP is the tool through which they are able to continue their federal careers at other DoD installations. Unfortunately, many employees affected in base closures typically seek and find other positions on their own and leave early to have greater certainty about their futures. For WRAMC, that kind of attrition was deemed a threat to continued quality care for wounded warriors. In August 2007, the DEPSECDEF directed the Guaranteed GPP for all WRAMC employees to transfer to the new WRNMMC or FBCH (see Appendix C). To successfully guide this transformation, a Civilian HR Council was charted and will be develop and communicate the implementing policies and actions to fulfill the GPP commitment.

The second precedential decision was logically aligned to the decision to stand up the new WRNMMC and FBCH as joint facilities—specifically the determination that all civilian employees in the new joint facilities of WRNMMC and FBCH will be DoD civilians. To implement that decision, current Army and Navy civilians will convert to DoD civilian status, which will require creation of a new governance structure. This structure must provide for the delegation of Title V authorities via a DoD Chain of Command to the Commander, JTF CAPMED and will shift the authorities from the traditional delegations via the Service Secretaries. Implementing this new structure will involve adapting a variety of programs and policies that will effectively replace those that the Services and the Service Surgeons General currently developed for recruiting, managing, motivating, and rewarding civilian MHS employees. This change will also provide unprecedented opportunities to create enhanced leadership roles for MHS civilian employees in the NCR that are in line with the MHS Human Capital Strategic Plan for 2008–2013 (see Appendix C).

This transformative undertaking will affect stakeholders at all levels within the DoD and within other agencies. Most obviously, the work and careers of WRAMC, NNMC, and DACH employees and managers will be directly impacted by decisions made across the civilian personnel program areas. Congressional representatives will continue to track the progress of the transition to ensure the well-being of their constituents affected by the move, and the Office of the Secretary of Defense representatives in Health Affairs, Personnel and Readiness, Civilian Personnel Policy, and the Civilian Personnel Management Service will be developing new policies and procedures to implement the DEPSECDEF decisions. Labor unions will be actively engaged as the exclusive representatives of bargaining unit employees in the region, while Service and DoD Equal Employment Opportunity (EEO) and Injury Compensation Program Managers will be involved to ensure the proper execution of their program goals during and after the transition. The Service Headquarters, Manpower and Reserve Affairs, and the Offices of the Surgeons General will be consulted to ensure needed alignment with the civilian policy and structure in the Service medical organizations. The working-level civilian HR organizations will be essential to the effective preparation and transition to the new joint MTFs.

Civilian Human Resources Council

The Civilian Human Resources (CHR) Council was chartered in September 2008 to oversee the transition of civilian personnel to the new regional alignment by mid-September 2011. The members of the Council are the WRAMC, NNMC, and DACH Deputy Commanders who have the delegated authority to create and modify civilian personnel policy within their organizations. The role of the Council is to work collaboratively to mitigate the adverse impact of transition, while simultaneously identifying, nurturing, and leveraging opportunities to begin thinking and operating regionally on issues affecting civilian personnel (see Appendix C). The CHR Council has already approved a detailed project plan containing more than 15 major CHR program areas and more than 300 discrete tasks identified to achieve the transition (see Appendix C). The CHR Advisory Group, composed of senior HR experts, strategic communication specialists, and DCIs, is providing advice and analysis, making recommendations, and carrying out the decisions of the Council (see Appendix C). The CHR Advisory Group includes full-time CHR consultants at WRAMC, NNMC, and DACH. These consultants serve as "embedded" HR support who work within the organization's civilian personnel organizations and focus on work related to developing and implementing new processes and ensuring that communication to managers and employees is aligned with a common regional message.

Major Program Areas

Transition Staff

It is essential to have civilian personnel experts focused on developing, defining, and "pre-positioning" the regional end state during the transition. Internal HR staffs in organizations affected by BRAC are typically overwhelmed with daily operations and sustainment. They do not have the time, or in some cases the skill sets, to develop new business rules or prepare employees and managers to operate effectively when they move into their new organizations. Because JTF CAPMED is committed to leveraging available assets rather than building a large headquarters staff, the transition staff will be positioned in the facilities where they can see the changes firsthand and effect the most change. The JTF has already succeeded in hiring "embedded" consultants in each of the HR offices (see Appendix C). The only remaining task is to recruit the program lead for the JTF. Currently, the Special Assistant for Civilian Human Resources Highly Qualified Expertise is performing this task.

Communications

Consistent, frequent, detailed communication is essential for maintaining workforce confidence in the face of the scope and complexity of changes that will occur over the next two years. A CHR strategic communication plan (see Appendix C) was developed and every major program area plan includes a specific communications approach. The goal is not only to communicate to employees and managers what they need to hear, but to hear what they need to say.

Labor

All of the facilities that the transition will affect have labor unions representing roughly 1,500 employees, yet no two negotiated agreements or bargaining units are the same. The Commander's goal is to have a regional civilian workforce with common rules and procedures to support interoperability and consistency across the region. Clearly, the development and execution of a labor strategy that meets statutory and regulatory requirements and produces an optimum outcome for the region will be a considerable challenge.

Classification and Position Management

The region will include civilian employees covered under the National Security Personnel System (NSPS), the General Schedule (GS), and the Federal Wage System (FWS). Classification is the process by which a pay plan, series, and grade are assigned to a set of duties for each position. The Army currently uses an automated system called FASCLASS and does not adhere to the standard format for its NSPS positions. The Navy uses a standard position description (PD) library for its medical positions but does not have a centralized system for classifying non-medical positions. The Advisory Group has identified a substantial number of potential inconsistencies in the classification of positions at WRAMC and NNMC and must address them prior to transition. A working group is currently reviewing the various position classification approaches and will recommend to the JTF Commander a single regional approach standard. WRAMC, NNMC, MGMC, and DACH all use similar approaches for Position management, the process used to review and approve/disapprove new positions or modifications to existing positions. The challenge over the next two years will be to shift those deliberations to a regional view to avoid decisions that will produce unintended consequences when merging workforces.

Performance Management

The region currently includes civilian employees covered by the NSPS five-level performance management system, the Navy's two-level system for non-NSPS employees, and the Army's five-level system for non-NSPS employees. When workforces are merged, a systemic standardization of performance objectives and measures will need to be in place to ensure consistency and equity across the region.

Personnel Servicing

Transactional and advisory personnel services for civilians are currently provided through Service-directed HR offices and processing centers. Those servicing offices are not organic to the MTFs and belong to either the Navy installation support organizations or the Army's Civilian Human Resources Agency (CHRA). Prior to transition, the JTF will need to identify and negotiate a servicing agreement with an existing HR service provider. Attributes of the new provider should include best value and the ability to meet the unique requirements of a regional healthcare delivery system.

Change Management

To mitigate the stress associated with transformative change while supporting continuing effectiveness for employees transitioning to the regional end state, a rigorous change management strategy is needed. This strategy will be linked to strategic communications but will include a broader range of services and training.

Recruitment and Staffing

The GPP commitment adds challenges to civilian personnel transition, while providing a unique opportunity to preserve critical skills and demonstrate how the region will care for its civilian workforce. In addition to the GPP, the continuing shortage of certain healthcare specialties will continue to stress WRNMMC and FBCH standup efforts. Today's recruitment and staffing efforts must focus on a workforce that will triple in size at Fort Belvoir and respect the desire of the majority of current WRAMC employees to migrate to Bethesda when WRAMC closes its doors in 2011. The NCR is among the most fiercely competitive markets for healthcare professionals in the United States and the ability to accommodate geographical preferences has the potential to be one of our most powerful recruitment and retention tools. Recruitment and staffing strategies are being developed to focus on hiring for Fort Belvoir in 2011 and developing plans to maximize the placement of WRAMC employees at their desired locations.

Federal Employees' Compensation Act

Medical and wage replacement benefits paid to employees who have become ill or injured at work represent a substantial financial liability. For employees on permanent disability, the payments are made by the Department of Labor and the costs are charged back to the Services. Prior to the transition, JTF will need to assess the Federal Employees' Compensation Act (FECA) caseload in the current activities, determine the appropriate disposition of existing cases, and ensure that the funds currently allocated to the Services to reimburse the Department of Labor are transitioned to the new facilities. Because the new facilities may also have an obligation to return previously injured employees to work and must be ready to process new claims immediately after the transition, it will also be necessary to ensure that an effective FECA Program transitions into the new region.

Equal Employment Opportunity

A key element of maintaining the trust and confidence of the civilian workforce will be the manner in which employee concerns and complaints are managed. Planners anticipate that there will be a number of ongoing EEO complaints in the existing Army and Navy facilities when the employees become DoD civilians in the new joint activities. To resolve these complaints, the JTF will need to determine and carry out the appropriate disposition of those complaints and ensure the corresponding development of a robust EEO Program in the new region.

Transition Assistance

A significant element of the transition will be caring for employees who are ending their careers or who are choosing to leave rather than to transition to another work location or position. Effective transition assistance will include the use of incentives to shape the workforce where it is determined that there are surplus or obsolete skills.

Recognition

Each of the Services has specific civilian awards for outstanding and meritorious performance. Those traditions and values must be adapted and embedded within the new joint MHS environment to provide for comparable levels of recognition based on civilian contributions to the mission.

Gap Analysis

The conversion of more than 4,000 Army and Navy civilians in three facilities to two joint facilities will require creation of some surge capacity for needed redundancy in some operational areas and to address the doubling of the transactional workload that will occur when the serviced civilian population moves from one HR organization and Service database to another.

The transition of a motivated, confident force of healthcare providers and support personnel is critical to achieving the transformational objective of "a world-class region, anchored by a world-class Medical Center." Failure to transition the civilian force in a credible, transparent, and compliant manner is likely to result in the increased personnel costs that typically accrue from poor personnel management decisions. Perhaps more importantly, a loss of employee trust and confidence will have the potential to adversely affect patient care for years into the future. The creation of joint hospitals manned by DoD civilians working with military personnel from all Services provides an unprecedented opportunity to create world-class regional healthcare that leverages the best of each Service's medical culture and best practices throughout the NCR.

Education, Training, and Research

This integration and establishment of a regional healthcare delivery system, which includes the Air Force's MGMC, FBCH, and the Uniformed Services University (USU), will establish a model for future military healthcare, education, training, and research. Several hundred trainees and research personnel will relocate from WRAMC when it closes in 2011. These trainees will require clinical and research platforms at the new WRNMMC and the new FBCH.

The SECDEF's justification for establishing the new WRNMMC is, in part, to transform legacy military medical centers into a world-class joint operational platform. Creating a joint education, training, and research platform in the NCR is optimal due to collocation with other institutions such as the National Institutes of Health, National Cancer Institute, National Intrepid Center of Excellence for Traumatic Brain Injury and Psychological Health, USU, National Library of Medicine, Armed Forces Radiobiology Research Institute, and Suburban Hospital.[3]

The JTF CAPMED Education, Training, and Research Directorate (J7) was established in September 2007 to serve as principal staff to the Commander, JTF CAPMED on health professions education, training, and research issues and functions that evolve in the JOA during integration and transformation. Key to this directorate is maintaining military education, training, and research capacity by providing programs needed to meet changing mission requirements resulting from the closure of WRAMC.

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[3] Murray, J.S. (2009). Joint Task Force National Capital Region Medical: Integration of education, training & research. Military Medicine, 174 (5), 448-453.

Ensuring that military medical education programs appropriately prepare future healthcare providers and leaders is essential to mission success. The J7 also develops partnerships for collaborative education, training, and research among the military Services, with other federal institutions such as the Department of Veterans Affairs and Department of Health & Human Services, across healthcare professions such as nursing and medicine, and with civilian agencies such as local hospitals and academic institutions.

The J7 Director established a JPG in January 2008 to oversee the transition of education, training, and research programs to a regional focus. Members of this group include representatives from the WRAMC Health System, NNMC, MGMC, and the USU. The role of the group is to work interdependently to identify and develop mitigating strategies to address identified concerns that may impact education, training, or research programs in the NCR. Members of the J7 JPG are also representatives of various subcommittees (or cells) that specifically focus on the following: Enlisted Training, Graduate Medical/Dental Education (GME/GDE), Health Professions Education (HPE) and Research. In January 2008, the JPG met to develop a strategic plan for areas to focus on during BRAC construction and transition and for the establishment of a regional healthcare delivery system.

Since October 2007, the J7 has carried out joint initiatives to prepare for the future state of education, training, and research in the NCR.

Stakeholders

Stakeholders military healthcare, education, training, and research span a diverse set of health professions personnel from WRAMC, NNMC, DACH, and MGMC; faculty from the USU; and federal entities such as the National Institutes of Health, National Cancer Institute, National Intrepid Center of Excellence for Traumatic Brain Injury and Psychological Health, Department of Veterans Affairs, Department of Health & Human Services.

Graduate Medical and Dental Education

The GME/GDE) section of the J7 will oversee the impact of integration and BRAC on the GME/GDE programs and will ensure that these programs are optimally positioned for the provision of world-class training now and in the future. This section currently tracks eight active elements.

Accreditation

There are 53 physician training programs and 11 dental programs in the NCR accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Dental Association's Commission on Dental Accreditation (CODA), respectively. Additionally, the oversight bodies for these programs, the National Capital Consortium (NCC) and the Naval Postgraduate Dental School, are also accredited by those bodies. Accreditation is for a period of one to five years, and the final date for site visits is typically known three months in advance. Table 1 displays the schedule for when programs are DUE to have their site visit, based on the timing of their last site visit. The actual date of the inspection will be 3–6 months after this date, and this data will be updated in the MTP as it becomes available.

Table 2 - Site Visits Conducted Within the Last 12 Months lists those programs that have had site visits in the last 12 months and Table 2 lists the site visits conducted within the last 12 months but the next inspection date has not yet been identified.

TABLE 1- SITE VISIT SCHEDULE BASED ON LAST VISIT

National Capital Consortium Programs	Projected Site Visit Date
Internal Medicine—WRAMC	April 2009
Cardiovascular Disease	April 2009
Critical Care Medicine/Internal Medicine	April 2009
Infectious Disease	April 2009
Nephrology	April 2009
Pulmonary/Critical Care Medicine	April 2009
Rheumatology	April 2009
Neurological Surgery	June 2009
National Capital Consortium	June 2009
Orthopedic Surgery	June 2009
Radiation Oncology	July 2009
Anesthesiology	October 2009
Critical Care Medicine/Anesthesiology	October 2009
Pediatrics	October 2009
Pediatric Endocrinology	October 2009
Pediatric Hematology/Oncology	October 2009
Pediatric Infectious Disease	October 2009
Neonatal/Perinatal Medicine	October 2009
Pain Medicine	October 2009
Clinical Neurophysiology (NNMC/NIH)	November 2009
Family Medicine	May 2010
Family Medicine/Sports Medicine	May 2010

National Capital Consortium Programs	Projected Site Visit Date
General Surgery—NNMC	June 2010
Naval Postgraduate Dental School	June 2010
Comprehensive Dentistry	June 2010
Endodontics	June 2010
Maxillofacial Prosthetics	June 2010
Oral Diagnostics and Radiology	June 2010
Oral Pathology	June 2010
Oral Facial Pain	June 2010
Peridontics	June 2010
Prosthedontics	June 2010
Allergy/Immunology	September 2010
Transitional Year	November 2010
Dermatology	March 2011
General Practice Dental Residency	June 2010
Otolaryngology	August 2011
Forensic Pathology	September 2011
Obstetrics/Gynecology	May 2012
Clinical Neurophysiology—WRAMC	May 2012
Oral Maxillofacial Surgery	June 2012
Orthopedics/Hand Surgery	June 2012
Physical Medicine and Rehabilitation	August 2012
General Surgery—WRAMC	October 2012
Pathology (Anatomic and Clinical)	October 2012

National Capital Consortium Programs	Projected Site Visit Date
Neurology	November 2012
Internal Medicine—NNMC	January 2013
Endocrinology	January 2013
Gastroenterology	January 2013
Hematology/Oncology	January 2013
Preventive Medicine (NCC)	March 2013
Preventive Medicine (USU)	March 2013
Ophthalmology	May 2013
Advanced Education in General Dentistry	June 2013

TABLE 2 - SITE VISITS CONDUCTED WITHIN THE LAST 12 MONTHS

Site visits conducted within the previous 12 months. The next site visit due date not yet identified.	
Child Neurology	Child and Adolescent Psychiatry
Nuclear Medicine	Forensic Psychiatry
Pediatric Gastroenterology	Geriatric Psychiatry
Psychiatry	Radiology-Diagnostics
Urology	Vascular Surgery
Sleep Medicine	

Designated Institutional Official/GME Organizational Structure

The organizational structure for education and research for the WRNMMC will be led by a Deputy Commander for Education and Research. This position will be a Corps-neutral position. Under this Deputy will be four Directors, a Director of Graduate Medical Education (physician), a Director of Health Professions Education (Corps-neutral), a Director of Research (Corps-neutral), and a Director of Faculty Development (Corps-neutral). A decision will need to be made as to what will happen with the NCC in the future and where the Designated Institutional Official (DIO) (the individual who is responsible to the ACGME for all matters related to the physician training programs) position will be placed.

Integrated Medical Library

The JOA will maintain an Integrated Electronic Medical Library and a medical information system. Developing it will require multi-phased process that occurs over the next two years with multiple tasks and milestones, as shown in Table 3.

TABLE 3 - INTEGRATED MEDICAL LIBRARY MILESTONES AND TASKS

Task	Milestone Date
Integrate WRAMC, DACH, and Kimbrough library management systems into the USU library system	15 March 2009
Stand up electronic library services, provided by USU, to personnel assigned to WRAMC, DACH, and Kimbrough	1 October 2009
Integrate the NNMC Medical and Dental library management systems into the USU library system	1 April 2010
Stand up electronic library services, provided by USU, to personnel assigned to NNMC	1 October 2010
Stand up electronic library services, provided by USU, to personnel assigned to the JOA	1 April 2011

Additionally, the Medical and Dental Libraries at NNMC will be consolidated due to BRAC-related construction. It is anticipated that this will take place no later than 1 October 2010.

Monitoring Impact – Construction on Educational Programs

The impact of construction at NNMC on educational programs is an ongoing process that is monitored via a variety of avenues by the JTF Chief of GME and GDE, the NCC Executive Director, the Director of GME at WRAMC/NNMC, the Dean of the Naval Postgraduate Dental School, the USU Liaison Officer to the J7, and the USU Undergraduate Medical Education Representative to the GME/GDE/UME Cell of the J7. Identified issues are discussed monthly at the GME/GDE/UME Cell meeting and on an ad hoc basis as needed. One of the formal mechanisms for tracking this information will be the educational dashboards discussed in the next section.

GME, GDE, and Allied Health Dashboards

In December 2008, the JTF CAPMED Joint Transition Planning Board (JTPB) approved the concept of an educational dashboard system that would allow JTF and Component leadership visibility on key metrics that reflect robustness, risks, and trends in the GME, GDE, Allied Health, Nursing, and Enlisted Training programs. These dashboards, currently under development, will provide a single, easily accessible location where current and relevant data is housed that will address the "health" of training programs. Under consideration by the JTF/J6 is a joint portal for the JOA-wide dashboard. Key metrics for each of these programs and data entry are currently underway, with a projected final presentation to the JTPB in mid-2009.

Standardized Medical Intern Simulation Training

The CJTF has directed that training in basic procedural skills be conducted using simulation resources for incoming interns assigned to WRAMC and NNMC. A group of GME leaders developed a training plan that the JTPB and CJTF both approved. Tasks and milestones for this project are shown in Table 4.

TABLE 4 - STANDARDIZED MEDICAL INTERN SIMLUATION TRAINING

Task	Milestone Date
Brief program directors on training plan at NCC GME meeting	11 March 2009
Collect and review SOPs currently being used for teaching procedural skills	31 March 2009
Determine Simulation Center equipment and faculty needs	17 April 2009
Conduct basic procedural training	Mid-year 2009

Partnerships with Civilian Community and Other Federal Agencies

Many of the GME programs have relationships with medical facilities in the civilian community to maximize educational opportunities for their trainees. In some instances, the civilian community provides additional opportunities to increase the number and variety of medical procedures for trainees; in other cases, the civilian community provides clinical and research opportunities that are not available in the MTFs. The need to expand this outreach is one of the metrics that will be monitored closely to measure the impact of BRAC and integration on the graduate and undergraduate educational programs.

Undergraduate Medical Education Dashboard

Similar to the educational dashboards mentioned above, Undergraduate Medical Education (UME) leaders are developing a dashboard that will allow them to track the "health" of their UME programs. This effort is being led by the USU representative on the GME/GDE/UME Cell of the J7 and was briefed to the JTPB in May 2009 when the other educational dashboards were presented for final. This dashboard may be maintained in a joint portal for the JOA that the J6 is currently exploring.

Health Professions Education and Partnerships with Civilian Community and Other Federal Agencies for Nursing and Enlisted Training

The OASD/HA Human Capital Human Resources working group is looking into the feasibility of partnering with Northern Virginia Community College with to enhance nurse and allied health recruitment throughout the NCR. J7 HPE became involved as this has potential to greatly influence logistics, nursing workload, professional satisfaction, and nurse transition planning at the target FBCH. FBCH does not currently operate a new nurse transition program. Such programs, however, have proven effective for helping newly degreed nurses transition to professional practice and achieve competency sooner than those nurses who do not participate in transition programs. Nurses with bachelor's degrees enter the

workforce at approximately an advanced beginner stage of professionalism. New nurses prepared at the Associate's degree level would have an even greater need for a transition program. Discussion and analysis of the risks to patient safety, nursing staff satisfaction, and the cost of implementing a transition program need to be raised. J7 HPE representation will serve as the catalyst for those discussions and analysis. The risk of not having a voice in these negotiations is miscommunication of nursing needs, decreased patient safety, and the bird's eye view from a nursing/HPE perspective.

J7 HPE entered into discussion and partnership with the Medical Education and Training (METC) Campus at Fort Sam Houston, San Antonio, Texas. Open dialogue and transparency of integration efforts is essential to avoid conflicting curricula content and intent. The Chief, Enlisted Training and the Chief, HPE have visited METC to address curriculum requiring immediate approval (e.g., medication administration), the effect of NCR integration on any Phase II training programs, the quality of life of trainees in the NCR, and the impact of declining patient enrollment on Phase II programs. The J7 anticipates at least semiannual site visits to maintain quality interaction and partnership with METC. The risk of not partnering with METC is in producing conflicting or incomplete curricula and gaps in Phase II training opportunities. Ineffective Phase II training can jeopardize program accreditation.

Nursing Education Dashboard

The nursing education dashboard (see Table 5) was developed by HPE cell members who are either education and training SMEs or leaders from medical care facilities in the JOA. The intent of the dashboard is to enable viewing of key metrics that reveal the status of nursing education programs and training compliance. Graduate nurse education includes Master's degree programs in the Graduate School of Nursing at the USU. These programs prepare advanced practice nurses for family practice, anesthesia, peri-operative nursing and adult mental health. Monitoring utilization of these programs helps the CJTF CAPMED understand readiness from a health provider perspective. Advanced critical care and resuscitative courses are required or highly recommended for enhancing the skill set of nurses who may be deployed. Nurse transition programs include the formal education and training programs designed to help new graduate nurses transition to a competent level of clinical skill and military leadership during their first tour as a professional nurse.

TABLE 5 - PROFESSIONAL NURSE TRANSITION INFORMATION

Nursing Education Dashboard		
Education Type	Metric	Organization
Graduate Nurse Education	Utilization Completion Certification	USU
Deployment Skills	Utilization Compliance	WRAMC, NNMC, DACH, 79th Medical Wing (MDW)
Nurse Transition Programs	Utilization Intern Satisfaction Supervisor Satisfaction	WRAMC, NNMC, 79 MDW
• Utilization = # seats filled/total seats available • Compliance = # individuals completed/total number required • Certification = # graduates successfully passing certification exam • Satisfaction = outcomes data from survey completed at specific times after training/education completed		

Organization of the Health Professions Education Directorate

As part of transition planning, the HPE Directorate for WRNMMC must be defined to ensure that the correct number and type of services and personnel are planned for the transition. Roles, responsibilities, and PDs need to be developed or adapted from current and corresponding positions already in place at facilities in the JOA. HPE cell members have designed proposals for the organization of this Directorate and will be presented to the J7 JPG for review. The risk in not identifying the organization and responsibilities of this Directorate prior to transition is chaos with a loss of information and a lack of readiness of hospital staff personnel.

Integration of Directives and Policies

Currently, each medical facility and Service has policies and directives that affect and guide the education and training of its medical department staff. These policy documents need to be studied to identify commonalities and Service-specific requirements and issues. The HPE cell has begun gathering these documents from the various Services and medical facilities for review. The HPE cell will report its findings and recommend courses of action (COAs) to the J7 JPG, which addresses how and when to combine directives and policies that have common intent and purpose. The goal is to have integrated directives and policies in place approximately one year prior to the transition to mitigate confusion and increase compliance with policies and directions related to education and training. The risk of not integrating these documents is confusion, personnel dissatisfaction, and possible degradation of readiness.

Standardized Newcomer Orientation

Similar to the integration of directives and policies, it is necessary to design a command orientation that addresses the mission, vision, and other vital information about the new medical centers for newly reporting staff. This orientation is not only a higher authority requirement, but also is a key standard required for facility accreditation. The HPE cell has a subgroup reviewing the current command orientation content and policies of the medical facilities. This subgroup will report to the HPE cell, which will in turn develop a COA for a command orientation plan to present to the J7 JPG. The integrated command orientation plan should be finalized and staffed several months prior to n order to reserve classroom space and schedule instructors and presenters. The risk of not integrating a command orientation is the loss of opportunity to impart vital command information to new staff. Additionally, there would be a loss of productivity if new staff were to arrange their own training for systems such as Armed Forces Health Longitudinal Technology Application (AHLTA) or DMHRSi, and delayed computer system access if Health Insurance Portability and Accountability Act of 1996 (HIPAA) or information awareness training were not completed.

Single Learning Management System for the JOA

Currently, training is established and tracked by separate means within the Services. There exists no common database to access availability, schedule, or view training completion in a single learning management system (LMS). The HPE cell is working closely with staff from OASD/HA and the Human Capital Joint Education Training team to encourage develop computer interfaces for the Army and Air Force's LMS to the DMHRSi Education and Training Module. The Navy already uses DMHRSi as its LMS, which interfaces with Navy Knowledge Online (NKO) and Military Health System E-Learn (MHSLearn) where online training is stored. The OASD/HA is gathering needs and lessons learned from users of the Navy's DMHRSi to increase the functionality and desirability of using the Education and

Training Module. The risk of not establishing a single LMS is poor visibility of class offerings for required training such as Basic and advanced life support, which will result in decreased completion and certification compliance. Lack of a single LMS will also decrease the visibility of required training compliance for staff and leadership, thus jeopardizing readiness and patient safety.

Standardized Training Records

Each Service has unique directions and methods of recording and monitoring staff training. The HPE cell has asked a subgroup to examine the means and methods each Service employs for managing training records and to compare these means and any directives associated with training records. The goal is to present a recommended COA to the J7 JPG to integrate training record management. The risk of not having some methodology for training record integration is increased workload at the first line supervisor level (multiple data entry and typing), a loss of information, and potential non-compliance with accrediting or other higher authority direction and standards.

Simulation Techniques for JOA Inter-professional Education

Use of simulation such as integrated human patient simulators, partial task trainers, standardized patients, computer-based virtual reality, and role-playing are successful methods of teaching hospital personnel clinical skills and interdisciplinary teamwork. Competent teamwork and clinical skills are associated with increased staff, patient, supervisor satisfaction, and patient safety. Simulation allows a medical staff to increase clinical and interpersonal competencies in a risk-free environment that does not jeopardize patient safety. To capitalize on the simulation resources thought to exist in the JOA, the CJTF requested that a Simulation Cell be established within the division of J7 HPE. This chartered cell is consists of simulation and education SMEs from military and civilian organizations.

To date, the Simulation Cell has inventoried the major simulation resources in the JOA and will maintain a database of these resources for future training planning purposes. A web-based learning needs assessment was also created, with data collection to be completed by mid-April 2009. Goals, in addition to those generated by the needs assessment, include providing oversight of the design of the simulation center to be established at WRNMMC; establishing a memorandum of agreement with the Washington Hospital Center simulation center and ER One; creating and standardizing evidence-based simulation curriculums for various skills and team training; and conducting outcomes research surrounding simulation techniques and learning strategies.

Joint Competency-Based Orientation Program for Enlisted Medics

The Enlisted Training Cell reviewed and approved a training program for enlisted medics in alliance with similar efforts developed and implemented at Landstuhl Regional Medical Center (LRMC) in Germany. The desired effect of the program is to standardize the scope of practice for in-garrison environments at all medical facilities within the JOA, with joint enlisted medical personnel and/or supporting joint rotations for enlisted personnel.

Because of each Service's unique training requirements, culture, medical delivery systems and enlisted medical scopes of practice, it was evident from the start of this new partnership that collaboration, training, and medical enlisted competencies would be required to facilitate interoperability and maximize cooperation between the three Services.

Standardized Joint Medication Administration Plan

The Enlisted Cell, in collaboration with nursing SMEs from each Service, convened to establish a standardized medication administration training plan to ensure that all medical facilities in the JOA with joint enlisted medical personnel and/or supporting joint rotations for enlisted personnel were being taught the same competencies.

The Enlisted Cell members completed a gap analysis between the Navy Corps School, the Air Force Aerospace Medical Technician, and the Army 68W technical schools. This analysis revealed that all Services train on essentially the same information, although the Army's 68Ws are not permitted to administer medications in garrison, but they do so while deployed. The fact that the Army's 68W could not perform the same scope of care as the Navy and Air Force medics would hinder patient care; the benefit to the Services in standardizing joint medication administration is an established common curriculum that will standardize training and enhance interoperability and joint deployability. The blueprint for the standardized joint medication training plan was scheduled for completion in FY 2009, and at that time, the proposed product will be briefed to the HPE Cell for approval. Once approved, it will then be presented to the JTPB for final approval and implementation.

Joint Senior Enlisted Orientation Course

A joint senior enlisted orientation course was created to prepare Senior Enlisted Leaders (SELs) for duty in a joint environment and to ensure that SELs are well versed on the requirements necessary for enlisted advancement throughout the JOA. This course is an Air Force, Navy, and Army "101" primer that will train SELs to write annual performance reports, decorations, and joint awards; to ensure that their Soldiers, Sailors, and Airmen have the tools to meet promotion requirements and adapt to Service cultural differences; and to provide guidance to enlisted members that have not previously served in a joint assignment.

A draft course outline was approved by Tri-Service SELs, Navy Executive Medical Department Enlisted Course attendees, reviewed/approved by SELs that attended the Senior Leaders Conference, and members of the J7 JPG, HPE Cell, and the Enlisted Training Cell.

This course will provide JOA SELs with the knowledge and skills necessary to function effectively in a joint environment. The inaugural course will be held at the USU from 8–12 June 2009, with approximately 30 attendees from each of the Services. Once this course is underway, there are plans to develop similar officer and civilian orientation courses to provide them with rank-appropriate information and training.

Enlisted Training Educational Dashboard

The purpose of the Enlisted Training Educational Dashboard is to provide a means of viewing key metrics that reveal the status of enlisted training programs in the JOA. This dashboard was developed with Tri-Service involvement within the J7 Enlisted Training Cell. The dashboard provides a one-stop tracking system for JTF and Component leaders to review key metrics that reflect training status, risks, and trends in the performance of enlisted training programs. The dashboard is also intended to meet the CJTF CAPMED's priorities of casualty care, care for the caregiver, readiness, regional healthcare delivery, and common standards and processes.

Enlisted Specialty Integration Training Plans

The Enlisted Cell is responsible for integration planning of all medical specialties. Work has begun on developing a training and cross-flow plan that will include competency assessments, staffing utilization, professional growth/ development, and cultural awareness for enlisted personnel supporting the JTF.

Tri-service SMEs will engage in the review of each functional area's training plans and will develop standardized training plans that will ensure that gaps in training are addressed. To date, many of the clinical tasks each Service trains its staff on are similar and will require little additional training.

Research

The goal of the J7 Research Cell is to establish a single Department of Research Operations (DRO) that integrates the research oversight, monitoring, and education activities that existed in support of DoD Assurances for the Protection of Human Subjects prior to BRAC 2005 at National NNMC, WRAMC, and MGMC. In addition, the DRO will integrate and support research execution activities as appropriate throughout the JOA and facilitate the forming of research partnerships with federal and non-federal entities. The following paragraphs describe major objectives for establishing the DRO and progress to date toward achieving those objectives.

Application for Joint DoD Assurances for the Protection of Human Subjects

Federal agencies that were signatories to the Belmont Report, or so-called "Common Rule," agreed to follow ethical principals when conducting research using human subjects. The DoD was a signatory to the Belmont Report, and accordingly it issued directives that require military entities engaged in clinical research to apply for and maintain a DoD Assurance for the Protection of Human Subjects (comparable to the Health and Human Services Federal Wide Assurance) prior to conducting research.

Although policies and procedures the Army, Navy and Air Force developed to obtain a DoD Assurance were derived from the same DoD source documents, the military service medical institutions that engage in research in the NCR independently developed their own procedures for reviewing and approving research projects. The Service-unique administrative, scientific, and ethical reviews currently required to gain local approval to conduct research are complicated, time consuming, labor intensive, and frustrating for all who engage in research. This complexity is especially true for studies that are take place at multiple sites and that must undergo multiple reviews by the local Institutional Review Boards (IRBs). Furthermore, the current dependence on hard copy submissions aggravates an already cumbersome process.

From a research regulatory activity perspective, the 2005 BRAC law presented challenges but also profound opportunities. Our vision to integrate the research activities of the three Services is to establish a joint DoD Assurance for MTFs in the NCR. Our objective is to standardize, align, and streamline the research regulatory oversight procedures for the MTFs in the NCR without compromising the review standards. The intended result is that for investigators conducting intramural research, the review process appears seamless to the reviewer and that any one protocol will only need to be reviewed by one IRB.

A major step remains prior to applying for Joint DoD Assurance. The DoD Component Commander under which JTF CAPMED will operate must be identified in order to write a Human Research Protection Program Plan and synthesize SOPs needed to apply for a DoD Assurance.

Standardization and Alignment of Research Operations

A preliminary step toward achieving Joint Assurance is to standardize the various SOPs the Services use in their respective protocol review processes. Significant progress in this standardization has been made since 2006. Standard format and content for research protocol templates have been agreed to, as well as standard content and SOPs for conducting the administrative phase of research protocol review. Most

recently, the JTF proposed an SOP as a basic framework for conducting the scientific phase of research protocol review. It remains in the process of developing a standardized process for reporting adverse events and reviewing protocols that meet criteria for exemption from full IRB review.

Standardization of the Administrative and Scientific Phases of Research Protocol Review

Research protocols must progress through three major review phases to gain approval for execution: administrative, scientific, and ethical. In our efforts to standardize our SOPs, the JTF developed a common procedure for executing the administrative phase of review. More recently, JTF staff officers analyzed the several different models used for scientific review within the medical centers. After considering the strengths and weaknesses of the different models, the JTF developed a framework for a standardized review process. The "panel model" of scientific review was recommended, and an SOP was drafted for use throughout the JOA.

Conversion to Electronic Document Management

Integration and operation of the DRO will require an efficient and easily accessible document management system. Processing, approval, and monitoring of research is a complex and document-intense activity. The acquisition of an electronic IRB system is an important initiative intended to modernize and streamline JTF operations. Underway are efforts to standardize operating procedures throughout the JOA, which has the additional benefit of preparing the JTF for implementing an electronic IRB system.

In partnership with the Southeastern Regional Medical Command (SERMC), medical centers in the JOA were awarded funds to conduct pilot testing of the electronic IRB system, IRBNet. As part of the pilot testing, the necessary information management/information technology (IM/IT) approvals were obtained, and access to the system using a "single sign" through the Internet was developed. Computer servers, hardware, and software were purchased and installed on the SERMC post, and standardized protocol templates and other documents were uploaded to the system. Although the training of staff, review committee members, and investigators is ongoing, a "go-live" date is projected for SERMC. Other medical centers in the JOA, beginning with WRAMC, will follow in succession.

Merging of Medical Center Research Competitions

The WRAMC and the NNMC Center have traditionally held independent research competitions. The WRAMC convened the Bailey K. Ashford (BKA) research symposium for graduating trainees, and the NNMC held a research competition for trainees and staff. Awards in laboratory and clinical categories were presented to graduating trainees who won the BKA competition. Winners of staff and trainee categories in the Navy competition advanced to the Navy's national level of competition. A work group has been formed and is charged with exploring the potential of merging research competitions while preserving unique Service-specific characteristics where possible. A plan has also been developed and approved to merge the poster and oral presentation phases of the competitions. The first combined competition will be held in spring 2009.

Integration of Research Consultation, Education, and Training Assets

An important function of the clinical investigation programs that exist in the military medical centers is to provide consultative services, education, and training for the conduct of research. Consultative services are typically focused on helping investigators using biostatistics and other researchers with rational

experimental design. The JTF has identified the statisticians, inventoried biostatistical resources, and created a catalogue of the various formal and semiformal statistical training courses that are currently available. Our plan is to preserve the statistician staffing and maintain the resources while making the Service-specific courses open throughout the JOA. In addition to consultations in experimental design and the appropriate use of statistics, approximately 400 staff members or fellows are trained per year in one or more of the following courses:

- Web-based Collaborative Institutional Review Board Training Initiative (CITI) course that trains investigators in the ethical conduct of research
- NIH-sponsored course in principles and practices of clinical research
- Training in molecular biology techniques
- Training in statistics (basic and advanced courses)
- Courses to assist investigators in the execution of research and scholarly activities, such as the WRAMC "Portable" and the "Protocol Outreach" courses
- Instruction on current good clinical practice procedures.

Preservation and Coordination of Research Execution Functions

Nursing- and dental-specific research training and execution activities exist within the medical centers. The nursing and dental research activities at NNMC currently are staffed and operate within the Clinical Investigation Department. The nursing research activity at WRAMC is independent of clinical investigation, but collaborates in the research review and oversight activity. The plan through the transition is to incorporate these activities within the integrated DRO.

Bench laboratory research competency and capabilities also exist within the medical centers. The WRAMC maintains state-of-the-art laboratory services with space and equipment to support microbiology, immunology, and chemistry studies. In addition to providing research execution capabilities for staff and trainee projects, the laboratory services are also used in the research training mission. The laboratories themselves are used for training fellows and staff in modern techniques commonly used in molecular biology, protein chemistry, genomics, and immunochemistry. The JTF is currently tracking the demand for these services, projecting staff needs, inventorying equipment, and estimating space requirements.

Establishing Research Partnerships with Other Federal Agencies and the Civilian Community

Informal support exists in the medical centers for the many partnerships that exist to conduct research with extramural collaborators. In the future DRO, the mechanism for this informal support will become formalized. Collaboration with other federal and industry entities will be encouraged and facilitated through a DRO office of sponsored research. This office will facilitate enabling Cooperative Research and Development Agreements, Inter-Agency Agreements, Materiel Transfer Agreements, and other research partnership-related documents. If appropriate, the office will also provide oversight of extramural funding to ensure compliance with Federal Acquisition Regulations.

Perhaps the closest of projected partnerships is with the USU, which is on the north campus of the WRNMMC. Participation with the USU in a recent Clinical and Translational Science Award has clarified and advanced the research possibilities of this particular partnership.

Cooperation with sponsors of biomedical research such as the Army Medical Research and Materiel Command, the Navy's Office of Naval Research, the USU, the Defense Centers of Excellence, the National Institutes of Health, the Veterans Administration, and industry will be encouraged when interests

are aligned. The collaborations will be formalized through inter-agency agreements, memoranda of understanding, grants, and cooperative research and development agreements.

Collaborations with established, mutually beneficial partnerships such as with the US Military Cancer Institute, the Biospecimen Network, and the Infectious Disease Clinical Research Program will continue and be nurtured.

Process

The PROCESS dimension of change includes all of the activities that occur within the JOA to ensure that the needs of our people are being met by the creation of efficient JTF CAPMED operations. Within the process dimension, standardized processes and use of various tools such as the IMS and MTP for such activities as relocating patients, staffs, and services; managing transition; determining concepts of clinical and administrative operations; preparing for and conducting inspections; integrating staffs and services; assimilating cultures; and conducting the myriad other activities can be orchestrated effectively to reach FOC by 15 September 2011.

Currently there are thousands of individual processes in place at WRAMC, NNMC and DACH that ensure safe, state-of-the art medicine is occurring at these individual facilities. By merging not only two large medical centers (WRAMC and NNMC), but also establishing joint hospitals with integrated Service staff, the development of unified processes is imperative to mitigate risks, maintain accreditation and standards and facilitate a smooth transition.

This section of the MTP addresses the relocation plans, transition plans and the overarching processes requiring standardization. JTF CAPMED first addressed how and when to relocate patients and staff from WRAMC to WRNMMC at a transition wargame in February 2009. The wargame resulted in the recommendation to do a consolidated move of patients and staff from WRAMC to WRNMMC in the summer of 2011. To track and analyze the planning activities for the relocation of patients and staff, JTF CAPMED developed the Integrated Master Schedule. Staffs from JTF CAPMED, NNMC, WRAMC and DACH are currently in the process of establishing transition cells which will develop detailed plans of each move, including clinical activation and patient move checklists. Future versions of the MTP will include these plans in greater granularity.

The JTF CAPMED instituted the Joint Operational Planning Process to establish a systematic, fair decision making process. There are multiple working groups and cells analyzing and addressing numerous issues and processes that need to be standardized and tracked during the transition. These issues include, but are not limited to, external inspections, medical quality assurance, clinical and administrative concepts of operation, staff credentialing, and the development of joint issuances, patient administration and establishing the resource processes to support the JOA.

Relocation

JTF CAPMED, from its inception, has largely focused on the timely and effective relocation of services. In pursuit of this goal, the staff has participated in a broad array of activities focused on selecting an optimal move strategy, refining post-move departmental operations, sequencing the activities associated with the transition, and securing widespread buy-in for the transition plans. This section highlights some of the primary manifestations of this effort, including simulating and selecting a move strategy and the development of scheduling and project management architecture.

Moving forward, relocation efforts will likely align under a centralized transition planning office, encompassing transition SMEs and senior-level hospital administrators.

Wargame

In February 2009, JTF CAPMED sponsored a Wargame event to evaluate the merits and risks of the various WRNMMC transition strategies. The goal of the Wargame was to mobilize WRNMMC stakeholders to evaluate various strategies to existing transition services at WRAMC to their final location. The Wargame was designed to meet the following objectives:

- Explore strengths, weaknesses, and gaps of potential COAs for moving patients, staff, and equipment
- Identify and analyze levers that may impact various timelines
- Identify stakeholders' concerns—obstacles and derailers—with potential COAs, suggestions, and next steps
- Identify a preferred COA to best ensure access to medical services in the NCR.

A graphical depiction representative of the interdependent lanes of transition that were analyzed during the wargame, including DACH to the new FBCH, NNMC to the expanded WRNMMC, and WRAMC to FBCH and WRNMMC can be seen in Figure 8 below.

Current State vs. Future State of Healthcare Delivery in NCR

Current State: Two Large Medical Centers, Two Hospitals; Service Specific Staffing

| National Naval Medical Center *Large Medical Center* | Walter Reed Army Medical Center *Large Medical Center* | DeWitt Army Community Hospital *Hospital* | Malcolm Grow Medical Center *Medical Center* |

Merge and Expand   **Merge and Expand**   **Remove Inpatient Capacity**

| Walter Reed National Military Medical Center (Bethesda, MD) *Joint Military Medical Center* | Fort Belvoir Community Hospital *Large Joint Hospital Expanded Inpatient* | Malcolm Grow Clinic *Air Force (AF) Clinic No Inpatient* |

Future State: One Large Medical Center, One Large Hospital, One Clinic; Joint Staffing

Key
- Navy
- Army
- Air Force
- Joint Staffing

FIGURE 8 - CURRENT STATE VS. FUTURE STATE OF HEALTHCARE DELIVERY IN NCR

More than 130 stakeholders participated in the wargame, representing a mix of patients, Component clinicians (e.g., WRAMC, DACH, and NNMC), command staff, JTF CAPMED, administrators, logisticians, equipment planners, facility and construction experts. Throughout the four days, stakeholders were assigned to one of five teams (inpatient, outpatient, diagnostic and ancillary services, administration, and patients) and were asked to examine each COA and respond to specific questions.

A particular concern was meeting the intent of the FY 2008 NDAA Section 1674I), which requires that "patients, staff, bed capacity, functions, or parts of functions at WRAMC have not been moved or disestablished until the expanded facilities at the NNMC, Bethesda, Maryland, and DeWitt Army Community Hospital, Fort Belvoir, Virginia, are completed, equipped, and staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at WRAMC during fiscal year 2006."

The interim congressional report suggested several notional COAs. However, based on additional information, including an updated construction schedule and SME input, simulation participants evaluated three COAs. The COAs varied primarily in the duration of the planned move—ranging from an extended move of various services from as early as November 2010 and extending to August 2011 to moving all at once over the course of a long weekend in August 2011 (see Figure 9).

Simulation Transition COAs and Timeframes
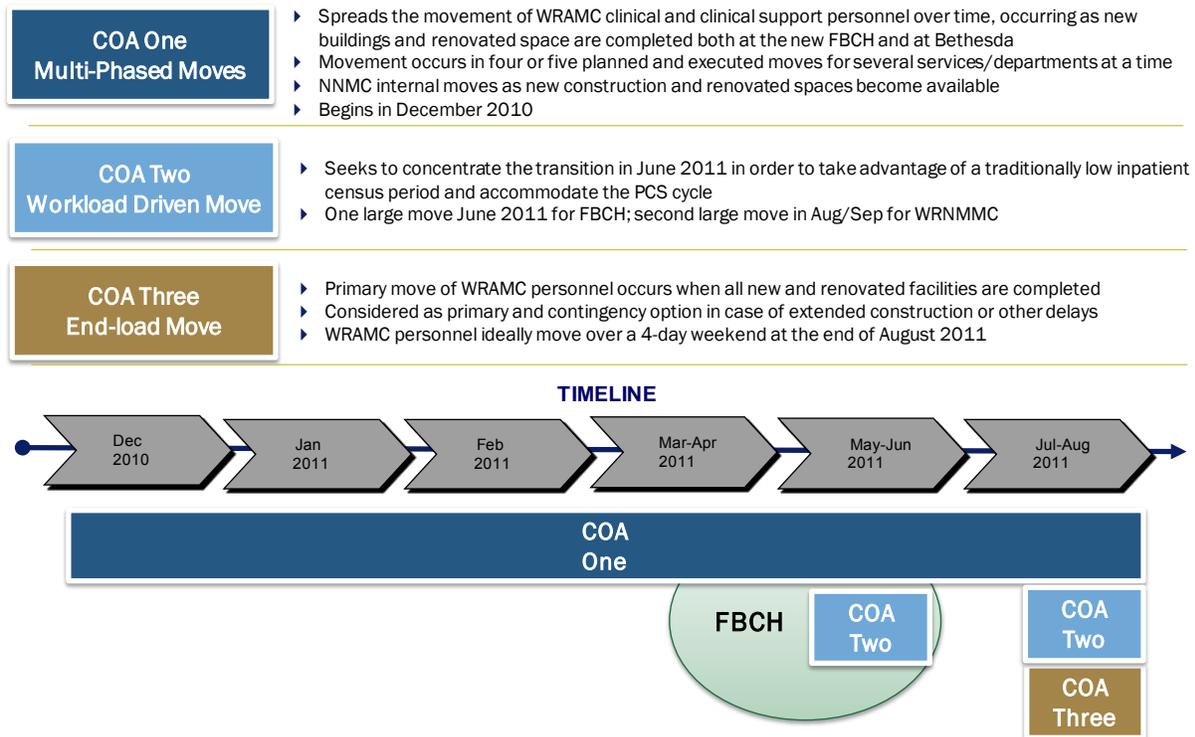
FIGURE 9 - WARGAME SIMULATION TRANSITION COA'S AND TIMEFRAMES

- COA One – represents a multi-phased approach that spreads the transition from WRAMC over a 6–8 month period. The "multi-phased" move requires completed construction and outfitting of all of FBCH and Buildings A and B at Bethesda. This option would occur in April 2011.
- COA Two – seeks to concentrate the transition in June 2011 to accommodate the Services PCS cycle and the GME) cycle (ending 30 June 2011) and take advantage of a traditionally low inpatient census period.
- COA Three – is the reverse strategy, end-loading the transition in the final month or so of the BRAC period. This "end-load" approach would occur in the August/September time frame of 2011.

ALL COAS OPERATE WITHIN THE FOLLOWING SET OF PLANNING ASSUMPTIONS:

- *Continuity of care will be 100 percent assured throughout the transition with minimum interruption in health service delivery.* While consideration may be given to sending patients out to the network, on an as-needed basis, this practice will be the exception, not the rule. The goal is to maintain the care of all WRAMC primary beneficiaries within the NCR to the greatest extent possible.
- *Internal moves at Bethesda and Fort Belvoir will occur as the space is made available at both campuses.* At Fort Belvoir, the transition will not occur until Building C, housing the inpatient, surgical, and most ancillary diagnostic services, is available. Given that the NNMC is already a fully functioning hospital, the transition will occur as each clinic/service is completed.
- *All certification, equipment testing, equipment training, and support system setup will be completed before the first patient day.* All activities relating to the installation, setup, and operation of both fixed and moveable equipment will occur in advance of any major patient moves from WRAMC.
- *Accreditation will be maintained or achieved.* The JTF will work with accrediting bodies, including The Joint Commission and the ACGME, ensuring that the WRAMC transition does not impede or negatively impact accreditation.
- *All staff training, including conducting "day-in-the-life" exercises (as necessary), will have been completed before the first patient day.* Day-in-the-life and other staff training will be conducted months prior to the first patient day, ensuring that staff has full knowledge and understanding of the "new" facility's layout, equipment, processes, etc.
- *A strategic communication plan will be executed.* A comprehensive strategic communication plan will be developed and executed, with appropriate messaging for all stakeholders affected by the WRAMC move, including WRAMC patients, their families, personnel, and the community.
- *Transition moves occur during times that minimize patient and staffing disruptions.* The physical movement of patients will occur ideally over a long weekend and/or at times to leverage a low patient census.
- *Resources ensuring the viability of the preferred COA will be provided.* Funding supporting an extended weekend move during the transition, e.g., extra shuttle services for patients, etc., will be provided to support the smooth efficient transition of patients.

- *All WRAMC primary beneficiaries will be accommodated in their final healthcare "home" by the BRAC deadline.* Most beneficiaries who previously had been enrolled with a primary care manager at WRAMC will be enrolled with a new primary care manager.

In any scenario, Warriors in Transition receiving only primary and secondary care should be relocated to Fort Belvoir (pending completion of the Warriors-in-Transition Center adjacent to FBCH) and Fort Meade (pending provision of similar support facilities at Fort Meade) as soon as facilities are made available to accommodate them. However, Warriors in Transition requiring tertiary services may need to remain at WRAMC until their consolidated Warrior Transition Center (dormitories, dining, and support facilities) are opened at the end of summer 2011. Likewise, services accessed by Warriors in Transition may need to be maintained at WRAMC until the warriors are transferred to WRNMMC. Essential Warriors in Transition services include all physical and behavioral care modalities, along with surgical and ancillary services. The DoD is fully committed to maintaining sufficient clinical, administrative, and support capabilities at WRAMC to care for Warriors in Transition until the replacement facilities or other locations are ready to assume their care. This level of support and clinical activity may affect transition actions at WRNMMC and FBCH.

Much of the wargame discussion focused on challenges associated with moving services in a phased approach (see Figure 10 - WRAMC to WRNMMC Transition Challenges). While some services such as the OR and cardiology *could* move as early as January 2010, related and interdependent services such as the inpatient medical surgical services and cardiac rehab will not be constructed and outfitted until August 2011.

WRAMC to WRNMMC Challenges
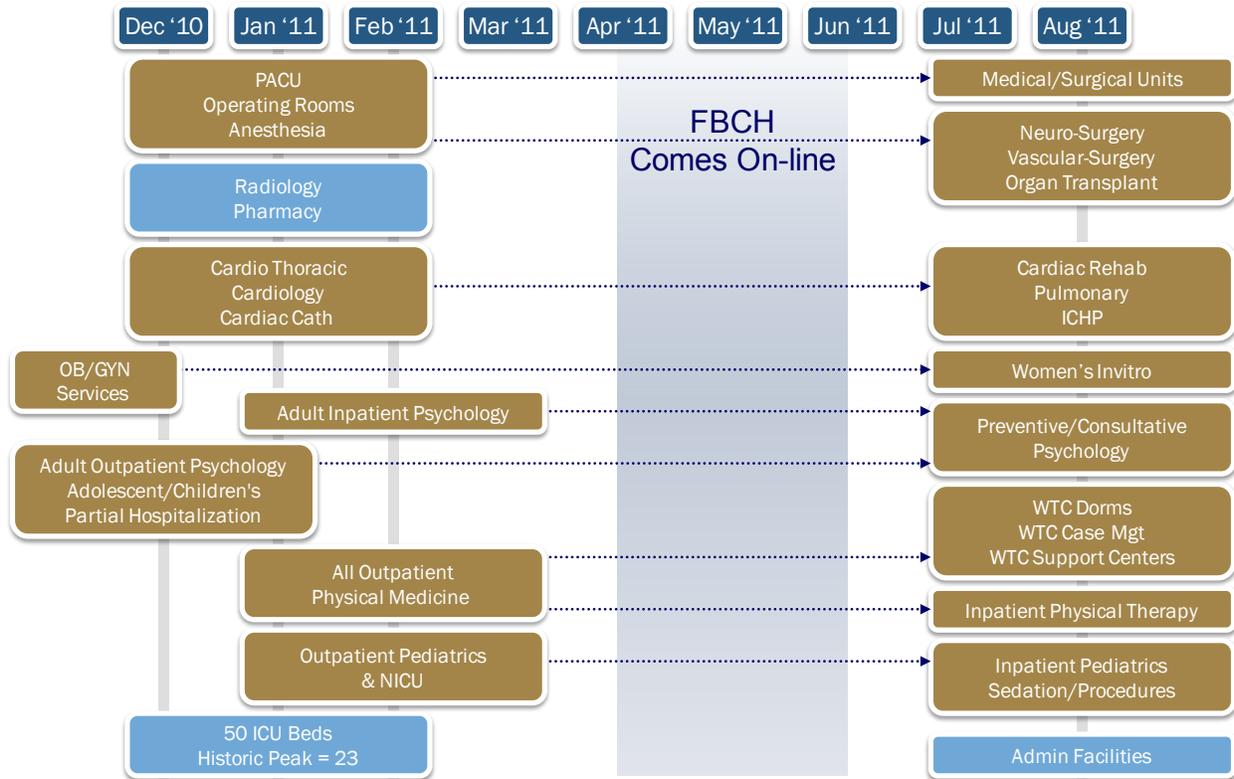
FIGURE 10 - WRAMC TO WRNMMC TRANSITION CHALLENGES

Various risks and mitigation efforts surrounding an incremental move were discussed during the simulation, which gave way to strategic thought and critical planning needs. Such discussion included the risk of losing Residency Review Committee (RRC) accreditation due to the loss of procedural volume, loss of staff supervision, and the loss of interdependencies at WRAMC. Basically, the consensus was that the longer the transition, the more the risk. A coordinated and synchronized clinical transition plan that ensures consideration of interdependencies could mitigate such risk. Another mitigating effort includes incorporating input from the RRCs into the "staff" plan to make certain that accreditation requirements are being met.

Similarly, another risk with an incremental move is the risk of losing clinical accreditations (e.g., blood bank, radiology, The Joint Commission, etc.). Again, the consensus was that the longer the transition, the more risk involved with losing accreditation. In addition to involving accrediting agencies in the "staff" transition plan, another mitigation effort would be to have single governance for the two MTFs. This solution would help in standardizing communication and developing common NCR-wide policies and procedures.

A protracted move spreads out the "inconvenience factor" for access to clinical services over a five-month period. This transition spread has the potential of decreasing patient satisfaction, decreasing the continuity of care, and increasing patient leakage/cost to civilian networks. Mitigation efforts for the inconvenience of a spread-out transition include developing a central appointing system and

implementing effective STRATCOMM messages to both internal and external community stakeholders (a longer move would require more STRATCOMM, more inconveniences, and greater risk for error).

Preferred Course of Action

After four days, the consensus among all stakeholder groups was to recommend a modified COA 3

- Fort Belvoir and Bethesda's internal moves should occur as new and renovated space comes online
- For Bethesda, these internal moves occur from spring 2009 through August 2011
- For Fort Belvoir, patients move from DACH to FBCH in April 2011 for outpatient services and diagnostic care and in June 2011 for inpatient care
- WRAMC functions transition to Fort Belvoir and Bethesda over a compressed time frame, ideally over one long weekend in late August/early September, following completion of several key trigger activities at Bethesda including:

  - Parking garages, Warrior Transition Center Complex, inpatient renovations, and administrative complex
  - Equipment installation, certification, testing, and training
  - Support system setups and commissioning
  - Building systems commissioning
  - Staff training, including "day-in-the-life" exercises

- To ensure that this COA is successful, all critical joint lines of operation must be resolved and in place
- Mitigation strategies to ensure sustained patient care will be developed by the MTF transition cells
- Attrition of inpatient census at WRAMC will occur prior to the consolidated move as inpatient spaces come available at NNMC/WRNMMC.

Following the four-day simulation, the principal directors of the Clinical Transition Wargame Exercise met with those senior leaders in the National Capital Area having joint oversight of the WRAMC transition. Attendees discussed the results of the wargame exercise and debated the way forward. Group consensus was that, other than by exception, services should not transition from WRAMC to WRNMMC and FBCH until critical trigger activities are completed at the Bethesda campus and/or mitigation strategies are leveraged. A key trigger activity is ensuring that essential clinical and supporting services are in place and fully functional. Several facilities, including staff parking garages and the Warrior Transition Center Complex, are not expected to be ready for occupancy until late summer 2011. The consensus of the group was that it would be risky to attempt to transition patients and staff with construction contractors still spread across the Bethesda installation and inadequate staff parking available.

Following completion of critical trigger activities, delivery of a "quick" transition is desired. While advantageous to shift services in phases over a longer period of time, the group discussed the identified industry standard to transition whole services all at once, over consolidated period of time. CJTF concurred with the concept and directed the transition team to provide supporting case studies and develop a detailed execution plan for all precedent activities and mitigation strategies required to facilitate a coordinated transition. Appendix D is the Transition Wargame Report 2009.

Justification of End-Move Strategy

The simulation participants believed that the chosen option best matched their knowledge of the hospital industry's approach to transition. To verify this, the JTF conducted a study of recent high-profile facility moves, with a goal of extracting a common set of lessons learned and best practices in merging and moving hospitals. Hospitals and health systems selected for the study were chosen for their similarity to WRNMMC/FBCH's situation. Most selected hospitals represented major, tertiary care facilities, whose moves involved the relocation of a large number of patients, furniture, and equipment to a renovated or replacement facility; some institutions involved the consolidation of multiple sites into one, and several had robust teaching programs.

Of the key study findings, nearly all administrators underscored the importance of minimizing the length of the patient move to a one- to two-day window, with an initial "soft" move of non-clinical administrative and support areas occurring two to three weeks prior to the move. According to those interviewed, extending the patient move any longer multiplies the potential for risk to patients, as the degree of concentration and synchronization needed to successfully move inpatients is not sustainable for an extended period of time. Even for outpatient services, there is value in an all-at-once "first patient day." The staff is prepared, energized, and motivated, and patients are excited about being in a newly opened/renovated environment.

In a few of these case studies, the move was virtually "across the street." Thus, it might appear that the NCR is in a more difficult position because it requiring a move "across town." Yet, on closer examination, these examples are equally compelling in favor of an "all-at-once move." In cases where a major medical center built its replacement facility "across the street" and moved over a weekend, that action, in itself, demonstrated that there was little or no advantage to transitioning services early or in a piecemeal fashion because otherwise that entity would have done so—being located just "across the street." Patients and staff could walk back and forth for complementary services and yet these institutions did not to exercise that option.

Other findings supported the importance of carefully sequencing inpatients during the physical move, the benefits of hosting strategically planned orientations and walkthroughs, the necessity of developing a robust move plan including contingency plans, and suggestions for how to effectively structure a transition team to promote efficiency. Finally, administrators reported a common set of challenges, including ensuring that all department heads faithfully carry out their individual move plans, maintaining patient-centered care in the existing facility, securing patient and family buy-in to the move, and managing the extent of the media's involvement with the move. Appendix E is the complete "Hospital Moves Best Practice Report"

Planning For Relocation and Transition

To facilitate planning, JTF CAPMED developed the Integrated Master Schedule (IMS) and is assisting the three MTF's to establish transition management offices. The Physical Infrastructure of this MTP contains the relocation plans for patients and staff based on construction milestones. Transition managers from the three MTFs are meeting and developing detailed relocation plans based on process standardization for patients and staff which will be included in future versions of the MTP.

Plans take into consideration several key events dictated by BRAC recommendations. Leading up to the final BRAC implementation date of 15 September 2011, the DoD anticipates that the design for both WRNMMC and FBCH will be completed during 2009. It also expects construction and renovations to be completed between the beginning of 2010 and August 2011. Efforts continue to meet all BRAC-imposed deadlines. The IMS and MTP will both facilitate plans, execution and implementation of all the activities required to meet the BRAC deadline.

In evaluating the move, it is crucial to understand that there are a number of services that will be new to FBCH such as oncology and critical care. Also, the relocation of patients and staff from WRAMC to WRNMMC is a complex process which will require detailed, adaptive plans. These relocation plans will entail dedicated staff training, equipment testing and certification, transition services and clinical activation checklists and any associated licensing and credentialing. Mitigation strategies to ensure safe, continuity of patient care during the transition will also be developed.

Integrated Master Schedule

The IMS (Tier 2) is a project schedule that aggregates and integrates all of the detail, discrete work, and planning activities supporting the execution of events and leading to the successful transition of WRAMC to the new WRNMMC and FBCH. The IMS tracks milestones (Tier 1) and assimilates tasks from multiple schedules (Tier 3), including geographic and JTF functional schedules into one master schedule as shown in Figure 11 – Schedule Framework.

Schedule Framework
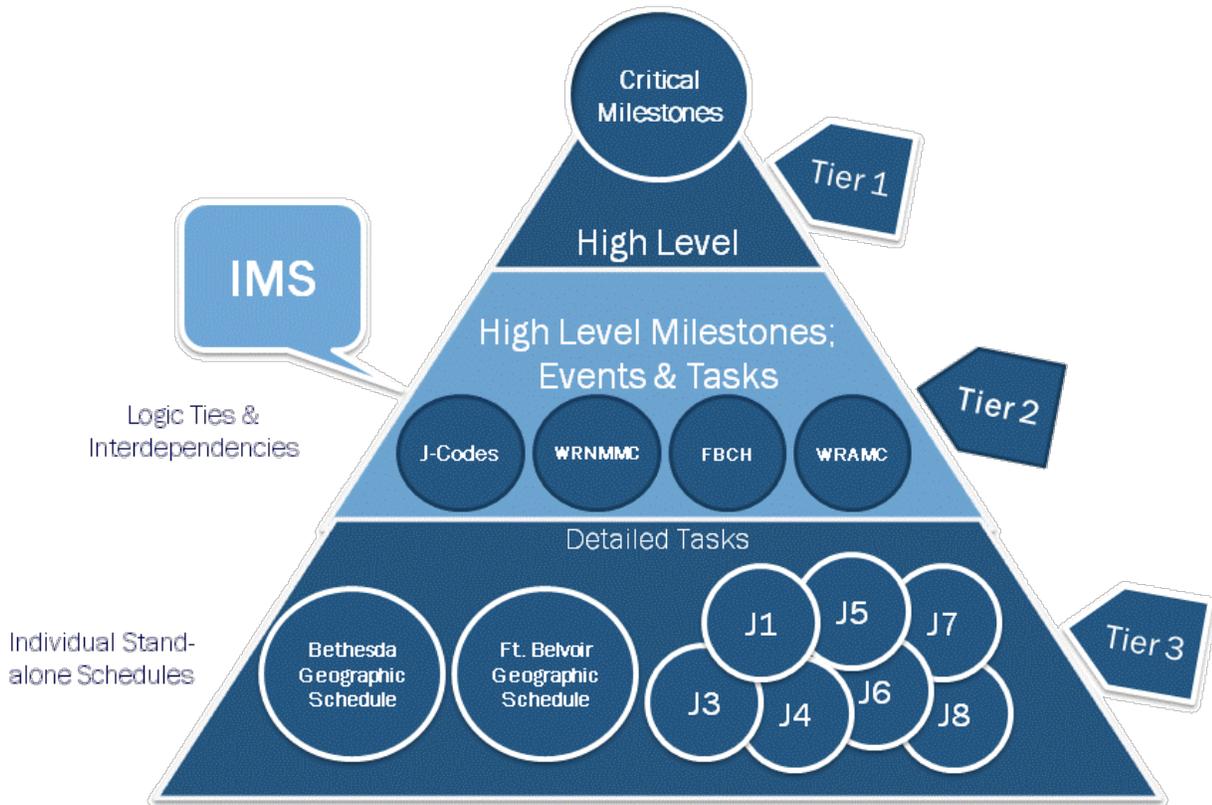
FIGURE 11 – SCHEDULE FRAMEWORK

Each task on the IMS has a discrete beginning and ending date. Task information flows from individual schedules that are integrated through logic ties known as interdependencies (predecessors, successors, and constraints). IMS project schedule data resides in a database on a server and can be aggregated and sorted. It can produce numerous project schedules and reports, thus providing information at varying levels and in varying formats for different stakeholder groups. This live database is updated monthly to reflect progress and maintain plan consistency.

The IMS Information comes from a variety of sources. Primary sources include the JTF CAPMED Senior Staff, Division Heads, and Action Officers; Component Commanders and Deputies; the DCIs; Project Office Staff; Naval Facilities Engineering Command (NAVFAC); and the Army Corps of Engineers. Secondary sources include the Health Facilities Project Office (HFPO), the Health Facility Planning Agency (HFPA), and other contractors.

The IMS provides JTF CAPMED, WRAMC, Fort Belvoir, and NNMC, as well as other stakeholders, with an understanding and appreciation for the complexities and interdependencies among various stakeholders, including the JTF J-Codes, WRAMC, Fort Belvoir, NNM Component Commanders and staff, the DCIs, the Construction Project Offices, and outside stakeholders, including TMA, HA, MHS, and others.

Geographic Schedules: Five (Tier 3) geographic schedules are under development: the WRAMC move, the NNMC to the new WRNMMC, the WRNMMC gain, the DACH to the new FBCH, and the FBCH gain. Also note the following about the geographic schedules:

- The move schedules report tasks associated with functions leaving from or relocating at the respective location. Schedule components include clinic/service/room location, equipment/furnishings/staff, and associated tasks for activities, including training and relocation.
- The gain schedules report tasks associated with functions arriving at respective locations. Schedule components include design, construct, equipment, manpower, and transition.
- The primary focus of geographic schedules is BRAC tasks. However, non-BRAC tasks or other actions will be included to the extent that they affect BRAC execution.

JTF Schedules: Each J-Code is developing a detailed schedule (Tier 3) that includes detailed project activities that support the critical milestones, objectives and tasks in Tiers 1 & 2.

> **Milestone**: A significant event that marks progress in a project. Mission-critical milestones are activities that must occur for the project to be successful. Timely completion of critical milestones will result in an effective transition of WRAMC, DACH, and NNMC to the new FBCH and WRNMMC and a transformed and integrated joint healthcare delivery system.
>
> **Objective:** A concrete statement describing an element that the project is trying to achieve
>
> **Task:** A cohesive, individual unit of work that is part of the total work needed to accomplish an objective.

Given the interdependencies among and between J-Codes for tasks and activities associated with the WRAMC transition and integrated health system transformation, the IMS will facilitate and encourage cross-code collaboration.

People, Process, Technology, and Physical Infrastructure

The people, process, technology, and physical infrastructure dimensions are key enablers that JTF CAPMED will use to fulfill its mission (see Figure 12). These dimensions of change describe many features that work together to enable an organization's capabilities:

- People – organization structure and human capital management (e.g., workforce planning, leadership development, recruiting, performance management, training and development, reward systems, labor relations, and diversity management)
- Process – business activities performed by the enterprise, including associated sequence, rules, data, and metrics information
- Technology – data, applications, and technical infrastructure
- Physical Infrastructure – places and environments where the enterprise workforce (e.g., employees, contractors, mission partners, and service providers) performs work.

People, Process, Technology and Physical Infrastructure Dimensions

People
- Wounded Warriors
- Caregivers
- Joint Leadership
- Manpower— Military & Civilian
- Requirement for new skills
- Education Training & Research

Technology
- Medical equipment technology evolution or innovation
- Information management and Information Technology

Process
- Relocation & Transition
- Integrated Master Schedule
- Master Transition Plan
- New Concepts of Operation
- Business Rules

Physical Infrastructure
- Design, construction
- Enhanced facilities
- Space utilization

FIGURE 12 - PEOPLE, PROCESS, TECHNOLOGY AND PHYSICAL INFRASTRUCTURE DIMENSIONS

Monitoring milestones and tasks along these four dimensions will ensure that interdependent tasks are effectively coordinated across J-Codes and that tasks have the participation of the appropriate stakeholders to accomplish the mission.

JTF CAPMED Decision-Making Process

Since the inception of JTF CAPMED, integration planning has been carried out by military and civilian personnel representing the JTF and by various MTFs across the JOA. These people have been organized into JPGs and work groups aligned under the various J Directorates that have directed their work. Many of these individuals began their work under the Office of Integration or the MSMO and carried it to the JTF once the JTF became an active entity. Without the work from these groups, the JTF would not be able meet BRAC requirements or build a new MHS in the NCR.

JTF planning and decision making is being accomplished using the Joint Operation Planning Process (JOPP) as found in Joint Publication (JP) 5.0, Joint Operation Planning. The basic steps of the JOPP are as follows:

1. Initiation – The process kicks off by an event that provides guidance or direction to develop a COA to achieve an objective
2. Mission Analysis – Senior stakeholders provide a common sight picture. Threat vulnerability analysis identifies critical requirements, capabilities, and vulnerabilities. Vulnerabilities are categorized for further analysis, and SMEs assist with the process.
3. COA Development – Lines of operation (LOOs) are developed for each critical vulnerability. LOOs are logical lines that connect actions related in time and purpose with an objective. A COA is developed for each LOO during this step.
4. COA Analysis and Wargaming – In this step, advantages and disadvantages for each COA are identified. During wargaming, each COA is subjected to a rigorous application to real-world situations to gain better insight of its desirability and possible unintended consequences.
5. COA Comparison – The strengths and weaknesses of each COA are identified, and the COA with the highest probability of success is identified.
6. COA Approval – The recommended COA is presented to the CJTF for approval.
7. Plan/Order Development – A decision memorandum is written and signed by the CJTF for implementation within the JOA.

Generally, step 1 is completed either by the CJTF or the J Directorates. Steps 2 through 5 are carried out at the work group level, and the work is brought back to the JPG for initial approval and presentation to the JTPB for either approval or forwarding to CJTF for decision. The JTPB membership includes the JTF CAPMED HQ J Code Directors, the DCIs at the three MTFs, a USU representative, and ad hoc members. The Chair of the JTPB is the J5 Director. Once a decision is made by either the JTPB or the CJTF, a decision memorandum is written to communicate the decision to the appropriate lead (see Figure 13 - JTF CAPMED JPG Process).

JTF CAPMED JPG Process
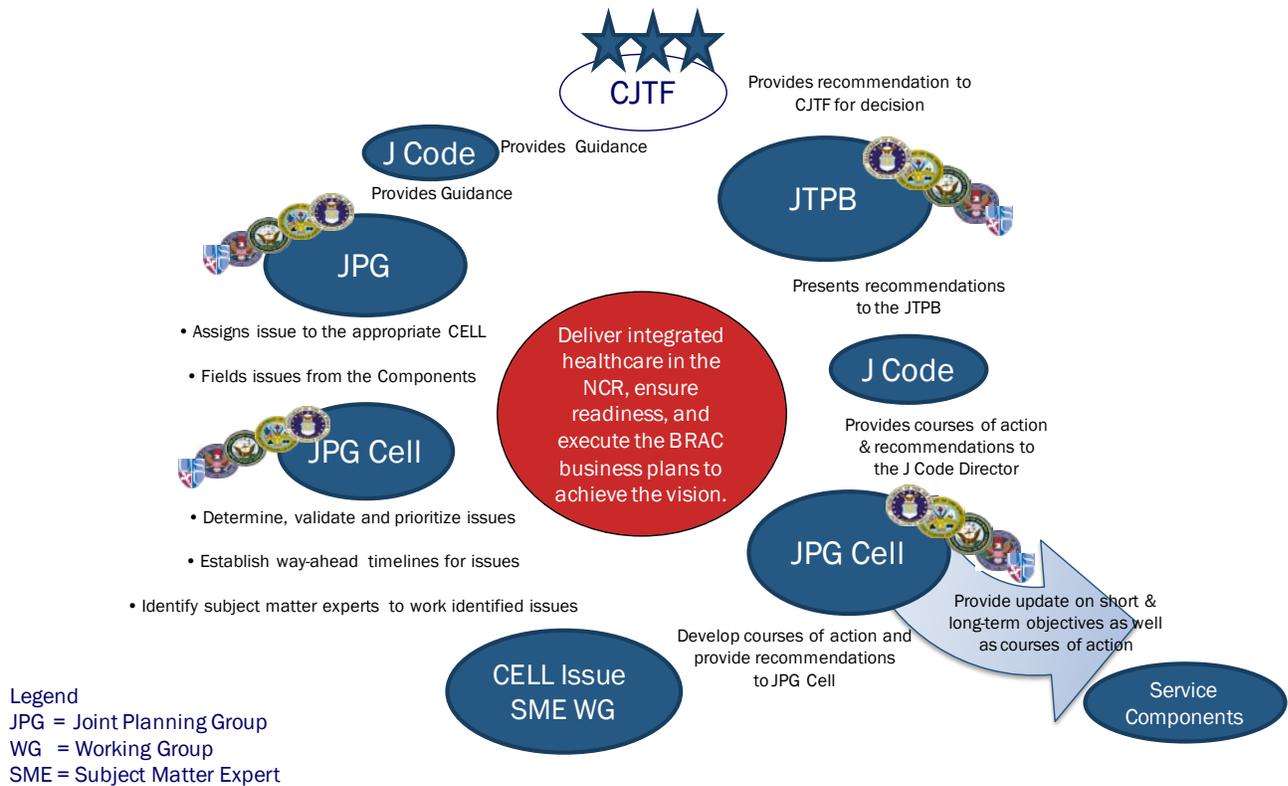
FIGURE 13 - JTF CAPMED JPG PROCESS

JTF CAPMED Headquarters Directorates

JTF CAPMED is organized into seven Directorates, roughly following the pattern shown in figure II-1 of JP 5-00.2, Joint Task Force Planning Guidance and Procedures. The Directorates are established as follows:

J-1	Manpower & Personnel
J-3	Operations
J-4	Logistics and Facilities
J-5	Plans & Policy
J-6	Communication Support (IM/IT)
J-7	Education, Training & Research
J-8	Resources

Each of these Directorates oversees a JPG that is headed by its J Code Director and generally consists of staff members from within the Directorate and staff members from other Directorates who serve as

liaisons for coordination and planning purposes. The purpose of these JPGs aligns with what is stated in JP 5-00.2, that Joint Planning Groups "…assist in planning and other directed tasks." As a rule, the seven JPGs provide direction downward to various work groups and receive the finished products of those work groups, which are then presented to the JTPB. Usually in the form of decision briefs, these products contain recommended COAs for the CJTF to consider and adopt for application throughout the JOA.

Many of the JPGs require work groups in order to have the correct mix of SMEs to adequately perform the JOPP analysis of a particular event or challenge. Generally, the work groups are chaired by a member of the JPG and consist of military and civilian personnel from JTF CAPMED and from MTFs and other organizations and facilities located in the JOA. The work groups analyze the mission or situation, develop the COAs and conduct a Wargame, compare the COAs, and make recommendations back to the JPGs about which COAs they consider preferable to meet the mission or situation. The work groups are either developed as standing groups or as groups that meet to meet the JOPP requirement and then disband. The various work groups aligned with their J Code are listed in Appendix F – Joint Planning Groups.

Conclusion

The bulk of the JTF's work is carried out in the working groups, where SMEs from various organizations collaborate to solve complex issues. As new issues arise, additional work groups will be formed to address them.

Transition Management

Having critically evaluated various transition strategies against criteria and chosen an optimal COA for transition, administrators are now developing the administrative infrastructure that will guide the transition plan through execution. As of June 2009, all plans are still notional, but the goal of the JTF is to institute a transition management structure by July 2009.

During the transition from four Service-specific MTFs to two joint facilities, staff and patients from the current four inpatient MTFs will relocate into one new MTF (WRNMMC) and one significantly expanded and modified MTF (FBCH). While most healthcare mergers merely append the operations of the acquired entity to those of the acquiring entity, the JTF is pursuing a "best practices" integration of three Services, while striving for transformational advancement in the process. At the center of the proposed hub-and-spoke structure is a Joint Integration Team (JIT), composed of subject SMEs with experience in hospital mergers and moves (see Figure 14).

FIGURE 14 - JOINT INTEGRATION TEAMS FRAMEWORK

This JIT will serve the crucial function of unifying the key functions and work groups involved in the transition. The JIT will synthesize the input of senior-level health system administrators (e.g., DCIs, DCAs, Non Commissioned Officers, Integrated Department Chiefs), manage the activities of transition teams and work groups, ensure the timely resolution of manpower- and space-related concerns, oversee the execution of CONOPS-related concerns, and maintain consistent oversight of the J-Code schedules.

Internal Transition Coordination

Combining the eight physical transition moves with desired integration across the three Services to meet transformation goals makes this transition a uniquely complex process.

The physical transition is being managed by BRAC Project Management Offices (PMOs) and Transition Cells at Bethesda and Fort Belvoir. The Army's HFPA has the most experience in managing large transition projects within the DoD, and the physical move is following its historically formulated guidance to establish and operate transition cells at the two receiving sites. Project offices and transition cells routinely interact and overlap in their responsibilities. And, given that there are two receiving sites in this transition, all transition and integration activities must be coordinated between the two transition cells. Figure 15 summarizes the typical project office and transition cell responsibilities.

Traditional Transition Office Responsibilities

Clinical	Administrative
• Staffing Realignment • Policies & Procedures • Patient Moves • Patient/Community Outreach • Patient Safety • Clinical Dept Coordination Teams • Regulatory Standards & Licensing • Health Professions Education, Training & Orientation • Research	• Central Appointing • Staffing Realignment • Policies & Procedures • Finance • Case Management • Supply Chain/Logistics • IT Integration • Records Management • Training & Orientation • Food Services • Housekeeping • Volunteer Management

Traditional Project Office Transition Responsibilities

Building Commissioning, Outfitting & Activation

- Transition Move Coordination (non-patient)
- Medical Equipment Acquisition & Installation
- Non Medical Equipment Acquisition & Installation
- Technology Readiness
- Building Readiness
- General Services Readiness
- Disposal/Surplus
- Facility Policies & Procedures

General Transition Management

- Risks & Issues Management
- Schedule Integration Management
- Project & Staff PAO Communications
- Contract & Budget Management
- Project Reporting
- Tasker Management
- Change Management
- Security
- Transition Coordination

FIGURE 15 - PROJECT OFFICE AND TRANSITION OFFICE RESPONSIBILITIES

The two project offices will stand up several transition teams and work groups, many with significant commonalities. Figure 16, Figure 17, Figure 18 and Figure 19 illustrate the organization of these transition cells.

NNMC Transition Cell

Transition Coordinator
Surgery Department

Transition Coordinator
OB/GYN Department

Transition Coordinator
Department of Medicine

Transition Coordinator
Department of Behavioral Health

Transition Coordinator
Department of Pediatrics

Transition Coordinator
Pharmacy

Transition Coordinator
Lab/Pathology

Transition Coordinator
Radiology

Transition Coordinator
Operating Room/CMS

Transition Coordinator
Wards

Transition Coordinator
Intensive Care Units

Deputy Commander Integration

Transition Manager

Transition Moderator

Executive Assistant

Program/Project Manager

Healthcare Administrator

Project Scheduler

Education Coordinator

Clinical Integration Coordinator

RFP #1 Project Manager

RFP # 2 Project Manager

Transportation Coordinator

Administration Coordinator

Marketing Leader

Archivist

Admin Assistant

Admin Assistant

Integration Project Manager for Moves

Integration Project Manager for Clinical Activation

Graphics Designer

Writer

FIGURE 16 - NNMC BETHESDA TRANSITION CELL

FBCH Transition Cell - HFPO
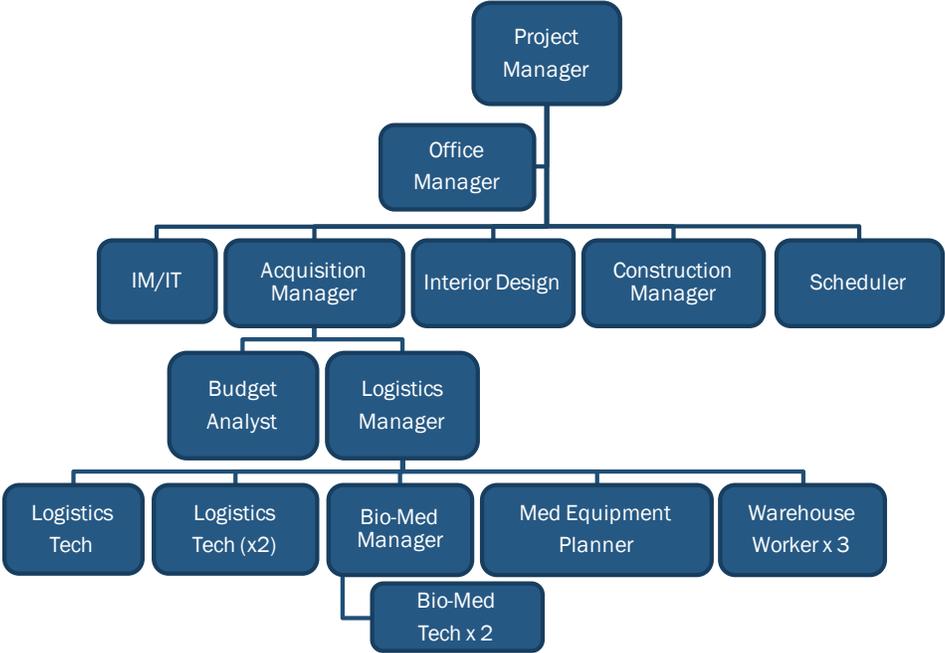
FIGURE 17 - FBCH TRANSITION CELL - HFPO

FBCH Transition Cell - Dewitt
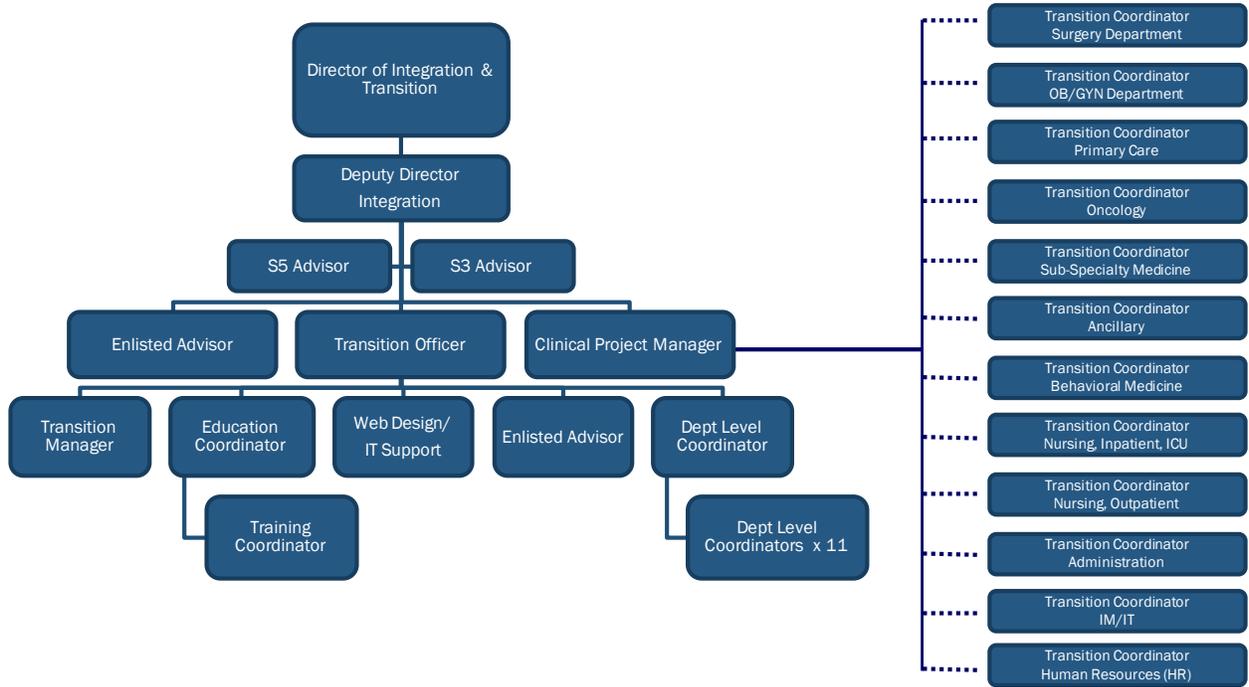
FIGURE 18 - FBCH TRANSITION CELL

WRAMC Transition Cell
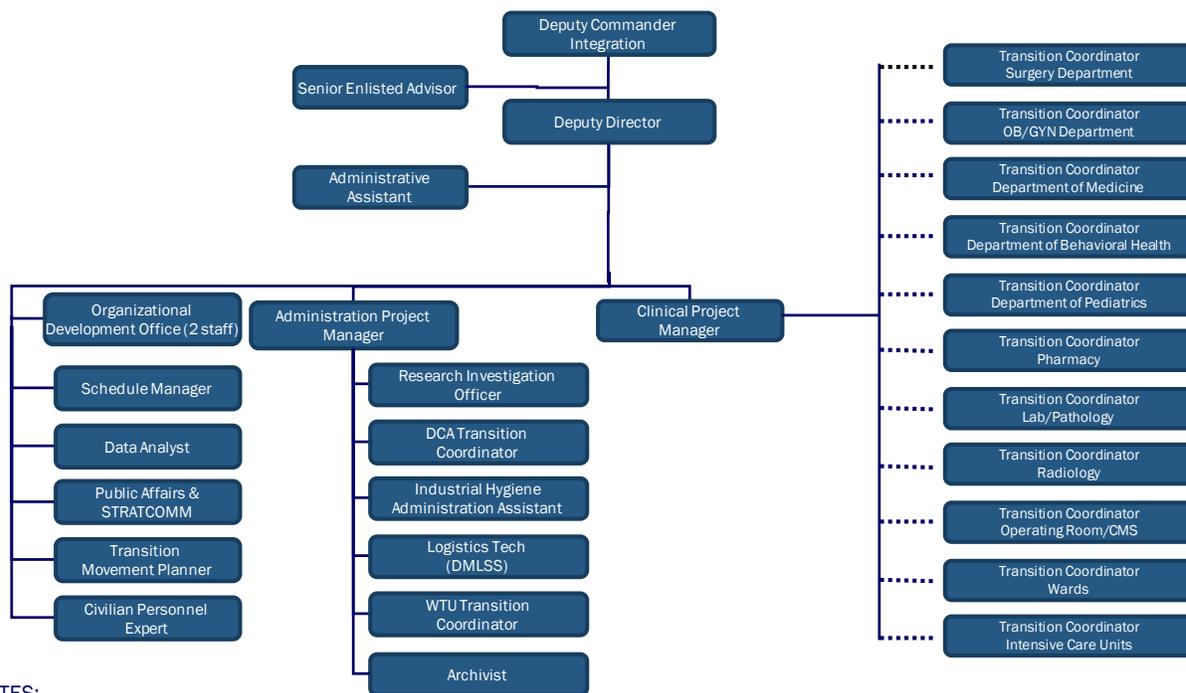
FIGURE 19 - WRAMC TRANSITION CELL

WRAMC is close to fully staffing its own transition cell. As the primary "divesting" MTF, WRAMC must take special care of the needs of its staff and patient populations. Roughly 4,500 staff alone will relocate from WRAMC to FBCH and WRNMMC. Part of the composition of WRAMC's transition cell are 13 Departmental Coordinators who will serve as the primary sending site's representative for all aspects of transition and integration that affect WRAMC's services and patients. Additionally, the JTF is in the process of initiating a contract to hire Departmental Coordinators to represent the two receiving sites. A minimum of 10 coordinators will represent the Deputy Commander distribution of the now organizational structure of the two joint MTFs. There are seven deputy positions under the new structure; however, the Deputy Clinical commander has the broadest range of responsibility, including surgical, medical, behavioral health, and ancillary services. An individual coordinator will be established under each of these clinical subdivisions.

The two receiving site transition cells, together with the project offices, will be organized to address transition and integration requirements from the "people, process, technology, and physical infrastructure" lanes

Transition Contract Support

The JTF is also securing contractor support for a JIT PMO for oversight and guidance. This PMO will include representation from a civilian transition services entity with robust experience in large complicated

transitions with national significance. The PMO will ensure that the JTF leverages industry best practices and guidance throughout the transition. At least one Systems Architect/Engineer (A/E) and Scheduling Director will be included on the PMO staff. It will operate under the direction of a Project Execution Board consisting of the current DCIs from the four hospitals and the J3 (Operations), J4 (Logistics and Facilities), and J5 (Plans and Policy) JTF Directors. This board will report to the DCJTF, with the JTF J4 functioning as the DCJTF primary lead and the Contracting Officer's Representative (COR) for all JTF sponsored transition and integration contracts (see Figure 20). Formal connectivity between the Project Execution Board and the equivalent Deputy Commanders at the four MTFs will be established.

Transition Support
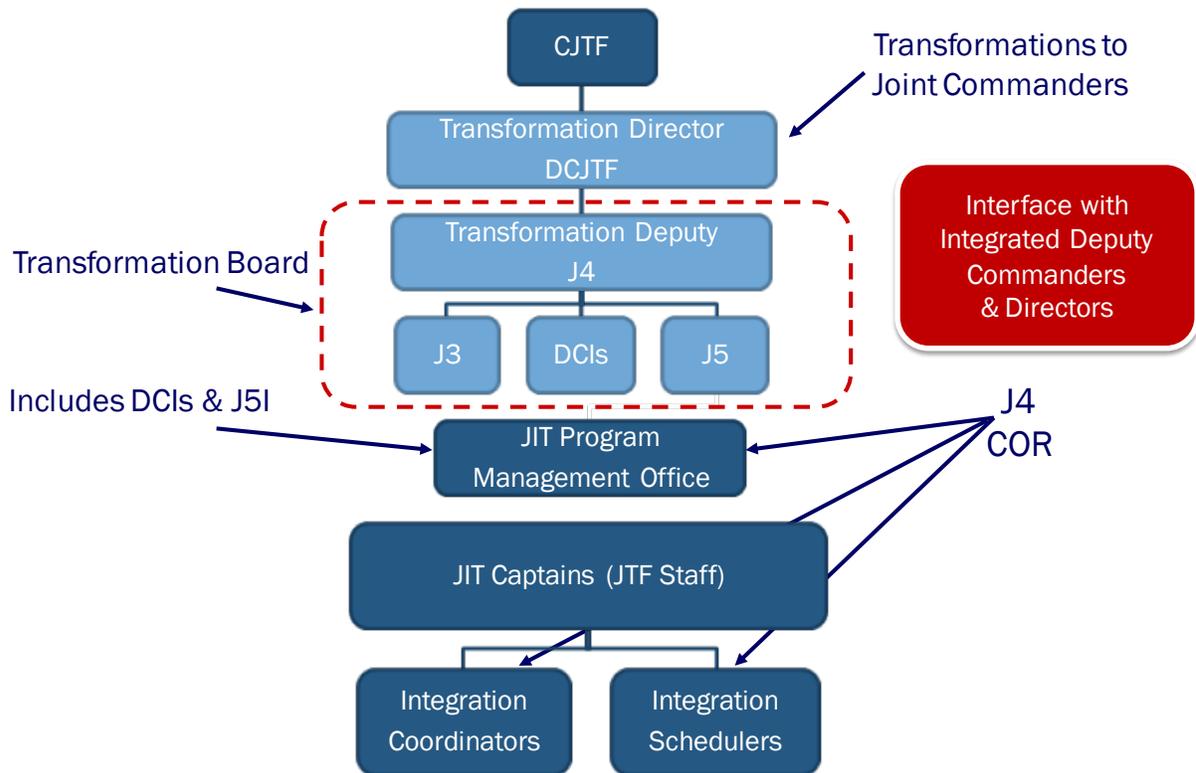
FIGURE 20 - TRANSITION SUPPORT

The sending and receiving Departmental Coordinators will act in unison, with organic coordinators from the JTF, Components, and MTFs, as JITs responsible for full integration of all activities occurring at the Project Offices, transition cells, JPGs and cells, and all Departments and services. They will ensure that all required products to support transition and integration are appropriately and adequately addressed in these domains. Figure 21 shows the notional relationship between the transition entities and example products.

Joint Integration Teams
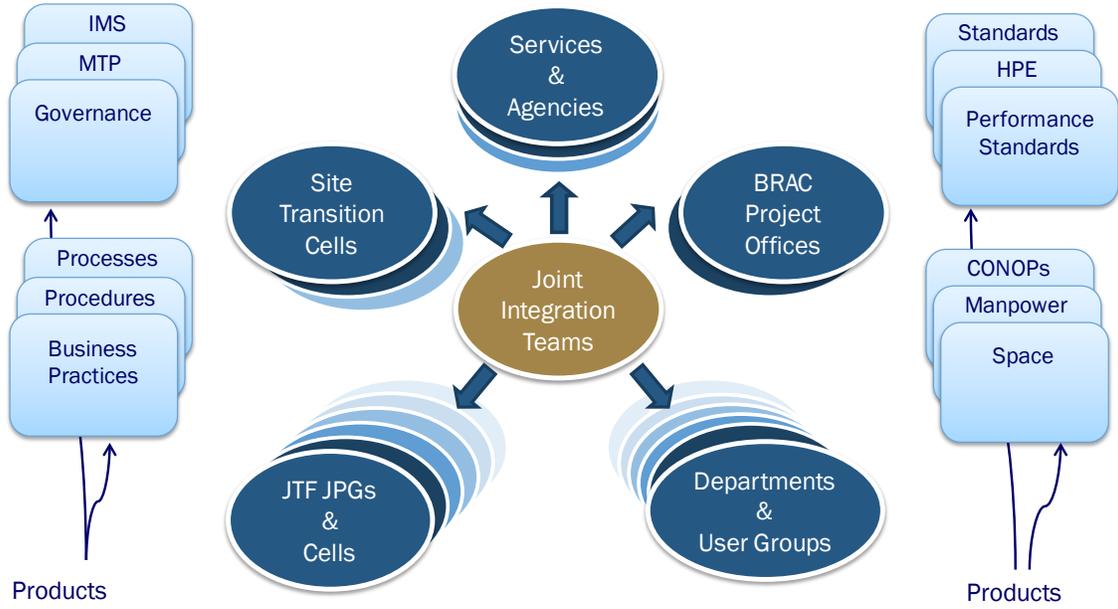
FIGURE 21 - TRANSITION RELATIONSHIP MATRIX
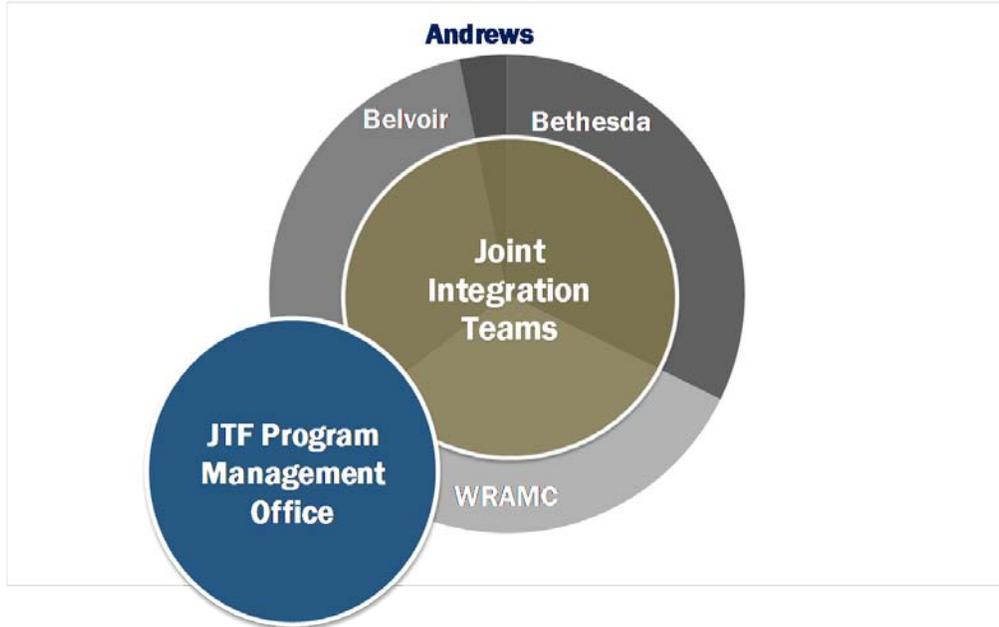
FIGURE 22 - TRANSITION CELLS AND JTF PMO

The JTF's existing transition and integration contract support staff has been instrumental in facilitating several baseline activities, including planning integration conferences, hosting clinical transition simulations, and analyzing industry best practices in transition. Every day, this contract is focused on designing, building, and maintaining the JTF's IMS. In addition to capturing the physical elements of the project, the IMS captures all the activities of the JPGs and cells. In this way, it provides a comprehensive map of all transition and integration activities occurring across all domains. As receiving site transition cells and JITs are formed, the JTF will need to further increase its scheduling and coordination capabilities, but since the current contract cannot be further expanded, other contracting vehicles will be used to augment transition efforts. .

The JTF, along with the U.S. Army Medical Research Acquisition Activity (USAMRAA) and TMA, is procuring initial outfitting and transition (IO&T) services to support the receiving MTFs. This contract will include support for the following tasks:

- Facilitating hospital transitioning and activation
- Provisioning/installing materiel, furniture/furnishings, and medical, non-medical, and IT equipment
- Providing initial transition and equipment training (operations and maintenance)
- Moving reused equipment and materiel to outfit the receiving MTFs.

This acquisition will be conducted though a full and open procurement to all interested and responsible sources. The Government intends to award a single award under a Cost Plus Incentive Fee contract with a period of performance that will begin approximately 14 November 2009 and run through 13 November 2010 with two one-year option periods. Most transition activities related to the physical movement and activation of "things" will be managed under this contract.

With an initiation date of November 2009, this contract will be in place well in advance of the completion of FBCH facilities and the first additions and major renovations at WRNMMC. IO services required for preliminary and phasing moves in advance of these major moves are being supported by various partners, including the Defense Supply Center Philadelphia (DSCP)/Navy Medicine Logistics Command (NAVMEDLOGCOM) and the US Army Corps of Engineers (USACOE) (Norfolk). The JTF is optimistic that the IO&T procurement strategy will yield favorable monetary results. By packaging most of the physical IO&T requirements under one contract, the JTF is allowing prospective contractors to realize huge purchasing discounts due to the scale of the contract. This benefit, combined with the insertion of a profit sharing element within the contract, should ensure a favorable outcome from a cost. Figure 23 illustrates the transition time line with respect to the existing transition contract, the forming JIT structure, the move and activation transition services, and the implementation team.

JTF Transformation Timeline
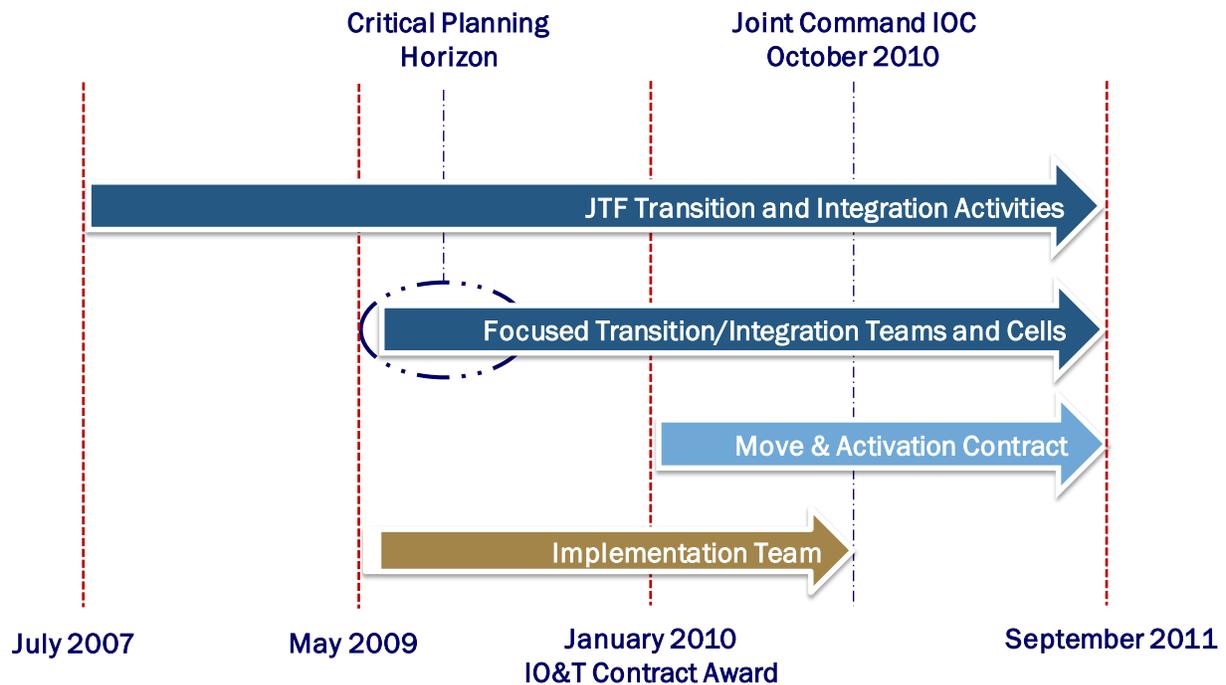
FIGURE 23 - TRANSFORMATION TIMELINE

Analysis of Capabilities across the Entire Transition Period

Moving forward, a key imperative for administrators will be to ensure that high-quality care is maintained at each facility within the JOA during the entire transition period. To maintain continuity of care, administrators are focusing on three areas:

- **Outpatient capacity analysis** – Given the far-reaching network of the Services' outpatient clinics throughout the JOA, it will be crucial to systematically track and project clinic volumes and capacity as the transition approaches. This information will serve as the foundation of the JTF outpatient transition strategy and will enable administrators to make well-informed choices for how to reroute patients from their existing clinics to their new clinics and for how to sequence the moves of interdependent clinics.

- **Inpatient capacity analysis** – While the volume of inpatients to be transferred between facilities during the transition is minimal as compared to the number of outpatients, administrators must also ensure that adequate inpatient capacity is secured at the time of the move. For this reason, bed utilization data, by ward and by month, will be analyzed to help inform the transition strategy.

- **Continuity of care tracking** – Maintaining continuity of care throughout the transition is one of the JTF commander's key priorities. Apart from pure capacity analysis, a variety of other quality-of-care metrics—including clinical quality indicators, patient satisfaction scores, and average wait times—will be monitored to ensure that the standards of care delivery are sustained before, during,

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and after the transition. The JTF, in collaboration with contractor staff, is currently developing systems to track these metrics.

Integration

To successfully transition from four Service-centric military MTFs to two joint facilities, the JTF must ensure a process that will entail more than just the physical move or transition of staff, equipment, and patients, but the development of standardized policies and procedures and unified business practices across the JOA. Each Service has specific policies and traditions that shape the patient care environment at the individual Service-specific facilities. With joint facilities, a strategy for a new way of doing business is necessary to fully achieve integrated healthcare throughout the NCR. Three goals will help the JTF formulate this strategy. The first goal is to establish joint leadership to ensure integrated clinical and administrative practices and standard CONOPS discussed in the *People* section. The second goal of the strategy is to homogenize all issuances and directives to improve patient care and decrease the risk of Service-specific "ways of doing things," which cause unnecessary turbulence during the transition and beyond. Equally important in this second goal is to monitor and track all external inspections of the commands impacted by the transition to ensure that medical standards of care are sustained across the transition period. The third goal is to merge staff, including all three Services' civilian and contract employees into a joint, unified team focused on providing world-class patient care, while also understanding Service differences and leveraging the best-of-Service practices and cultural norms.

Issuances

JTF CAPMED faces a significant challenge in the creation of a standardized set of joint medical issuances (directives, instructions, manuals, etc.) throughout the JOA, and in particular, at Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). Each service's governing instructions, policies and regulations have a distinct tone consistent with the jargon of its particular service.   Although the four existing inpatient military medical treatment facilities received fully accredited status from the Joint Commission, each got there in a significantly different way. The following is a breakdown of existing policies, directives and instructions by individual facility:

Walter Reed Army Medical Center	236
Dewitt Army Community Hospital	169
National Naval Medical Center	341
Malcolm Grow Medical Center	141

JTF CAPMED faces the challenge of reviewing hundreds of issuances from multiple installations and arriving at an appropriate set of issuances to govern WRNMMC and FBCH in a manner that facilitates world-class healthcare.

Implementation Plan for JTF CAPMED Issuances

Initially, personnel assigned to WRNMMC and FBCH will utilize JTF CAPMED issuances and then develop their own as necessary. Over the next 12-18 months, existing Army, Navy & Air Force issuances will be translated into joint issuances that assigned staff from both facilities will use in the execution of their missions.

The challenges faced by the JTF Issuances work group stem from Service culture and nomenclature. Each Service has a unique process for updating their medical issuances and each service Medical Treatment Facility received higher headquarters guidance on how facilities should be administered. While all Military Medical Treatment Facilities strive for accreditation from the Joint Commission (And other functional-specific governing bodies), their approaches are different and these differences provide a

challenge in integrating more than 800 existing policies, regulations and instructions into a standardized library of JTF CAPMED joint issuances.

This comprehensive re-write of issuances will assist the JTF in fully preparing for the transition effort as the sheer magnitude of the re-write will ensure a complete top-to-bottom review of all issuances necessary to manage MTFs throughout the NCR and anywhere in the JOA.

External Inspections

Between 1 March 2009 and 15 September 2011, BRAC-affected MTFs in the NCR will undergo at least 85 visits by 42 different inspecting agencies. These agencies will visit and inspect installations, facilities, programs, clinics, services, and equipment. Most of these inspections affect the accreditation required to provide care for warriors and their families in the NCR. As we transition from four Service-specific facilities into two joint facilities, it is imperative that the JTF CAPMED be prepared for these inspections and not, though a lack of preparation or distraction, inadvertently create a situation that would negatively affect one or more of these inspections.

These inspections have a number of stakeholders to keep in mind (see BRAC MTF Integrated Accreditation Inspections). Up until 15 September 2011, 26 GME programs will be undergoing accreditation inspections. Failure to pass accreditation not only affects the programs, but also it reduces the number of specialty physicians for all military Services and the Public Health Service. The medical laboratories of DACH, NNMC, and WRAMC will be facing 11 accreditations during the same period. Failure to pass any of these inspections will result in either a reduction of medical care or an increase in costs to send specimens to outside reference laboratories. The radiology and nuclear medicine departments, including oncology and mammography, face a total of 13 inspections across the 3 facilities. Not passing will result in a loss of diagnostic procedures and oncology treatments.

To keep track of these visits and inspections, the J5 Integration Division developed a Microsoft Excel® database. The information from that database was then was placed into Microsoft Project® and converted to milestones. These two documents are useful tools for the BRAC transition process.

Development of the External Inspections Database

Requests for information about upcoming inspections were sent out to the 79th Medical Wing, DACH, NNMC, and WRAMC. As the information filtered back to J5 Integration, it was added to the Excel® database. The inspection name, the inspected activity, the date of the last inspection, and the date of the next inspection were all recorded on the spreadsheet. The spreadsheet was divided into MTF, GME, HPE, orthopedic/rehabilitation, pharmacy, preventive medicine, and radiology worksheets. For the most part, the next inspections were recorded as month and year. Some of the upcoming dates went as far out as 2015.

After the spreadsheet was completed, a project was created in MS Project®. The main project was the BRAC timeline, ending 15 September 2011. The data was entered into no specific order, but Project® automatically tagged them with a sequential number that is recorded in column one. Each of the inspections was listed in the second column by MTF and specific activity, i.e., WRAMC Lab. The third column listed the inspecting agency. All inspections were listed as "0" days in length so that they would show up on the timeline as milestones. The dates selected for the milestone were the first working day of

the month and year recorded in the Excel® spreadsheet. Some events did not have specific times and were either recorded in the same month as the last inspection or not given a specific date other than the default date of the 30 January 2009, the day the project was initiated. The stars were chosen to mark the milestones and the stars were color coded: silver is the 79th Medical Wing; olive is DACH; blue is NNMC; green is WRAMC; black is Walter Reed Army Institute of Research; yellow is NCC; and purple is USU of Health Sciences.

Upon completion of the External Accreditation Inspection Milestones Project (EAIM), the database was uploaded onto the JTF Portal and distributed for use in the IMS to members of J5 Integration and J3.

Surveillance of External Accreditation Inspections

Throughout the transition period, members of the J5 Integration Division will monitor the IMS and scheduled external inspections on the EAIM for potential conflicts. As conflicts are identified, the J5 Integration Division will notify the J5 of the situation. The J5 will then distribute the information, along with possible mitigation strategies, to the Component Commanders for distribution to the individual or group that can implement the most effective resolution of the conflict. As inspections are completed, delayed, or accelerated, resulting changes will be recorded on the database and EAIM by the J5 Integration Division members.

Possible Mitigation Strategies for Conflicts between the EAIM and IMS

MTFs require numerous inspections and accreditations in order to provide healthcare. From January 2009 through 15 September 2011, BRAC-affected MTFs in the JOA will face 85 inspections by at least 42 different agencies. The JTF must monitor the inspections to ensure that all the MTFs remain fully compliant and capable to provide care for their constituents. The EAIM and IMS provide tools for the J5 Integration Division to monitor projected conflicts between inspections and movements. Proactively oversight of this process assists in providing the JTF Commander the assurance that the high level of healthcare in the NCR is maintained over the duration of the BRAC projects.

When conflicts between the EAIM and IMS occur, most mitigation strategies involve contacting the inspecting agencies and requesting an adjustment in the timing of the inspections. When there is a conflict, Integrated Department Chiefs will ensure that the agencies are contacted with plenty of time to either advance or delay an inspection.

Another mitigating strategy would be to delay or advance a move to a new facility. This solution would potentially have an impact on interdependent services offered or required by other elements that would either remain in place or move without them. This solution would require much more coordination and attention to detail and should only be used under dire circumstances such as the loss of accreditation or the closing of a service or program.

Clinical Concepts of Operation for WRNMMC

To ensure successful integration, the JTF established a baseline understanding of where each medical service area stood with regards to consolidation and formed a clinical transition plan. The process of establishing this baseline of understanding led to developing an integrated clinical CONOPS for each medical service area. This effort kicked off in October 2005 and has been an ongoing, iterative process,

with the most recent updates occurring in November 2008. This clinical CONOPS serves as the cornerstone upon which the BRAC transition plans are being built. It was critical that the CONOPS correctly reflected the scope of service and functions that would be offered in the new WRNMMC and FBCH. Each of the CONOPS provides an ideal outline of clinical operations, describes facility layout requirements, and offers a manpower request for a consolidated service area in the new institution.

The organizational structure for the new WRNMMC and FBCH was used as the backbone for validating the soundness of the clinical CONOPS. This validation included all of the areas under the Deputy Commanders of Clinical, Nursing, Dental, GME, HPE, and Clinical Research. Two additional areas were also included in the clinical CONOPS validation process: congressionally sponsored programs and new clinical missions added after 2005.

Additionally, there is a fair correlation between the CONOPS input gathered at the July 2008 off-site and the reviews conducted in November 2008. The template for the CONOPS was changed and abbreviated in July 2008, but the mission, function, and scope of service did not markedly change from the original CONOPS discussions held in 2005–2006.

The Clinical CONOPs report provided the following:

- Analysis of the July 2008 clinical CONOPS validation data
- Clinical CONOPS November 2008 validation report
- Action steps required for resolution of discrepancies in the clinical CONOPS
- Correlation between the July and November 2008 clinical CONOPS validation.

At the time of the report, the Directors for Clinical Integration formally recommended that the CONOPS development effort should be viewed as an iterative process and recommended that the J5 lead a team composed of the DCIs, J-1, J-3, and J-4 Directors to meet biweekly until all issues were resolved.

Analysis of the July 2008 Clinical CONOPS Validation Data

During the July 2008 off-site, 258 total line items were identified that pertained to the CONOPS for the new WRNMMC and FBCH. Of these 258 total line items, 185 items related to clinical CONOPS and 73 related to non-clinical CONOPS (see Figure 24).
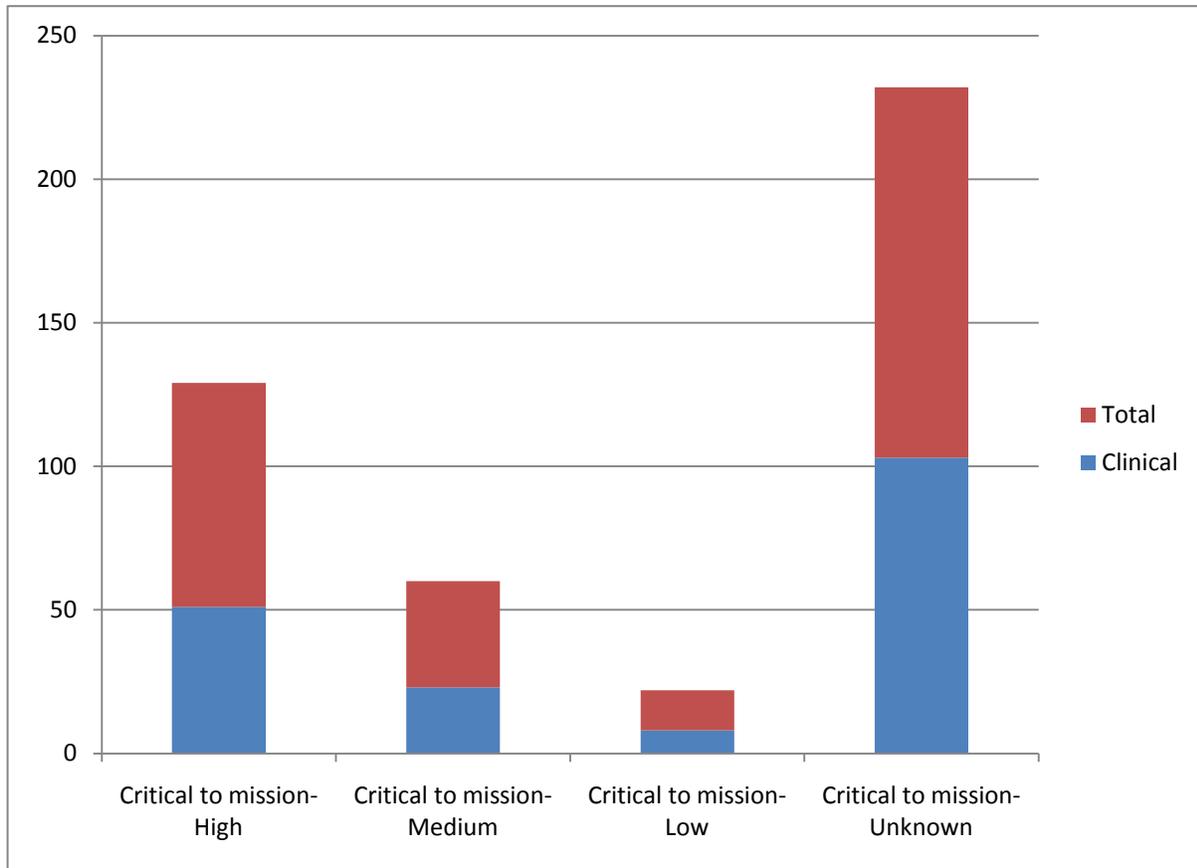
FIGURE 24 - JULY 2008 CONOPS DATA – 258 TOTAL LINE ITEMS

The 258 items were then placed into four categories:

1. Critical to mission – high
2. Critical to mission – medium
3. Critical to mission – low
4. Critical to mission – uncertain

Of the 185 clinical CONOPS line items, 51 were identified as critical to mission – high, 23 were identified as critical to mission – medium, 8 were identified as critical to mission – low, and 103 were identified as critical to mission – unknown. Further analysis of the line items revealed that three major categories were readily identifiable: space concerns, manning/workload concerns, and CONOPS concerns (see Figure 25).
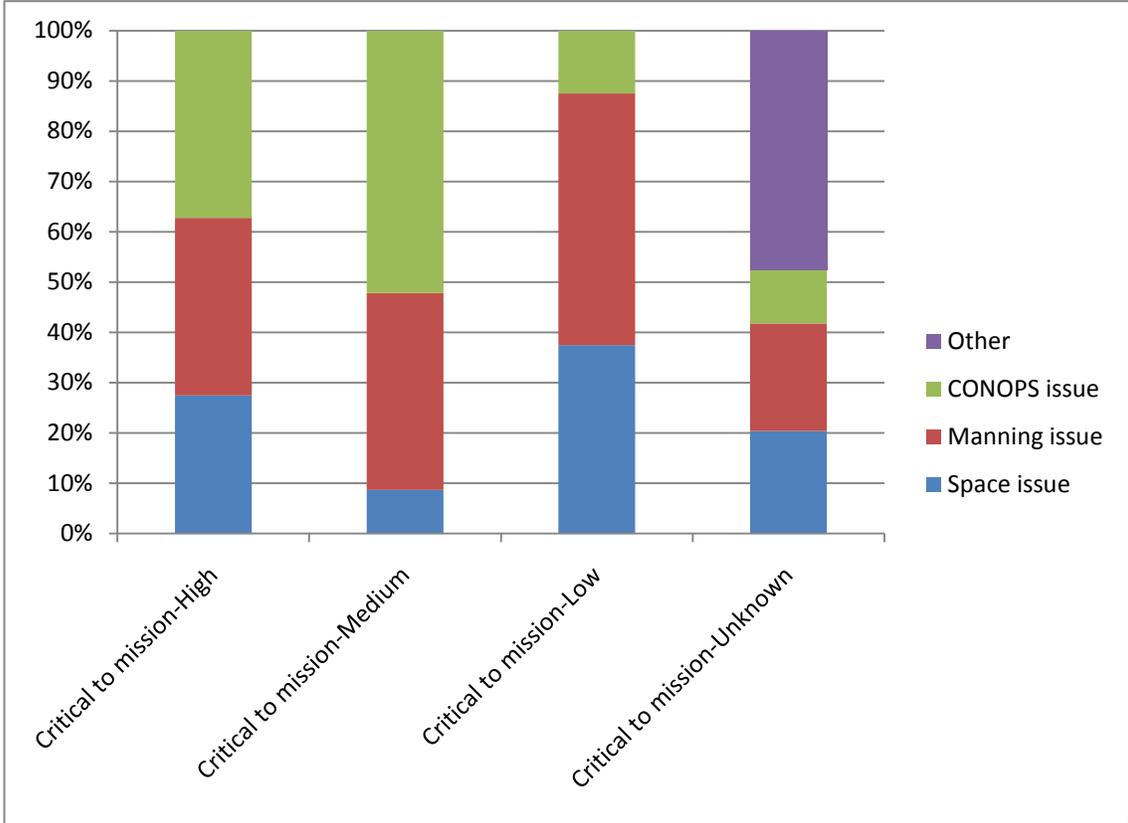
FIGURE 25 - JULY 2008 CONOPS DATA – CLINICAL CONOPS LINE ITEMS

TABLE 6 - JULY 2008 CONOPS DATA – ACTIONABLE ITEMS

Clinical CONOPS line items	Critical to Mission
Clinical Investigation Dept (N/S)	High
Critical Care (N/S)	High
Dental (N)	High
Family Practice (N)	High/ Medium
HPE Department (N/S)	High/Medium
Clinical Research (N/S)	High/Medium
Prosthetics and Orthotics (S)	High
Pediatric Specialty Care (S)	High
Social Work (N/S)	High
Radiation Oncology-Conscious Sedation (N)	High/Medium
Traumatic Brain Injury Service (N/S)	High
Chiropractic (S)	High/Medium
Joint Pathology Center	High
3-D Medical Applications	Medium
Faculty Development	Medium
Nephrology (N/S)	Medium
Rheumatology (N)	Medium
Simulation Center	Low
Immunizations	Unknown
Audiology and Speech	Unknown
ENT (N/S)	Unknown
Wound Care Clinic (N/S)	Unknown
Tumor Registry (N/S)	Unknown
Preventive Medicine (N/S)	Unknown
Public Health Directorate (N/S)	Unknown
Medical Readiness (N/S)	Unknown

Clinical CONOPS November 2008 Validation Report

A GREEN, AMBER, and RED system was used to evaluate the clinical CONOPS to determine whether the CONOPS supported the clinical service's ability to execute its mission. The colors are defined as follows:

GREEN	Clinical CONOPS includes the full scope of services and supports all functions required to execute the mission
AMBER	Clinical CONOPS does not include the full scope of services and supports all functions and therefore the mission is compromised
RED	Clinical CONOPS does not include the full scope of services and supports all functions and the mission cannot be executed.

The DCIs, along with the JTF staff, are currently addressing the issues raised through the CONOPS validation process (see Table 7) by meeting with the medical service areas in order of the issues' relevance and importance. As a part of this effort, the clinical CONOPS team will work closely with the Administration/Logistics CONOPS team and compare overall manpower and space requirements as they pertain to projected administrative and clinical missions in the new facilities.

TABLE 7 - CORRELATION BETWEEN THE JULY AND NOVEMBER 2008 CLINICAL CONOPS VALIDATION

Clinical CONOPS Line Items	Critical to Mission July 2008	Mission Execution Nov 2008
Clinical Investigation Dept (S)	High	YELLOW
Critical Care (N)	High	YELLOW
Dental (N)	High	GREEN
Family Practice (N)	High/ Medium	RED
HPE Department (N/S)	High/Medium	YELLOW
Prosthetics and Orthotics (S)	High	YELLOW
Pediatric Specialty Care (S)	High	GREEN
Social Work (N/S)	High	GREEN
Radiation Oncology-Conscious Sedation (N)	High/Medium	Resolved
Traumatic Brain Injury Service (N/S)	High	RED
Chiropractic (S)	High/Medium	GREEN
Joint Pathology Center	High	TBD
3-D Medical Applications	Medium	GREEN
Faculty Development (N/S)	Medium	YELLOW
Nephrology (N/S)	Medium	YELLOW
Rheumatology (N)	Medium	GREEN
Simulation Center	Low	YELLOW
Immunizations	Unknown	YELLOW

Clinical CONOPS Line Items	Critical to Mission July 2008	Mission Execution Nov 2008
Audiology and Speech	Unknown	
ENT (N/S)	Unknown	
Wound Care Clinic (S)	Unknown	
Tumor Registry (N/S)	Unknown	
Preventive Medicine (N/S)	Unknown	
Public Health Directorate (N/S)	Unknown	
Medical Readiness (N/S)	Unknown	TBD

Administration and Logistics Concepts of Operation for WRNMMC

In October 2008, the CJTF directed the JTF Component Command Chiefs of Staff to address the integration of medical administration and logistics functions. Specifically, they were asked to address, using a phased approach, how to shift approximately 2,300 authorizations from the existing WRAMC, DACH, and NNMC to the new WRNMMC and the FBCH.

Phase 1 consisted of a manpower authorization drill in summer 2008 led by the JTF CAPMED J-1 Director. This phase was significant because it outlined the numbers that J1 proposed serve as the foundation the Chiefs of Staff would use to compare their overall authorization recommendations for the new facilities.

Phase 2 was led by the J1 directorate and was held at the USU in October 2008. At the time, the functional SMEs met in Tri-service work groups, completed an assessment of required missions necessary in the new facilities, and produced an initial study determining the manpower authorizations required for the new facilities. The challenge this study presented was overcoming facility "nepotism" and a projected overage of more than 1,000 authorizations. When these results were initially shared with JTF senior leadership, CJTF reiterated his expectation that Environmental Impact Statement (EIS) caps of no more than 5,932 (North Campus) and 3,198 (South Campus) would be strictly adhered to. He also added several additional expectations:

- Expected efficiencies (decrease manpower and decrease overhead) as a result of mission consolidations
- Existing manpower numbers would not change unless there was a change to existing missions (provide clear justification for any increased manpower requirements)

From 6 through 23 January 2009, representatives from the NNMC, WRAMC, 79th Medical Wing's MGMC, and DACH met to address the Administrative and Logistics CONOPS, manpower authorizations, and the space necessary to support them at the WRNMMC and FBCH. Multiple meetings co-hosted by the NNMC and WRAMC Chiefs of Staff and facilitated by the NNMC and WRAMC Deputy DCIs were held over a three-week period. These meetings were attended by Chiefs of Staff, Administrators, and SMEs from each branch of the Service and the four primary NCR MTFs. Representatives were led through a series of discussions that addressed the requirements necessary to carry out the various Administration/Logistics missions at the new facilities, the CONOPS which provided a detailed risk assessment to validate the

requirements, and the spacing necessary to support the manpower authorizations. Extensive documentation provides JTF senior leadership with an executive summary of the validation process of the Admin/Logistics CONOPS. This CONOPS serves as the cornerstone upon which the entire BRAC transition plans will be built.

The organizational structure and projected manpower requirements for the WRNMMC and FBCH established during Phase 2 were used as the backbone for validating the soundness of the Administrative/Logistics CONOPS. This validation included all of the areas under the Deputy Commanders of administration, resource management, logistics, and other administrative functions listed as Special Assistants, Command Suite, Strategy & Future Operations, and Readiness & Base Operations.

The team's initial focus was on the Administrative "big rocks." In all meetings, groups were briefed on what the desired end states were and what was expected of them in getting there. DCIs explained how the JTF Phase 2 baseline draft authorizations were determined and shared with them the overall constraints imposed as a result of BRAC law, EIS caps, and other mitigating factors. Additionally, participants were advised to differentiate between those authorizations required to directly support the MTF mission and those required to support installation/garrison operations. This particular distinction proved difficult for many and several areas were marked RED for manpower and space reasons because of a failure to make this distinction.

The Administration/Logistics CONOPS interim report also provides the following:

- Analysis of the CONOPS validation data broken down by sub function (e.g., IM/IT, Logistics, Patient Administration [PAD], etc.)
- Action items required to address items of concern (transitioning areas listed as RED and AMBER to GREEN)
- Issues deemed irresolvable at the Chief of Staff level by the DCIs.

The preponderance of REDs were the result of disconnects between SME manpower authorization requests and JTF Phase 2 baseline projected authorization. Additionally, as a result of this disconnect, there was a bleed over into the spacing necessary to house the additional SME-requested requirements.

Administration and Logistics CONOPS Data Analyses: July and October 2008

During the three weeks of Administration/Logistics meetings, the team addressed 26 primary functional items the. These 26 primary functions were further broken down into more than 100 total line item functions identified as falling under the Administration and Logistics CONOPS during the July and October 2008 off-sites that pertained to the new WRNMMC and FBCH. Those 100+ functions were broken into four primary areas:

- Command Special Assistants
- Deputy Commander, Administration
- Deputy Commander, Strategy & Future Operations
- Deputy Commander, Readiness & Operations.

When analyzing each function, the team further assessed summaries broken down into three specific categories:

- CONOPS
- Manpower
- Space

The team then assigned them a color to reflect their overall ability to support the missions of the new facilities:

GREEN	The right mix of space and personnel exists to accomplish mission
AMBER	A compromise exists, impacting the ability to accomplish mission
RED	Degradation of manpower or space will prevent mission accomplishment

Every function was stratified, aligned under all four primary areas, and given either a GREEN, AMBER, or RED rating. The ratings were then rolled up for an aggregate summary. In all, an excess of 200 sub functions for each facility were reviewed and rated based on the GREEN/AMBER/ RED scale.

Administration and Logistics CONOPS Report

The organizational structure for the new WRNMMC and FBCH was used as the backbone for validating the soundness of the Administration/Logistics CONOPS. This validation included all of the areas under the Deputy Commanders of administration, logistics, resource management, and other administration-related functional chiefs. The following list contains the functional areas that were reviewed:

- Deputy Commander of Administration
- Comptroller
- Patient Administration
- Human Resources
- Information Management/Information Technologie
- Logistics
- Facilities Management
- Clinical Nutrition
- Safety
- Deputy Commander Strategy & Future Operations
- Healthcare Operations (HCOPS)
- Quality Management (QM)
- Strategic Communications
- Deputy Commander Readiness & Operations
- Army Support
- Navy Support
- Air Force Support
- Commercial Services
- Security
- Operations & Emergency Preparedness

- Commander's Special Assistants
- Command Suite
- Command Secretariat
- Senior Enlisted Advisor
- Healthcare Mediation
- Legal Services
- Chaplain Services
- Executive Medicine
- Executive Services
- Inspector General/Internal Review/Command Evaluation
- Warrior Transition Unit (WTU).

Figure 26 contains the organizational chart used in the report based on organizational structure received from the JTF J1 directorate.
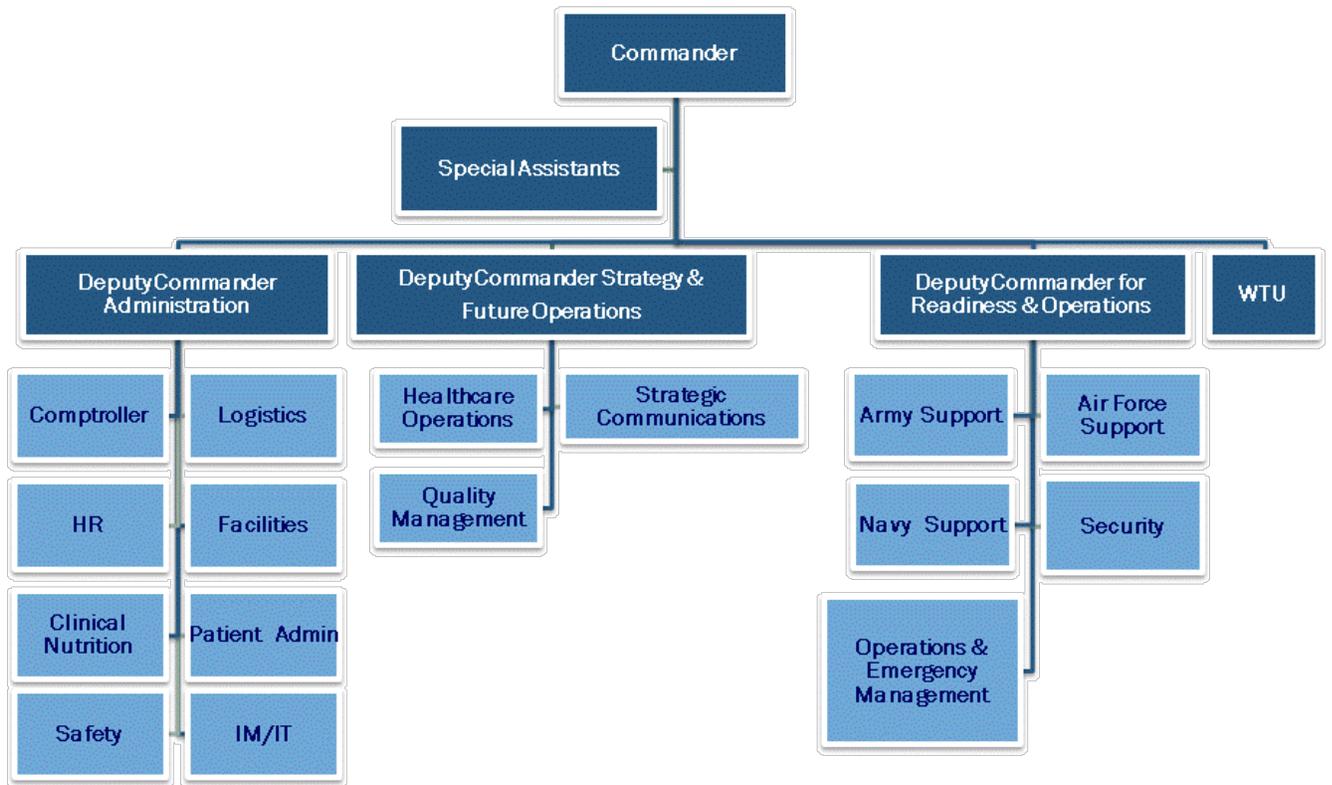
FIGURE 26 - SAMPLE JOINT HOSPITAL ORGANIZATIONAL STRUCTURE FOR ADMIN AND LOGISTICS FUNCTIONS

However, there was not a clear organizational structure for Commander Special Assistants (CSAs), and as a result, the team discussed the definitions of some of the various commander support functions, redundancies with missions projected for the HR directorate, and large amounts of staff requested to support the commander (especially in the North). The organizational structure projected to support the WRNMMC and FBCH and used as a basis for determining the CSA functions is shown in Figure 27.

Special Assistants
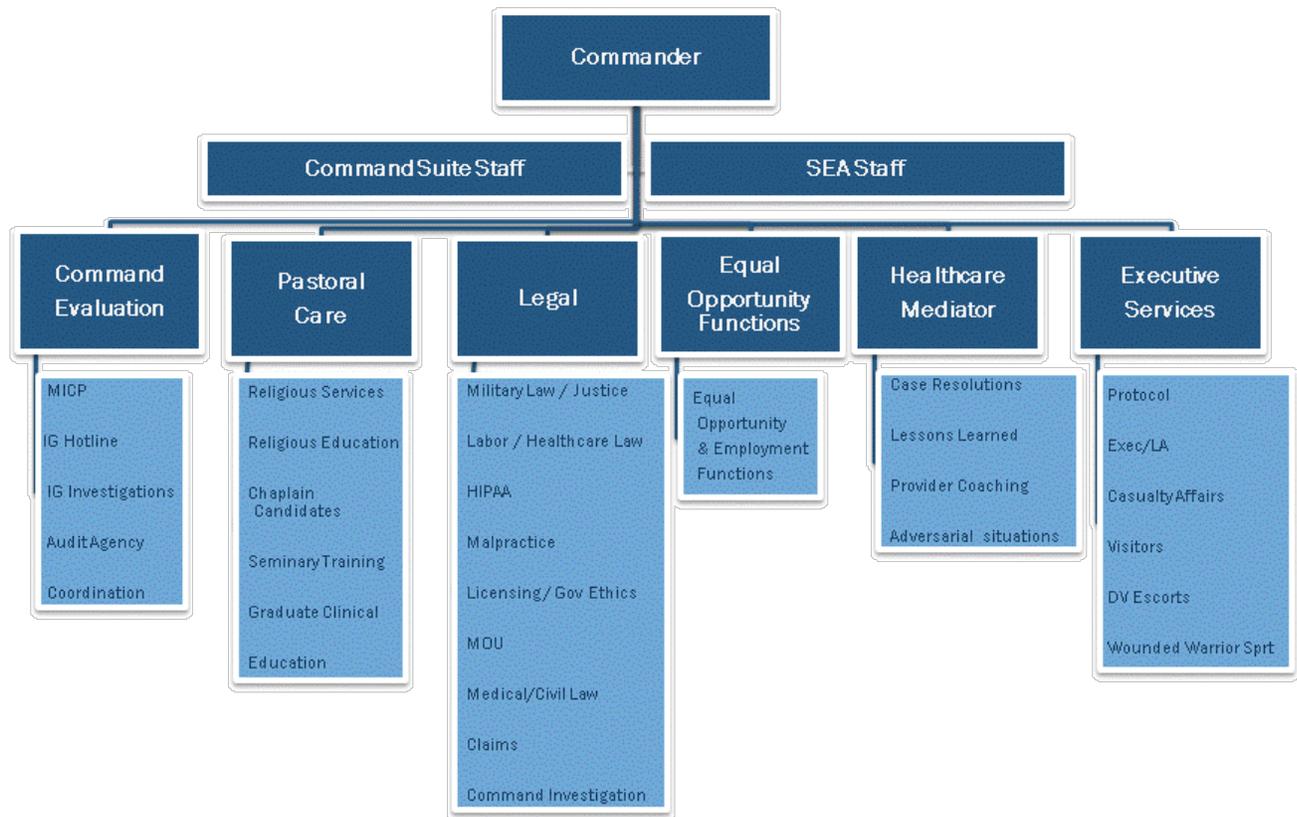
FIGURE 27 - ORGANIZATION CHART FOR COMMANDER'S SPECIAL ASSISTANTS IN THE JOINT HOSPITALS

The Phase 2 draft JTD was used as the manpower baseline with the understanding that our objective was to balance overall Administration and Logistics manpower at approximately 1,420 authorization requirements (North) and 763 authorization requirements (South), respectively.

SMEs were given clear guidance to:

- Validate the Administration/Logistics CONOPS, present it to JTPB, and forward unresolved issues to CJTF for disposition (11 February 2009)
- Keep projected authorizations aligned with the JTF Phase 2 baseline; if that is not possible, prepare statements on what the projected impact to the mission would be if all manpower requirements were not provided
- Not to use BRAC guidance as a reason to "get well"
- Lead comprehensive reviews across entire facilities (North and South)
- Address CONOPS, manpower authorization projections, and space allocations
- Improve information flow
- Update web sites containing CONOPS, documents, and space diagrams
- Develop mechanisms for continued feedback to leadership and user groups

CONOPS-related deliverables include the following:

- Validation of WRNMMC and Fort Belvoir CONOPS – no later than 23 January 2009
- Complete, accessible, and usable documentation for leadership and user groups
- Feedback from commands; comments from July and October CONOPS, manning, space, and facilities.

Additional direction was provided to address the existing manpower delta and to continue working, to conclusion, the remaining open items—all of which should be resolved by summer 2009.

CONOPs Way Ahead

The next phase of establishing Administrative and Logistics CONOPS will be to work closely with the clinical CONOPS team and to address overall manpower and space requirements as they pertain to projected administrative and clinical missions in the new facilities. Additionally, teams will continue to work closely with SMEs throughout the NCR to further develop processes and procedures with a joint methodology as its foundation. Whereas initially, manpower numbers were the challenge, the development of the JTD, for the most part, resolved the manpower challenges the team initially faced. Team will now focus on spacing, establishment of joint processes (in particular for logistics, contracting, and finance), and development of Service-specific administrative elements (Army, Navy, and Air Force) that will serve as liaisons to our staff's parent services.

Cultural Integration

Each Service has unique cultural traditions, norms, practices, and languages for managing its forces, cultivating its leaders, and bringing a unique perspective to the care patients receive. The goal of cultural integration is to recognize these individual differences in the Services, adopt the best practices from each Service, and maintain those defining cultural norms and specialties to ensure that Airman, Sailors and Soldiers stationed at WRNMMC and FBCH can leave the JOA and easily reintegrate into a Service-specific environment when needed.

In February 2009, JTF CAPMED's executive leadership attended a culture management issue identification workshop. Phase II of this workshop is scheduled for June 2009 with the Component Commanders and other key stakeholders of the WRNMMC, including USU personnel. The outcome of these workshops is the development of a comprehensive plan of action, including recommended strategies and tactics for JTF CAPMED to achieve cultural integration. This comprehensive plan for cultural integration will be published in October 2009.

Additionally, in June 2009, JTF CAPMED began conducting a course of instruction focused on "jointness." Joint is defined in the JP 1-02 Dictionary of Military Terms as "activities, operations, organizations, etc. in which elements of two or more Military Departments (Services) participate. Joint operations are governed by joint doctrine defined as fundamental principles that guide employment of US military forces in coordinated action toward a common objective. Military forces used in this manner are referred to as joint forces. A joint force is defined as a force composed of significant elements of two or more Military Departments (Services) operating under a single joint force commander." Using a top-down-driven approach, the first two courses will focus on senior leaders—first enlisted and then officers. By the transition period of April–August 2011, the goal is that all reporting members to JTF CAPMED, the WRNMMC, and FBCH will attend a newcomer's orientation with a briefing on Service cultures in joint

environments. The Joint Senior Enlisted Executive Leadership Course is scheduled for June 2009 and will cover the following topics:

- Breaking the language barrier
- Joint training
- Evaluations/fitness reports – understanding the Service-specific ways
- Joint career development
- History of the Services: customs, courtesies, and ceremonies
- Fitness programs
- Discipline and fraternization policies
- Service regulations and grooming standards.

Healthcare Services and Business Plans

The processes related to the JTF's charter for Base Realignment and Closure (BRAC) actions and the integration of healthcare services drive many layers of management from the Headquarters (HQ) level, through the Service components, down to workgroups, cells and teams at the clinic levels. The JTF Health Operations Directorate executes its missions in support of the Standing Joint Task Force (JTF) by balancing responsibilities related towards its readiness missions (ay-to-day, contingency & crisis response) and integrated healthcare delivery missions throughout the JTF Joint Operating Area (JOA).

In addressing all aspects of the JTF mission, healthcare operations balance requirements of readiness and healthcare delivery to ensure no degradation of day-to-day healthcare ops while maintaining a ready posture should a crisis emerge. Healthcare operations works closely with JTF teams JOA-wide and provides guidance/direction for the transition that ultimately affects all aspects of direct patient care services from family medicine and primary care to surgical services, behavioral medicine and ancillary support.

NCR Primary Care Strategy

Among the numerous Healthcare Operations diverse missions, development and integration of an NCR Primary Care Strategy is perhaps the most essential as it ties together so many of the numerous essential elements necessary to execute JTF CAPMED's integrated regional healthcare delivery mission. The NCR has nearly 600,000 beneficiaries, many of which will be affected by the transition. Ensuring they have a clear understanding of where they will receive their healthcare now, through the transition process and once the new hospitals are FOC as joint hospitals will require an aggressive step-by-step approach and a dynamic marketing/communications campaign.

As outlined throughout the JTF CAPMED Master Transition plan (MTP), transition efforts focus on the key impact areas of the BRAC process, specifically the impact on our People (staff, patients, and multi-Service wounded warriors), Processes (clinical, administrative, and military), Technology, and Physical Infrastructure. In order to ensure planners have a common site picture throughout the process, the JTF has established action plans to demonstrate major focus areas throughout the transition period from their current, pre-BRAC locations to their post BRAC-directed end-state guiding all planning efforts through the beginning of FY2012.

Minimizing the impact on patients, staff and most importantly, wounded warriors and their families, the MTP will clearly show the 'nuts and bolts' of a 4-2 hospital shift and 3-1 Service cultural integration minimizing the time necessary to perform the shift, while ensuring a seamless transition between healthcare delivery at the former sites one day to world-class healthcare delivery at two new facilities the next.

Seamless transition is expected by our patients for a number of reasons. Most importantly, when they call for care, they expect to receive appointments quickly and expect that care to be provided in a manner in which they are most accustomed. At most installations outside the NCR, primary care services are routinely provided on base with most referral services shifted to a local military hospital (If available) or to an off-base civilian hospital. Here in the NCR, with the robust healthcare available to all of our beneficiaries, establishing a common referral management data base is essential to effective referral tracking and even more important for patient case management. The JTF maintains a close-eye over available healthcare options throughout the JOA and is working closely with the Service components to ensure our plans are flexible enough to understand that while there may be subtle differences in processes at the 37 MTFs in the JOA, the referral management process must be the same at all of the them.

Common Standards and Practices

Achieving common business and clinical processes will be necessary to maximize regional potential. When medical staff supports missions in facilities across the region on a day-to-day basis, differences that could impact patient safety and outcomes will not be tolerated. Developing a common standards and practices throughout the region is essential towards developing a world-class platform NCR-wide. The question most often asked by our medics is, "When will we transition to common standards and practices across the region?" The answer is in two parts:

- First, most of practices and standards are common right now. While Service cultures are somewhat different in our various military hospitals, the medical standards and practices are consistent throughout our JOA. Where there exists significant differences are in many of the staff policies, administration/logistics practices, and service specific medical support requirements. A team of JTF staff was commissioned in May 2009 to establish a common action plan for the development of standard regulations/instructions/issuances, etc. that will be used at all of the joint medical facilities in the JOA. With more than 500 documents to review from each of the Services, DoD, JCS and other governing bodies, the task of re-writing each document into a common joint frame of reference is a challenging one.

- Second, by 1 October 2010, each joint facility is projected to achieve IOC. With that comes a leadership team that will guide the new hospitals towards FOC status. Working together with the JTF staff and MTF transition teams (outlined in the Process section of the MTP), IOC leadership teams will guide the integration of common issuances into the mission of each hospital. Each will clearly guide hospital staffs on their mission requirements and each will provide not only a common joint approach to healthcare but also an approach that takes into consideration many of the Service-specific healthcare requirements our medics provide today.

Medical Quality Assurance Program

Medical Quality Assurance Programs are regulated by two DoD instructions (DODI) – DoDI 6025.13 and 6025.13- the Medical Quality Assurance Program in the Military MHS. This pair of Secretary of Defense documents does not transmit authorities to CJTF CAPMED for the Medical Quality Assurance (QA) Program to the future joint MTFs or its future commanders. These DoD documents instead place the burden to carry out the Medical QA Program on the Secretaries of the military departments. The Service Secretaries must operate their MTFs to meet certain standards and maintain accreditation from The Joint Commission.

In aggregate, The Joint Commission conditions and standards require each accredited organization have a "governing body." For each Service's MTFs, the Service Secretary and Surgeon General have a canon of regulations and instructions naming the Service Surgeon General as the governing body. However, the three Services' canon of doctrine do not apply to the CJTF or to the future joint MTFs. Initial work on COAs has revealed the current limitation of the flow of authority and internal governance under the standing instructions and regulations. Further work to develop additional COAs will include at least one COA that will require changes to the DoDI 6025.13 and the DoDI 6015.13-R to ensure the Medical QA Program in the JOA is effectively administered. Plans are underway for a "summit" where stakeholders can draft a solution.

Before the JTF's intentions for a "governing body" summit are announced, the CJTF will decide, based on legal review, the procedures, ground rules, preparations, list of attendees, assumptions, deliverables, and

the range of possible COAs. For The Service Secretaries, Service Chiefs of Staff, and Surgeons General will be interested in the final solution, and we anticipate that the COAs might require wargames, tabletop exercises, and briefs to the Chairman of the Joint Chiefs and to the OIPT before a preferred solution is presented to the Office of the Secretary of Defense (OSD) and Deputy DEPSECDEF for final approval.

Staff Credentialing and Privileging Plan

All medical staff must have current credentials and privileges sustained across the transition period. Credentials and privileges ensure that all healthcare practitioners who are "responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical care must be subject to credentials review and must be approved for delineated clinical privileges by a designated privileging authority before independently providing patient care. Clinical privilege approval and medical staff appointments are required for those practitioners assigned to an MTF." [4] The JTF CAPMED Healthcare Operations Directorate, working with the Service Components, is developing a plan to ensure that the privileging and credentialing of healthcare practitioners is sustained during the transition. These plans are due 1 August 2009, with an anticipated date to execute the plan on 1 November 2010.

This actionable plan will verify the credentials of healthcare workers and grant privileges to licensed independent providers consistently across the JOA at all medical and dental treatment facilities (DTFs). Efforts are underway to develop a process to permit proper authorities to rapidly reassign privileged providers and credentialed non-privileged healthcare workers to different facilities on short notice. This process will require the following:

- Design medical staff bylaws for joint facilities that meet operational and governance needs while complying with The Joint Commission standards
- Ensure competence and appropriate performance of caregivers by:
  - Promulgating policies and standards of performance, conduct, and ethical behavior for all personnel
  - Monitoring staff member performance and providing feedback on the monitoring and assure this is covered in governance and QA sections
- Organize governance structure and processes to:
  - Facilitate effective communication with medical and other staff leadership
  - Ensure that patient and family views about facility operation are known to management and to the governing board
  - Ensure that the governing body is actively involved in overseeing care activities, quality, and safety

Patient Administration

Few places in military healthcare better showcase the need for standardized, joint processes then Patient Administration (PAD) services. Each service has a different approach to patient administration issues and each aligns specific functions in different areas of the hospital organizational structure. The PAD mission is responsible for tracking patients from the time they are identified to arrive at the medical treatment facility (MTF) until their final disposition. This process includes inbound medical aeromedical evacuation flights to patients transferred to VA facilities. Serving as our patient accountability lead while providing literally dozens of other medical support functions is one of the reasons why healthcare

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[4] BUMED INST 6010.17B 7 MAR 2003

operations stood up a PAD Cell to ensure PAD mission alignment. Comprised of medics from each Service medical department and the JTF staff, the PAD team is developing transition/integration plans that impact numerous functions, people, policies, work spaces, work/communication tools, and procedures that will be integrated to support the needs of its uniformed patients and all beneficiaries in its joint military treatment facilities.

Multi-Disciplinary Clinical Operations

The JTF will ensure establishment of a military only Level I Trauma Center at WRAMC that will transition to WRNMMC. This will provide expertise and standards like those of the American College of Surgeons Committee on Trauma (ACS-COT). This will also require the following:

- Hiring qualified personnel and preparing them stand-up trauma service

- Ensuring the right space mix at the new WRNMMC

Centers of Excellence (COE)

JTF CAPMED staff continues to work with the NNMC BRAC Project Office staff to ensure the right space at WRNMMC for Centers of Excellence and Institutes. The JOA will become home to many Centers and Institutes that will provide clinical care and research to beneficiaries that fall within the responsibility of the JTF or the interest of the JTF.

The JTF will ensure developing concepts for oversight of all clinical care and clinical research provided by all Centers and Institutes within the JOA to include the National Intrepid Center of Excellence (NICOE); Defense and Veteran's Brain Injury Center (DVBIC); the Joint Pathology Center (JPC); the Vision Center of Excellence (VCE); and the cancer centers of excellence.

Oversight (privileging and peer review) of that clinical care and research requires coordination as well. CJTF and the USUHS President presented proposals for governance of the centers and institutes, including the Joint Pathology Center to the acting OSD/HA in May 09.

JTF CAPMED will develop a concept for a Pain COE (PCOE). The PCOE will serve as the NCR's foremost COE providing comprehensive pain care management to include acute and chronic pain in both the inpatient and the outpatient setting. Pain is a major issue for America's wounded warriors as well as many of our beneficiaries. JTF CAPMED will ensure the development of new modalities and export those innovations into the JOA-wide—and DoD-wide—healthcare settings as well. A concept of operations and charter for a multidisciplinary group to work on this is underway and is once ultimate governance is established will present their recommendations.

JTF CAPMED is also focusing on developing a Wound Care COE at WRNMMC. An In Process Review (IPR) was presented to the DCJTF. Currently, WRAMC and NNMC have clinics performing complex wound care. Policies and procedure have been standardized. WRNMMC Surgery Clinic has 2 rooms available for wound care and work is being done to ensure adequate space for research personnel and Hyperbaric Mono-chambers at the new WRNMMC.

Standardized Ancillary Services throughout the NCR

Multiple Work Group's are established throughout the NCR with the goal of developing fully-integrated processes necessary to support our complex healthcare missions. An integrated laboratory, pharmacy, and other services will ensure that providers with patients receiving parts of their care in one facility will be able to clearly see updates when parts of that care is received in other facilities as well

Case Management Standardization

Medical case management, while a significant part of the healthcare delivery process, varies throughout the JOA. A work group was chartered to develop integrated standards of case management throughout the JOA able to immediately support joint healthcare operations in the new joint facilities once FOC is achieved.

Immunizations, Public health & Force Health Protection

FY 09 Influenza Vaccination Synchronization called for synchronizing influenza vaccine distribution throughout the JOA. Lessons learned are being incorporated into the 2009-2010 influenza season with special attention to the probability of 3 vaccines per patient including two for the H1N1 vaccine. Further Immunization Delivery Optimization for the 2009-2010 influenza season plans is in the final development stages and will be implemented by late summer 2009. Additionally, healthcare operations work groups have developed an organizational plan that formulates and optimizes public health delivery within integrated regional healthcare delivery system across the JOA and are developing a medical surveillance plan for the JOA.

Physical Evaluation Board/Medical Evaluation Board (PEB/MEB) Process

Healthcare operations, in coordination with the JTF's Service components, understand the significance of the Physical Evaluation Board/Medical Evaluation Board (PEB/MEB) Process. A swift, standardized and accurate PEB/MEB process is essential for ensuring Service readiness. The joint process the JTF is developing will be consistent across all Service lines of operation and will avoid duplication of staff needed to ensure a successful process.

Behavioral Health

The missions of America's military services are complex and stressful. World-class behavioral health services are essential to ensure our beneficiaries get the care they need when that care is needed. Behavioral Health (BH) serves as the JTF CAPMED functional proponent and CJTF's point of contact (POC) for Social Work Service (SWS), Mental Health (MH), Family Advocacy Program (FAP) medical issues, Exceptional Family Member Program medical issues, Educational and Developmental Intervention Services, Services' Substance Abuse Programs, Forensic Toxicology Drug Testing Laboratories (FTDTL), Deployment Cycle Support Program (DCSP), Combat and Operational Stress Control (COSC), and the Family Action Plan (AFAP) behavioral health issues. BH Coordinates and collaborates with appropriate host installations, Service headquarters, and DoD staff action officers to effectively implement all BH programs.

The BH team is developing subject matter policy and other implementing guidelines to facilitate integration of BH and SWS healthcare delivery across the JOA through such actions as an inpatient MH bed management policy, integrated psychology training programs, and a JOA policy for suicide prevention and response. Development of such policies ties to transition by promoting the collaboration and cooperation of the MTFs and components within the JOA and results in integrated and coordinated regional healthcare delivery.

Be Ready Now

Healthcare Operations Current Ops division is responsible for serving as the crisis ops eyes and ears of the CJTF and JTF CAPMED. Their multi-Service team develops the operational orders necessary to shift a 10,000-person work force and does so via joint Command, Control, Communications, Intelligence & Situation Awareness process. They have developed processes for the issuance of formal orders for medics throughout the JOA and provide command and control support during periods of increased threat (i.e., Inauguration activities in January 2009).

Command, Control, Communications, Intelligence (C³I) & Situation Awareness

The CJTF's essential mission tasks include command and control of assigned forces within the NCR JOA. To meet this requirement, CJTF must prepare for and respond to contingencies, develop and maintain functional relationships with critical DoD elements and other federal, state and local health and preparedness agencies. Developing the plans necessary to facilitate these relationships and thus execute them effectively remains a primary responsibility of the Healthcare Operations directorate.

Resources

The flow of O&M funding to MTFs within the NCR will be discussed in reference to fiscal years and by Military Medical Department. The DoD operates on a fiscal year budget cycle beginning 1 October and ending 30 September.

The OASD/HA receives funding in DHP appropriation for medical operations in the DoD. Funding levels are established and concurred with by the DHP Resource Management Steering Committee (RMSC) and approved by MHS senior leadership and are reflected on Funding Authorization Documents (FADs). FAD amounts are the obligation authorities subject to the provisions of 31 U.S.C. 1517 and DoD Directive 7200.1. Funding is executed in accordance with applicable provisions of the DoD Appropriations Act and all other laws, regulations, procedures, and policies necessary to support the DHP appropriation.

In FY 2009, all funds for military medical facilities in the NCR will be funded as they have been in the past. Specifically:

Army Facilities

U.S Army Medical Department (USAMEDCOM) receives funds from OASD/HA. USAMEDCOM allocates the funds to the Army MTFs. The Army MTFs in the NCR are under the control of the North Atlantic Regional Medical Command (NARMC). The Commanding General of Walter WRAMC also serves as Commander of the NARMC. This region covers 21 of the northeastern United States plus the District of Columbia. NARMC has the following resource responsibilities:

- Advise, recommend, and act for the commander on resource matters pertaining to the NARMC. These matters include expenditure of appropriated funds; budget formulation and execution; allocation; medical manpower expense and performance reporting; strategic planning; command performance reporting; management control measures and compliance; MOA/MOU review, drafting, and management; management of the Table of Distribution and Allowances for the command; and business operation of the command
- Advise commander on resource management matters pertaining to the overall management of the command
- Serve as the Chief Financial Officer (CFO) for the NARMC
- Provide technical and functional support to WRAMC and installation
- Serve as principal advisor on all areas of resource management, including coordination with USAUSAMEDCOM, Office of the Surgeon General (OTSG), and the Defense Finance and Accounting Service (DFAS)
- Coordinate and monitor the submission of Medical Expense and Performance Reporting System (MEPRS) data by MTFs to USAUSAMEDCOM; serve as MEPRS integrator for MTF MEPRS analysts
- Conduct MTF level quarterly performance review and analysis
- Serve as principal advisor to the commander on improving performance at NARMC MTFs. Use performance review and analysis to focus and measure the quality of healthcare delivery
- Serve as lead agent for the NARMC Business Plan
- Conduct staff assistance visits to subordinate units

Navy Facilities

BUMED receives funds from OASD/HA and allocates those funds to Regional Medical Commands. The Navy Military MTFs in the NCR receive funding from and are under the control of Navy Medicine NCR. The Regional Commander, Navy Medicine NCR also serves as the Commander of NNMC. Navy Medicine NCR has the following responsibilities:

- Exercise command and fiscal oversight of subordinate commands assigned to the region
- Ensure the delivery of efficient, effective, and quality healthcare services within the region
- Provide personnel and training oversight to support the full spectrum of Navy and Marine Corps combat and contingency operations
- Ensure planning and preparation for disaster and emergency management within the region

Air Force Facilities

The Air Force Surgeon General (AF/SG) receives funds from OASD/HA and allocates those funds to Air Force MTFs in the NCR.

In FY 2010 and 2011, funds for MTFs in the NCR will vary by Service medical department. The three medical department headquarters will receive funds from OASD/HA. This financial structure was supported by the DHP RMSC.   See Table 8 - Proposed Budgets for FY 2010 for details.

Service Allocation Flow

Army

USAMEDCOM will allocate funds to Army MTFs in the NCR. USAMEDCOM CFO will notify JTF CAPMED of the funds available for the Army MTF's within the NCR. JTF CAPMED determines the allocation of the funds to the MTFs and communicates through a financial management tool (RS-BUX) to the CFO. The CFO uses the JTF CAPMED allocation to distribute the funds to the MTFs and then passes funds to MTFs within the NCR via Program Budget Accounting System.

Navy

BUMED will allocate funds to JTF CAPMED. JTF CAPTMED allocates funds to the Navy MTFs in the NCR via Program Budget Accounting System.

Air Force

The Air Force Surgeon General's office will allocate funds to JTF CAPMED. JTF CAPTMED allocates funds the 79th Medical Wing via Program Budget Accounting System and the 79th Medical Wing will allocate to the medical clinics at Bolling and Andrews Air Force Bases.

TABLE 8 - PROPOSED BUDGETS FOR FY 2010

Medical Treatment Facilities	Budget Millions
Walter Reed Army Medical Center and Garrison	400
Dewitt Army Community Hospital – Fort Belvoir, VA	171
Kimbrough Army Community Hospital – Fort Meade, MD	79
National Naval Medical Center – Bethesda, MD	364
Naval Health Clinic – Annapolis, MD	14
Naval Health Clinic – Quantico, VA	23
Naval Health Clinic – Patuxent River, MD	13
Malcolm Grow Medical Center – Andrews AFB, MD	62

Billing and Collections

Public Law 101-510 (U.S. Code 1095) established the Third Party Collection Program (TPCP), which directs military hospitals to bill private insurance companies for the cost of care provided by the military facility. When a patient has commercial insurance, the government will bill the insurance company for outpatient clinic visits and bills this amount to the insurance company.

In FY 2009-2011, the MTFs in the NCR will continue to bill for the TPCP as they do now. All collections received are returned directly to the MTF that provided the care. The Navy and Army MTFs have a uniform billing office that collects insurance information and bills for healthcare provided. The Air Force MTFs have contracted out all functions of TPCP the MTFs retain the collections received for the healthcare provided.

In FY 2012, WRNMMC and FBCH will have a uniform business office that collects insurance information and bills for healthcare provided. The remaining MTFs in the NCR will follow the guidance of their respective service medical departments.

Military Services Account

The MSA function involves billing and collecting funds for medical services/supplies from DoD beneficiaries, non-DoD beneficiaries, and all other patients receiving treatment/services in the MTF. Non-DoD beneficiaries include but are not limited to foreign military, NATO, IMET, USCG, NOAA, PHS, CIA, FBI, FAA, VA. Other patients include but are not limited to civilian emergencies, and federal employees/contractors. Services/supplies include but are not limited to subsistence, family member hospitalization, elective cosmetic surgery, and dental services. A complete and reliable record of financial transactions, including collections control, accounts receivables, and deposits, must be maintained. The parent MTF will make collections and deposits for branch medical clinics.

In FY 2009–2011, the MTFs in the NCR will continue to bill for MSA as they do now. All collections received are returned directly to the MTF that provided the care. The MTFs have a uniform billing office that collects for healthcare provided.

In FY 2012, WRNMMC and FBCH will have a uniform business office to bill for healthcare provided. The remaining MTFs in the NCR will follow the guidance of their respective service medical departments.

Medical Affirmative Claims

The Medical Affirmative Claims (MAC) Program (42 USC 2651-2653 and 28 CFR 43, the Federal Claims Collection Act 31 USC 3711-3720A and 4 CFR 101-105, and the TPCP, 10 USC 1095, and 32 CFR 220 apply to these claims. The MAC Program provides the statutory and regulatory authority to recover the reasonable value of medical care rendered for injuries or illnesses provided at government expense to active duty members, dependents (as defined at 10 USC 1072, and retirees (as defined at 10 USC 1074(b), under circumstances creating third-party tort liability.

The MAC is the military program that addresses primarily claims for the recovery of the reasonable value of medical care furnished by (or through) the United States, including TRICARE subcontracted providers, to Uniformed Services beneficiaries—including active duty—due to injury or disease incurred under circumstances creating tort liability upon a third party. It also addresses the collection of accrued pay for lost time of Service members under circumstances creating tort liability upon some third entity. MAC often involves collection from health insurance, or other insurance carriers, in cases resulting from accidents, contractual medical coverage, such as no-fault or personal injury protection (PIP), and workers' compensation. Pursuant to the Federal Medical Care Recovery Act, the United States may recover in any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care, and treatment (including prostheses and medical appliances) to a person who is injured or suffers an illness under circumstances creating tort liability in a third party.

The Legal Support Office is notified by the MTF or a civilian lawyer that there is legal issue pertaining to the patient (for example, an auto accident). The Legal Support Office will file a military claim with insurance companies and/or correspond with the civilian lawyer handling the case. Settlements will be deposited to the MTF account.

In FY 2009–2011, the MTFs in the NCR will continue to bill for MAC as they do now. All collections received are returned directly to the MTF that provided the care. The MTFs have a uniform billing office that collects for healthcare provided.

In FY 2012, WRNMMC and FBCH will have a uniform business office to bill for healthcare provided. The remaining MTFs in the NCR will follow the guidance of their respective service medical departments.

The JPG, with representatives from Army, Navy and Air Force Components and FBCH resource departments, meet monthly to discuss and refine other issues like MEPRS codes, a Chart of Accounts, Defense Medical Information System (DMIS) codes, and others that need to be defined prior to the opening of the new medical facilities.

Technology

TECHNOLOGY represents a change dimension that sustains the process dimension and is intricately linked and is essential to the support of the people dimension. Data, applications and technical infrastructure is addressed in this dimension and it is here that the NCR as well as MHS performance will be influenced. Along with equipment and software applications, the technical expertise necessary to manage the data, information, and communication reside in this dimension.

Information Management/Information Technology

Ensuring the transition of technological systems and procurement of advanced technology is a key mission for JTF CAPMED necessary to support delivery of World-Class Healthcare across the JOA by providing a seamless, integrated, and interoperable information exchange. According to *U.S. News and World Report*, the "best" hospitals "incorporate advances in technology to deliver state of the art medicine, document patient care and ensure communication across networks and between staff and patients."

The offices of the Chief Information Officer for both WRNMMC and FBCH will provide the full spectrum of IM/IT services to more than 15,000 staff members. These services include:

Automation and maintenance services for hardware, software, and peripheral equipment in support of desktops and corporate information systems including but not limited to electronic mail support services for classified mail; centrally fielded systems such as CHCS I, AHLTA, Essentris, DBSS, and DMLSS; and other business and clinical systems deployed locally or throughout the region.

- Network engineering support services
- Office Automation support services
- IM/IT strategies, forecasting, project management, and acquisition of advanced technologies
- Clinical informatics including analysis, deployment strategies, management plans, and training plans for mission-essential and higher clinical systems
- Customer support services including call center services, repair, and system maintenance
- Audiovisual support
- Digital imagery and photography services
- Television and video production services
- Telecommunications
- Web and database design, implementation, and maintenance
- Information assurance (IA)

JTF CAPMED's J6 (Communications Support Directorate) manages and maintains customer-focused programs for Information Management/Information Technology (IM/IT) products and services. These capabilities include, but are not limited to:

- Network and Network-Based Operations
- Clinical Informatics
- Information Assurance
- Visual Information
- Office Automation
- Telecom
- Web Services
- Server
- IM/IT Administrative Support Services

The Communications and Support Directorate (J6) has several objectives in supporting the JTF mission. J6 facilitates the proper integration and guidance of the JOA tactical capabilities. J6 ensures connectivity

throughout the operational environment, thus providing the JTF with the capability to effectively plan, conduct, and sustain joint operations. J6 partners with the MHS and other agencies sponsoring innovative global solutions to collect, process, protect, and disseminate data and information. Lastly, J6 develops and implements internal IT strategic plans, policies and governance in support of JTF mission as follows:

- Establish IT capital planning processes linked to the budget and acquisition/program management processes
- Develop and use performance and result based management for all command, Information, Knowledge Management (KM) and systems
- Establish and implement modernization programs for IT, KM, and process throughout the command and across the JOA

IM/IT Transition Plans

JTF CAPMED/J6 hosted an IM/IT Summit from 7-8 January 2009. The purpose of this summit was to assist with the planning efforts for WRNMMC and FBCH. During the meeting, the IT Vision, IT Portfolio, and IT Milestones were addressed and action plans formulated. Additionally, multiple linkages with the MHS were determined. One of the summit's outputs was a high level milestone chart. The milestone chart established dates for developing the necessary migration and system integration plans, design and procurement activities for the new Walter Reed and Fort Belvoir facilities, renovation activities for the Bethesda campus and several other key activities. The IM/IT high level milestone chart is shown in Figure 28.

IM/IT Milestone Chart
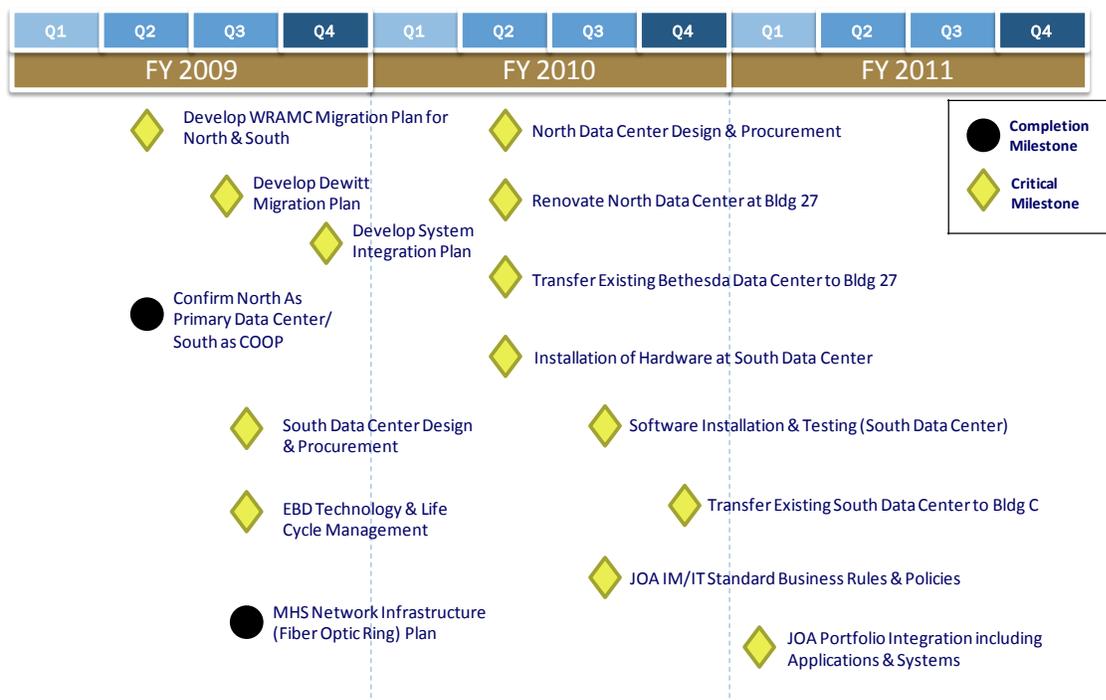
FIGURE 28 - IM/IT MAJOR MILESTONE CHART

Migration Planning

Walter Reed Army Medical Center (WRAMC) is required to close by legislative direction not later than 15 September 2011. The WRAMC base closure process involves migrating and transitioning the WRAMC campus, composed of its clinical, administrative, ancillary and business functions to two newly constructed Department of Defense's JTF-administered facilities, the new Walter Reed National Military Medical center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). The primary focus of the IM/IT Migration Plan is on the migration of IM/IT functions currently supporting WRAMC's transition to the two new JTF-administered facilities. There are three major activities associated with BRAC and migration at WRAMC. These are:

1. Timely migration of existing Army specific clinical and business systems from the WRAMC DOIM's Data Center to Fort Detrick for support of Army locations currently supported by WRAMC and the DeWitt Army Community Hospital
2. Timely transitioning of selected clinical and business systems to the new WRNMMC and FBCH facilities so that BRAC goals are satisfied in a seamless transfer of information and technological assets from WRAMC to WRNMMC and FBCH
3. The re-aligning of support functions currently executed by the WRAMC DOIM for North American Regional Medical Command (NARMC) IM/IT once its headquarters in WRAMC closes in September 2011

In addition to the WRAMC Migration Plan, the DACH (moves from DACH to FBCH) Migration Plan is scheduled for development by the 3rd quarter of Fiscal Year 2009.

Telecom/Cabling

The Telecom needs for both FBCH and WRNMMC are being incorporated during building construction and outfitting. Telecom will use Electronics Industries Alliance/ Telecommunication Industry Association (EIA/TIA) 568/569 standards for installation and implementation. Completion of cabling is projected to occur prior to Ready for Equipment (RFE) of both WRNMMC and FBCH. In the event of unforeseen delays, the projected back-up plan is to schedule cabling installation between RFE and Ready for Turnover (RFT) for both FBCH and WRNMMC. Communication cable trays and cabling are already underway in Building's A and E (the outermost clinic buildings). Building's B and D are about four weeks behind the schedules for building's A and E. Table 9 is a portion of the FBCH Clinical Turnover RFE to RFT. The entire FBCH Clinical Turnover RFE to RFT can be found in the Appendices.

TABLE 9 - CABLING PLAN SAMPLE

Line	Directorate	Department	Service Unit	Building/Floor	RFE	Duratation	RFT
1	Behavioral Health	Behavioral Health - Pediactrics	Partial Hospitalization Child	A1	Oct-09	2 Months	Dec-09
2	Pediatrics	Pediatrics	Pediatrics-- Primary Care (Outpatient)	A1	Oct-09	2 Months	Dec-09
3	Pediatrics	Pediatrics	Pediatrics General & Subspecialty	A1	Oct-09	2 Months	Dec-09
4	Behavioral Health	Behavioral Health	Preventive and Consultative Liaison Services	A2	Oct-09	2 Months	Dec-09
5	Surgical Services	Orthopedics/Rehabilitation Medicine	Chiropractics	A2	Oct-09	2 Months	Dec-09
6	Surgical Services	Orthopedics/Rehabilitation Medicine	Orthotic-Prosthetics	A2	Oct-09	2 Months	Dec-09
7	Surgical Services	Orthopedics/Rehabilitation Medicine	Occupational Therapy	A2	Oct-09	2 Months	Dec-09
8	Behavioral Health	Substance Abuse Prevention	Outpatient Substantive Abuse Services	A2	Oct-09	2 Months	Dec-09
9	Behavioral Health	Behavioral Health	Child and Family Service	A2	Oct-09	2 Months	Dec-09
10	Behavioral Health	Behavioral Health	Family	A2	Oct-09	2 Months	Dec-09

Hardware

The JTF is preparing to undergo a tremendous effort in support of the BRAC initiative. This effort will likely involve several sites throughout the National Capitol Area (NCR) (specifically Walter Reed, Ft Belvoir and Bethesda). While there may be additional sites involved, the initial three sites are the primary concerns facing the JTF at this time. The key for this effort is to ensure integration and interoperability between sites. Due to scalability requirements – the size of the datacenter at Fort Belvoir is considerably smaller than the datacenter at Walter Reed. While the solutions do not need to be exactly the same they must be interoperable in order to ensure seamless data transfer between both sites.

JTF CAPMED's goal is interoperable systems working together to ensure disaster recovery and systems integration across the NCR. These systems must meet the following criteria:

- Ease of use
- Interoperability
- Cost effective

The following are the requirements necessary for hardware:

- Blade Servers – size and number to be determined by site (for servers and PCs/workstations)
- VM Ware or Xen – virtualization of the environment.
- Storage solution (SAN, NAS or both) – database support

- File share support and virtualization support
- Data de-duplication – provide increased disk storage capacity
- Data transmission – capability to transmit data from one site to another for migration, COOP and/or disaster recovery
- Disk to disk to tape solution – provide for limited ready availability of backup data and fulfill requirement for long term off-site storage
- Virtual Desktop – works in conjunction with PC blades and active directory infrastructure

Information Systems

Currently several information systems exist throughout the NCR. To ensure an integrated community, the JTF must integrate the information systems provided by the three Services. This will require architectural modifications to the network in order to support the various software platforms used by each Service. Specifically, a seamless solution for the NCR requires a shared IT platform that will be used by all NCR Military Treatment Facilities (MTFs). This shared IT platform would facilitate quick and convenient access to all information systems (IS), computer-based healthcare records, and administrative/support files from any medical facility within the NCR that directly impacts several layers of our healthcare delivery system. This will result in enhanced care for our beneficiary community and facilitates interaction within the service-lines to meet administrative and support requirements. A system that allows continued high availability and increased performance of service-line culture is a critical requirement. Several efforts are under way to include:

- Send out a data template to the Services that will collect relevant information on each IS
- Consolidate the input from Services in to a single list, review this updated list with Planning Team, achieve consensus on IS to migrate, and integrate and/or consolidate during the transition process
- Conduct an IT summit to analyze how IT can support the proposed IS implementation on the proposed network
- Identify infrastructure and support technologies, business processes and governance structures needed to implement the enterprise solution
- Send the consolidated IS list to the Joint Transition Planning Board (JTPB) for decisions/guidance and agreement on recommended systems for enterprise solution

Data Center and Fiber Optic Ring

JTF CAPMED is planning for a joint infrastructure which incorporates WRNMMC and FBCH, and supports the sharing of pertinent information with other external agencies. Specifically:

- The North data center at WRNMMC will be state-of-the-art and flexible to accommodate future technologies.
- The South data center at FBCH will mirror the north on a reduced scale with a warm/hot COOP site for critical systems
- Partnering with MHS Network Infrastructure Office to develop a new Wide Area Network Configuration
- All JTF CAPMED Facilities will have the latest information exchange solution used to share information with the Department of Veterans Affairs (VA) and other pertinent external agencies

The J6 has recommended a multi-phased approach for transitioning from the "As-Is" to the "To-Be" target architecture. Phase 1 will start now and end September 2010. As part of this effort the J6 will convert the Bethesda and Fort Belvoir campuses into JTF CAPMED-directed and operated single Metro Area/Local Area Network (MAN/LAN) architecture. The J6 will oversee the Wide Area Network (WAN) Telecommunications infrastructure at Army, Navy and Air Force clinics that were pre-BRAC supported by Service lines in order to provide support lost due to WRAMC and NNMC transitioning to JTF-directed joint facilities. Figure 29 depicts the projected Phase 1 plan below:

IM/IT Phase 1 Plan
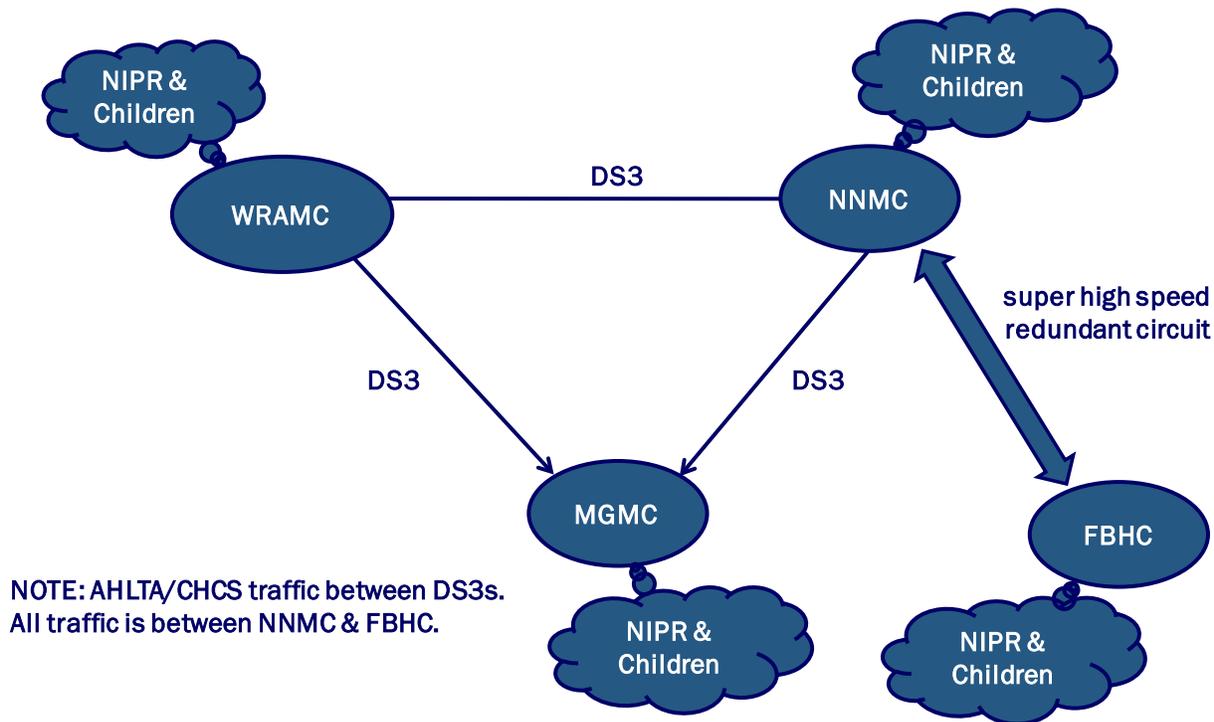
FIGURE 29 - IM/IT PHASE 1 PLAN

During Phase 2 the J6 will expand the WAN Telecommunications network between September 2010 and September 2011. This will include a subset of "children" (clinics) into the JTF-directed network of clinics. The J6 will re-align a pre-determined number of clinics such as the Army's Fort Meade so that they are incorporated into the JTF Wide Area Network architecture. The Air Force's Malcolm Grow Medical Center will become an enclave with connections to the JTF network for medical support. Figure 30depicts the projected Phase 2 plan:

IM/IT Phase 2 Plan
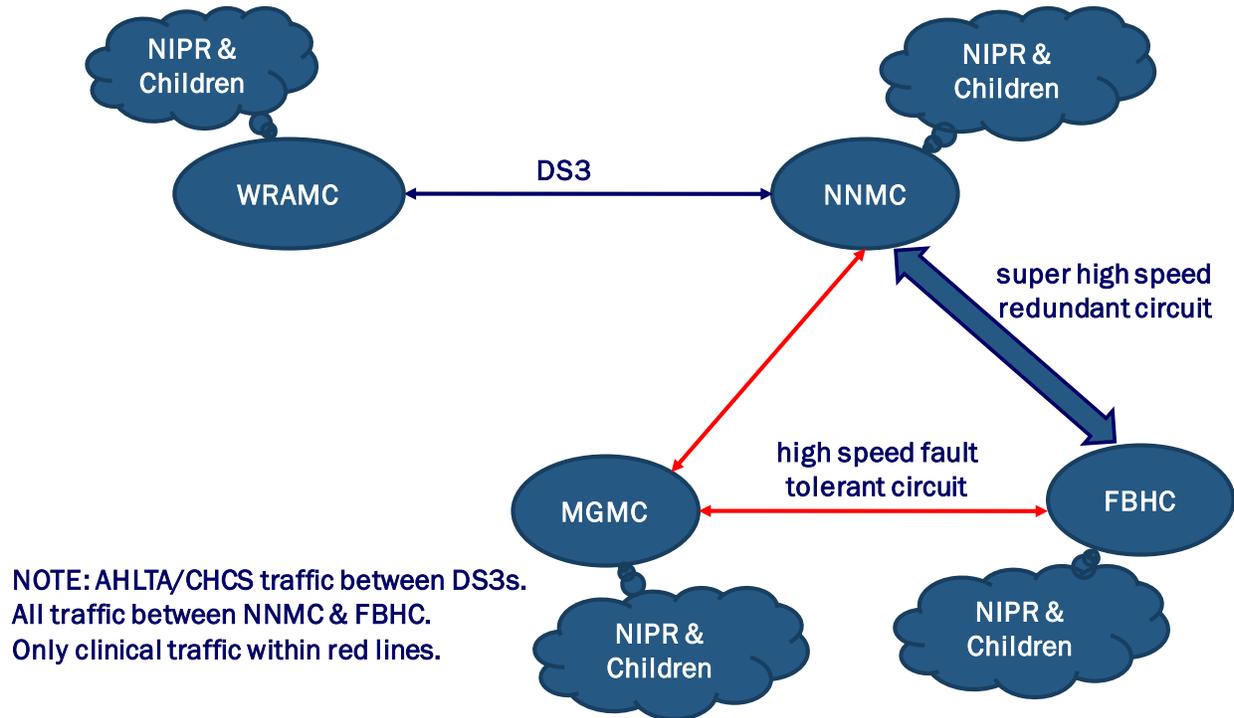
FIGURE 30 - IM/IT PHASE 2 PLAN

The J6 will complete transition (Phase 3) between September 2012 and September 2015 by enlarging the scope of clinics brought into the JTF network. The J6 will re-align Army, Navy and Air Force clinics to JTF-directed sites. In addition, J6 will re-design Wide Area Network Telecommunications support. Figure 31 depicts Phase 3 below:

IM/IT Phase 3 Plan
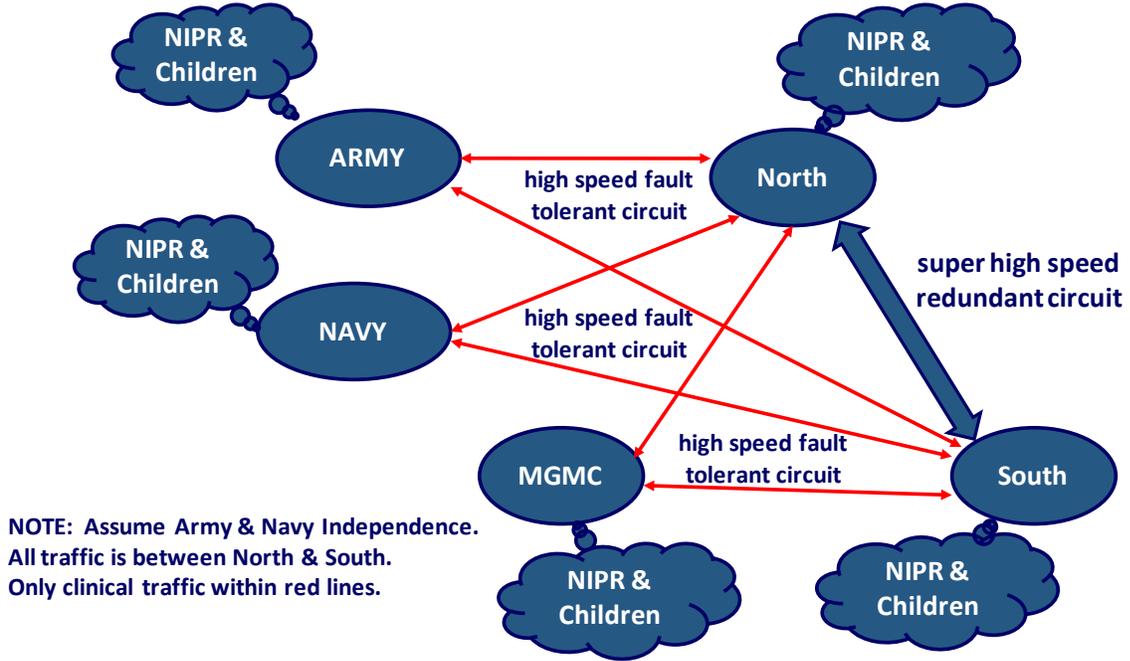
FIGURE 31 - IM/IT PHASE 3 PLAN

Evidence Base Design

JTF CAPMED has considered Evidence Base Design (EBD) principles that support patient and family centered care. The following are several EBD IT contributing factors the J6 is implementing at all facilities:

- Support patient and family centered care
- Implementation of "Smart Room" technology. A "Smart Room" looks to incorporate technology and workflow software to help improve consumer care and clinician efficiency with the incorporation of bed-side entertainment, patient educations, and two-way communication devices.
- RFID technology provides the ability for patients to control the temperature and lighting at the bedside.
- Mobile and handheld technology used to access bed status (Smart Suite by Cerner).
- There are plans to incorporate hard wired access in the patient rooms and considering the same in waiting areas of the outpatient buildings as well for attending family members
- Plans for extended patient services via electronic Kiosks, for example patient check-in and notification of pharmacy refills are being addressed.
- Finally, plans are being researched for Public Area Media Displays that can be used to play infomercials, as well as entertainment and communication in family waiting areas
- Improve healthcare quality and safety. There are plans for hands-free, wireless, communication devices that will allow staff to communicate internally thus reducing/eliminating noise. In addition there are plans for medication dispensing units and barcodes which will help reduce medication errors.
- Provide a positive work environment. There are plans for hands-free wireless communication devices that will enhance communicate internally thus reducing/eliminating noise.
- There are plans for Smart Beds which reduces physical demands on nursing staff thus improving quality and safety of the healthcare work environment.
- Design for maximum standardization, future flexibility and growth. To accomplish this there are plans for redundant and logical data pathways from the data center to each clinical building and then through vertical risers in no less than three locations in each building. Additionally, the project provides for future expansion requirements in the form of generous communications rooms and additional conduit paths between the data center and future rooms. There are plans for " near saturation" distribution plan to permit any communications outlet in any room to function as voice, data or fax offering expanded flexibility to support future needs.

Work Groups

The J6 indentified the need for work groups (WG) related to key business and design drivers. Together, their output comprises the contents of the BRAC Migration Plan. Each WG has representatives from the Army, Navy and Air Force. Members are drawn from the technical community at each service and include managers (Chief Information Officers (CIOs), Chief Technical Officers (CTOs) and Deputy Chief Information Officers (DCIOs). The output and outcome from the efforts of each WG are expected to facilitate the planning for solution systems to existing concerns.

An organizational chart of the WG is shown below in Figure 32:

IM/IT Organizational Work Chart

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                    ┌──────────┐
                    │   JTPB   │
                    └────┬─────┘
                         │
                    ┌────┴─────┐
                    │  J6 JPG  │
                    └────┬─────┘
        ┌────────────────┼────────────────┐
   ┌────┴────┐      ┌────┴────┐       ┌────┴────┐
   │  VIWG   │      │  TIWG   │       │  IMPC   │
   └─────────┘      └────┬────┘       └────┬────┘
                         │          ┌──────┴──────┐
                    ┌────┴────┐ ┌───┴───┐    ┌────┴────┐
                    │  IAWG   │ │ BGWG  │    │  CBIWG  │
                    └─────────┘ └───────┘    └─────────┘
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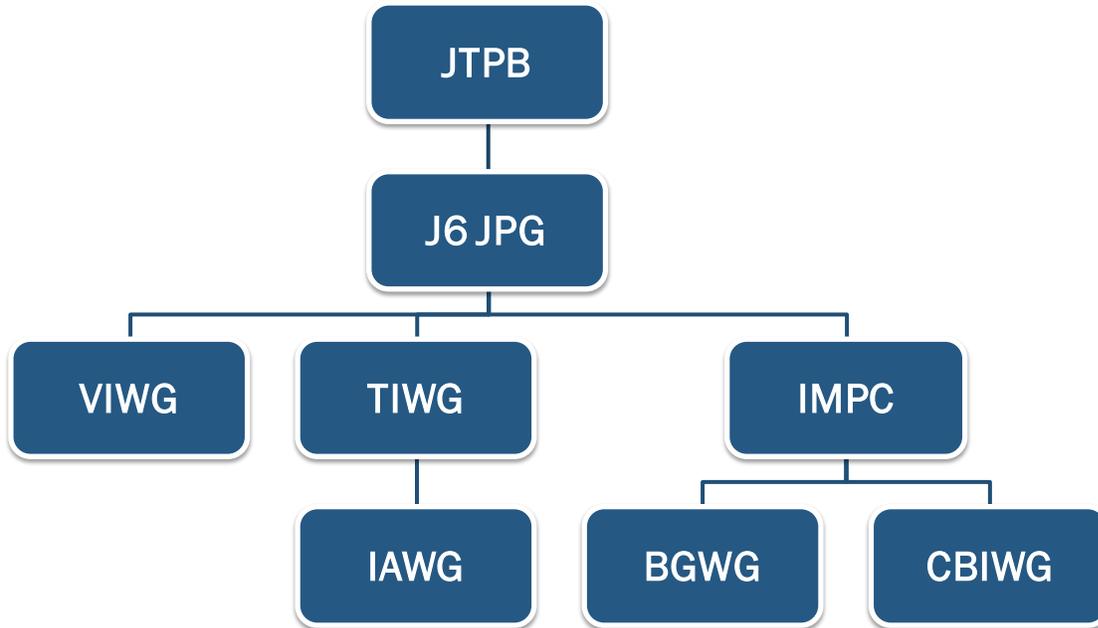
FIGURE 32 - IM/IT ORGANIZATIONAL WORK CHART

The first WG is the Visual Information Work Group (VIWG). The VIWG develops strategies and timelines for collecting visual information requirements. The group is responsible for records management, training videos, images, audio-visual aids, and video teleconferencing services.

The second WG is the Technical Infrastructure Work Group (TIWG). This WG develops strategy and timelines for collecting telecommunication network requirements. The WG is developing and documenting the phases for the way forward. After estimating the costs and identifying risks for each, the group will provide a recommendation to the JTPB. In addition, the TIWG will develop and document a Decision Matrix describing key success factors in terms of timely decisions to be made at the Service Chief and JTF senior management levels. Another duty for the TIWG is to develop and document a Risk Management Plan describing potential risks which could potentially attribute to mission failure. The WG will determine Internet Protocol infrastructure for integrated operations throughout the JOA.

The third WG is the Information Assurance Work Group (IAWG) which is a subgroup of the TWIG. This WG develops strategies and timelines for collecting information assurance requirements. The WG focuses on the Computer Network Defense Provider and Certification and Accreditation (C&A) Authority.

The Business/Governance Work Group (BGWG) and the Clinical/Business Integration Work Group (CBIWG) are overseen by the Information Management and Planning Commission (IMPC). The association and responsibilities of these entities is seen in Figure 33 below:

Governance Structure For CBIWG

- Identify clinical & business systems for integration into JTF environment
- Decide on strategy/timeline for transitioning legacy systems to North & South Campuses (e.g., LIS @ WRAMC)
- Develop strategy/timeline for implementing warm backup site at South Campus for North campus

- Identify business & governance structure and rules for making decisions on integration issues
- Make decisions ASAP e.g., on issues in the TIWG Decision Matrix
- Develop strategy & timeline for implementing warm backup site at South Campus

FIGURE 33 - GOVERNANCE STRUCTURE FOR CBIWG

JOA IM/IT Standard Business Rules and Processes

The J6 is underway in the development of plans to standardize the business rules and processes throughout the JOA. First, the use of existing systems from the MTFs to build a performance picture of the JOA. Next, the development of plans to partner with the Services to develop a better common operating picture. J6 will author a MOU/MOA with the Army OTSG to add JTF Navy and Air Force MTFs to the Army Medical Department (AMEDD) Command Management System. J6 will use the Enrollment Capacity Model and Practice Management Revenue Model for all JTF MTFs. Moving forward, J6 will use the MHS Insight Tool as it matures to capture more leading vice lagging indicators. Another effort will include piloting the use of MHS Value Dashboard Key Performance Measures. J6 will work with the BUMED, AF/SG, and the Army OTSG for Financial Management Regulations (FMR) and Satisfaction Collaboration on behalf of the JTF. The project plan model is shown in Figure 34 below:
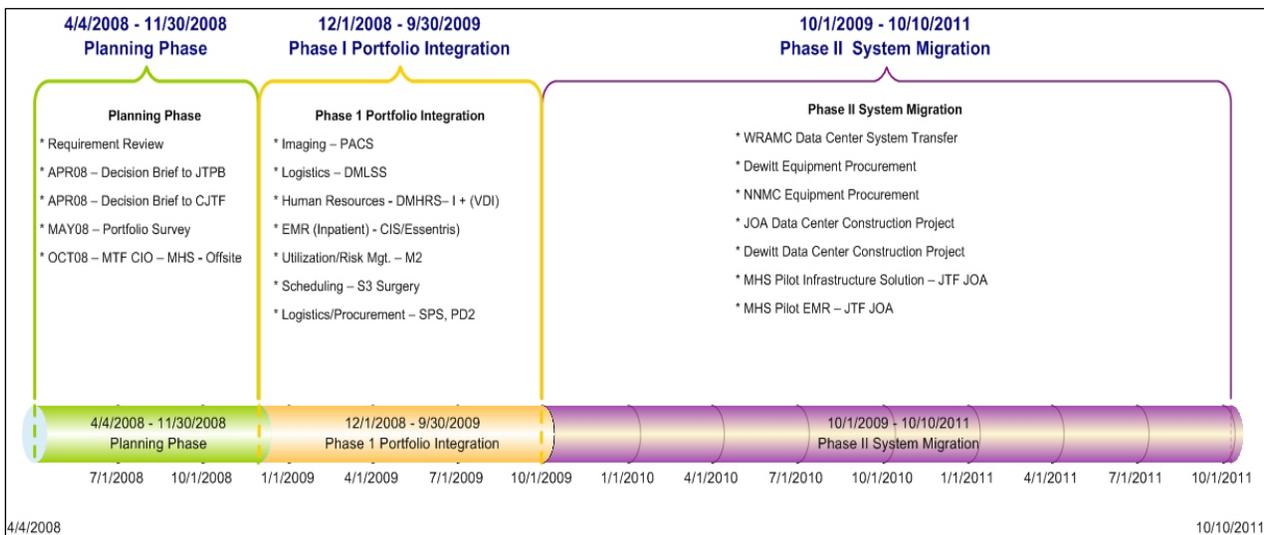
FIGURE 34 - IM/IT JOA-WIDE BUSINESS RULES IMPLEMENTATION TIMELINE

Risk of Issue

Challenges posed by the migration from WRAMC to the new WRNMMC and FBCH include satisfying the JTF CAPMED Commander's Vision of a fully integrated healthcare network throughout the NCR. To get there, J6 requires that the following goals be met for DOD's healthcare delivery system in the NCR:

- Single integrated Active Directory Authentication/Email Infrastructure
- Single integrated in-patient care system
- Single integrated patient appointing and administration
- Integration of administrative systems to clinical repositories
- Single sign on for all JTF facilities
- Provider presence and location awareness system
- LAN based asset tracking
- COOP/Warm failover capability for North and South data center
- Smart Room technology for all patient rooms to support EBD for the North and South
- Single network management platform for all JTF facilities
- Provide tele-services, tele-psychology, tele-neurology, remote patient monitoring, remote ICU concept, tele-surgery
- Provide world-class education and research facilities
- Integration with outside clinical partners (i.e. laboratories, Veterans Administration, commercial hospitals and trauma and research centers, Radiology grid computing at the Uniformed Services University of the Health Sciences (USUHS), National Institute of Health (NIH) and the Center for Disease Control (CDC)
- Single homogeneous Open Systems Interconnect layers 2 (data link) and 3 (network) between North and South facilities to support extension of layer 2 IP broadcast domains and Quality of Service (QOS) between North and South

Line	Directorate	Department	Service Unit	Building/Floor	RFE	Duratation	RFT
1	Behavioral Health	Behavioral Health -	Partial Hospitalization Child	A1	Oct-09	2 Months	Dec-09
2	Pediatrics	Pediatrics	Pediatrics--Primary Care (Outpatient)	A1	Oct-09	2 Months	Dec-09
3	Pediatrics	Pediatrics	Pediatrics General & Subspecialty	A1	Oct-09	2 Months	Dec-09
4	Behavioral Health	Behavioral Health	Preventive and Consultative Liaison Services	A2	Oct-09	2 Months	Dec-09
5	Surgical Services	Orthopedics/Rehabilitation Medicine	Chiropractics	A2	Oct-09	2 Months	Dec-09
6	Surgical Services	Orthopedics/Rehabilitation Medicine	Orthotic-Prosthetics	A2	Oct-09	2 Months	Dec-09
7	Surgical Services	Orthopedics/Rehabilitation Medicine	Occupational Therapy	A2	Oct-09	2 Months	Dec-09
8	Behavioral Health	Substance Abuse Prevention	Outpatient Substantive Abuse Services	A2	Oct-09	2 Months	Dec-09
9	Behavioral Health	Behavioral Health	Child and Family Service	A2	Oct-09	2 Months	Dec-09
10	Behavioral Health	Behavioral Health	Family Advocacy	A2	Oct-09	2 Months	Dec-09
11	Behavioral Health	Behavioral Health	Outpatient Integrated Adult	A2	Oct-09	2 Months	Dec-09
12	Behavioral Health	Behavioral Health	Preventive and Consultative Liaison Services	A2	Oct-09	2 Months	Dec-09
13	Medical Services	Medicine	Dermatology	E1	Dec-09	2 Months	Feb-10
14	Medical Services	Medicine	Endocrinology Service	E1	Dec-09	2 Months	Feb-10
15	Medical Services	Medicine	Optometry	E1	Dec-09	2 Months	Feb-10
16	Medical Services	Medicine	Infectious Disease	E1	Dec-09	2 Months	Feb-10
17	Medical Services	Medicine	Rheumatology	E1	Dec-09	2 Months	Feb-10
18	Surgical Services	Surgery	Ophthalmology	E2	Dec-09	2 Months	Feb-10
19	Medical Services	Medicine	Pulmonary	E2	Dec-09	2 Months	Feb-10
20	Medical Services	Medicine	Allergy and Immunology	B1	Mar-10	3 Months	Jun-10
21	Medical Services	Primary Care	Family Practice	B1	Mar-10	3 Months	Jun-10
22	Medical Services	Medicine	Cardiology	B2	Mar-10	3 Months	Jun-10
23	Public Health (Branch	Occupational Health	Occupational Health	B2	Mar-10	3 Months	Jun-10
24	Surgical Services	Orthopedics/Rehabilitation Medicine	Sports Medicine	B3	Mar-10	3 Months	Jun-10
25	Surgical Services	Orthopedics/Rehabilitation Medicine	Physical Therapy	B3	Mar-10	3 Months	Jun-10
26	Surgical Services	Orthopedics/Rehabilitation Medicine	Chiropractics (PMR)	B3	Mar-10	3 Months	Jun-10
27	Surgical Services	Orthopedics/Rehabilitation Medicine	Orthopedics	B3	Mar-10	3 Months	Jun-10
28	Surgical Services	Orthopedics/Rehabilitation Medicine	Podiatry	B3	Mar-10	3 Months	Jun-10
29	Clinical Support Services	Radiology	Radiation Oncology	D1	Apr-10	3 Months	Jul-10
30		Veterans Administration	Ft. Belvoir VA Clinic	D1	Apr-10	3 Months	Jul-10
31		Radiology	Breast Care Center	D1	Apr-10	3 Months	Jul-10
32		Cancer Care	Breast Clinic	D1	Apr-10	3 Months	Jul-10
33	Surgical Services	Surgery	ENT Otolaryngology	D2	Apr-10	3 Months	Jul-10
34	Surgical Services	Surgery	Audiology/Speech	D2	Apr-10	3 Months	Jul-10
35	Surgical Services	Surgery	Urology	D2	Apr-10	3 Months	Jul-10
36	Medical Services	Neurology	Adult Neurology	D3	Apr-10	3 Months	Jul-10
37	Surgical Services	Womens Health	General OB/GYN	C1	*1/10/2011	4 Months	Apr-11
38	Surgical Services	OB/GYN	Gynecological Oncologic Service	C1	*1/10/2011	4 Months	Apr-11
39	Medical Services	Emergency	Ambulance	C1	*1/10/2011	4 Months	Apr-11
40	Surgical Services	Surgery	Oral Maxillo Facial Surgery	C1	*1/10/2011	4 Months	Apr-11
41	Clinical Support Services	Pharmacy	Hematology Oncology	C1	*1/10/2011	4 Months	Apr-11
42	Executive Medicine	Executive Medicine	Executive Medicine	C1	*1/10/2011	4 Months	Apr-11
43	Surgical Services	Surgery	Anesthesia	C2	*1/10/2011	4 Months	Apr-11
44	Surgical Services	Surgery	General Surgical Clinic	C2	*1/10/2011	4 Months	Apr-11
45	Surgical Services	Surgery	Vascular Surgery	C2	*1/10/2011	4 Months	Apr-11
46	Surgical Services	Surgery	Cardio Thorasic Surgery	C2	*1/10/2011	4 Months	Apr-11
47	Critical Care	Critical Care	Critical Care	C2	*1/10/2011	4 Months	Apr-11
48	Medical Services	Medicine	Gastroenterology	C3	*1/10/2011	4 Months	Apr-11
49	Behavioral Health	Substance Abuse Prevention	Inpatient Substantive Abuse Services	C4	*1/10/2011	4 Months	Apr-11
50	Nursing	Psychiatry	Psychiatry (Inpatient Behavioral	C4	*1/11/2011	2 Months	Apr-11
51	Nursing	Mother Baby	Antepartum	C5	Apr-11	2 Months	Jun-11
52	Nursing	Mother Baby	Couplet Care	C5	Apr-11	2 Months	Jun-11
53	Nursing	Mother Baby	L&D	C5	Apr-11	2 Months	Jun-11
54	Pediatrics	Pediatrics	Pediatrics--In-Patient	C6	Apr-11	2 Months	Jun-11
55	Adult Medical-Surgical	Adult Medical-Surgical	Medical Surgery	C7	Apr-11	2 Months	Jun-11

*Date requires concurrence of contractor and COE, currently in negotiations

FIGURE 35 - FBCH CLINICAL TURNOVER READY FOR EQUIPMENT TO READY FOR TURNOVER

Physical Infrastructure

PHYSICAL INFRASTRUCTURE as a change dimension is especially critical during this transformation as it is highly complex and intersects with all the other change dimensions. As the oversight authority, JTF CAPMED demands program stewardship in areas of governance and program management that drives, integrates and coordinates the BRAC transition and the transformation to an integrated regional healthcare delivery system.

The building of WRNMMC and FBCH is the largest medical military construction project in history. These physical infrastructures will enable the delivery of world-class medical care in the National Capital Region. On the NNMC base, multiple capital improvement projects are underway including the construction of the WRNMMC, renovation of existing clinical and administrative sites and construction of the National Intrepid Center of Excellence. Fort Belvoir Community Hospital in the south of the JOA is being constructed utilizing innovative designs and will dramatically increase the medical capabilities offered to our beneficiaries living in Northern Virginia. The transition plans for these two projects included in this MTP include the design and construction history of the facilities, a detailed overview of the construction at NNMC, including a breakdown of the two construction projects – Request for Proposal (RFP) 1 and Request for Proposal (RFP) 2, the proposed sequencing and timing of relocation plans based on clinical construction milestones, and the Initial Outfitting and Transition Strategy.

Design and Construction Overview of New Hospital Facilities

The process of hospital construction in the private sector evolved significantly in the last several years to achieve time efficiencies by overlapping the traditional components of a sequential Design Bid Build (DBB) process. The truncation, through overlapping and other means, of the DBB process is current practice in the private sector and allows for defining of contract cost for materials while still affording flexibility in design to allow for advances in technology and practice.

Traditional Design Bid Build Process

Design

Procure (Bid)

Construction (Build)

Traditional DBB Process – a construction delivery method in which the owner contracts with separate entities for the design and construction of a project. It consists of three phases; Design Phase, Bidding or Tender Phase and Construction Phase.

FBCH Design and Construction Overview

The new FBCH is being designed and constructed through the Integrated Design Bid Build (IDBB) procurement process instead of the traditional DBB process where the design and construction contracts are awarded separately. The IDBB is an innovative process that uses coordination between the hospital design firm and the actual construction contractor to improve constructability and provide accurate cost/schedule impacts of design decisions. The process accommodates design updates much easier, and enables the USACE to establish a construction contract for the hospital long before traditional processes would have permitted, thereby meeting the aggressive construction timelines dictated by BRAC. In the IDBB method, the design contract and construction contract run concurrently as separate Government

managed contracts. This allows what would have been a five year process (if done sequentially) to be completed in just under 4 years. The Department's decision to enhance and accelerate these projects was also accommodated within this IDBB process and further reduced the original schedule. IDBB also requires the independent architect/engineer (A/E) firm and the construction contractor to work closely together under Government control and produce a higher quality, more responsive end product.

The contractor, Turner Gilbane Joint Venture, was formed in November of 2006 for the specific purpose of building FBCH. They bring expert healthcare preconstruction and construction knowledge as separately they were already two of the nation's largest and most successful healthcare builders with 35 years of award-winning construction history in the Washington Metropolitan Region. The designers, HDR/Dewberry Joint Venture, have an equally impressive resume of world-class accolades. HDR is ranked as the number one architectural firm in healthcare design by both *Modern Healthcare* and *Interior Design*. Dewberry is an *Engineering News Record's* "Top 50" design firm, and ranks in the top 25 in several of *Engineering News Record's* market categories.

FBCH Integrated Design Bid Build (IDBB) Process

Design

Procure IDBB

Construction Integration

Construction Phase
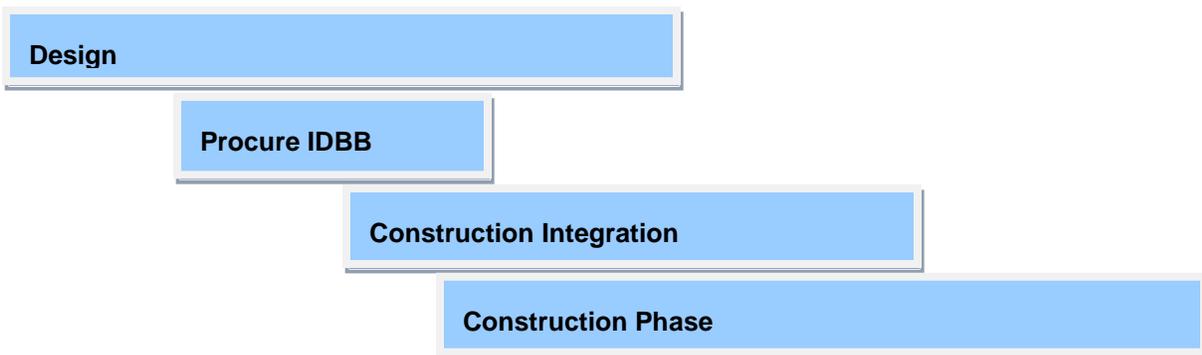
FBCH IDBD Process – an acquisition strategy in which the government directly holds separate Design and Construction contracts (Similar to Design Bid Build) and the Contractor is involved early in the project design cycle (as in Design Build).

WRAMC Design and Construction Overview

The new WRNMMC is being designed and constructed through a Design Build (DB) method where the project's design and construction are included within one contract versus the traditional DBB type of contracts where design and build are separate contracts. This affords several efficiencies. First, administration costs are reduced because there is only one contract to monitor. This is contrary to more traditional approaches where design, construction and other needs are covered by several contracts. Second, timely design changes can be readily implemented as construction and design are done simultaneously. When unexpected design changes are needed, it is easier and less costly to alter the design during the design phase rather than ordering a change once the design phase is completed. Also, when using a single contract for both design and construction, the Government does not have to coordinate the activities of the designer and builder since one entity is responsible for both functions.

In the DB method, the initial design is developed to about 35% completion by top medical designers before it is put out to bid for a design/construction contract. The design for WRNMMC was prepared by an independent A/E design firm joint venture of HSMM/HOK (Hayes, Seay, Mattern & Mattern/Hellmuth, Obata and Kassabaum), designers of award-winning state-of-the-art medical facilities across the country. The one million square foot Barnes-Jewish Hospital, St. Louis, Missouri which won the *Modern Healthcare*/AIA Design Award and the 2.1 million square foot Northwestern Memorial Hospital Chicago, Illinois, which won the Building Design and Construction (BD&C) Building Team Project of Year, are two recent examples.

In developing the design for the new WRNMMC, HSMM/HOK, working with Departmental engineers and military service medical facility offices, collaborated and consulted with the medical staffs from both NNMC and WRAMC, Wounded Warriors, patients and their families and residents of the surrounding communities. A series of three iterative design meetings were held with all stakeholders. The end product was a set of floor plans depicting 90% complete functional layout of buildings, clinics and supporting facilities plus the technical specifications, quality standards and hospital building code requirements. It also included the government's required construction schedule and phasing plan in order to meet statutory BRAC deadlines with minimal disruption to ongoing healthcare operations.

This package became the basis for soliciting and awarding a DB contract. The contract was awarded to Clark/Balfour Beatty, Joint Venture (CBB), Bethesda, Maryland, who in turn, was required to hire an A/E firm to develop a complete set of construction documents and specifications that comply with the HSMM/HOK medical design. CBB selected and hired the A/E firm of HKS, Inc., which is also an award winning healthcare design firm. The construction documents that HKS will prepare will become the basis for CBB to complete construction of the facilities. The Department's health facility planning team maintains control and oversight of the designers and construction contractors throughout the planning, design and construction process. This ensures that the Government team remains in control of the process and responsive to its customers.

WRNMMC Design Build (DB) Process

Design

Construction Phase One (Build)

Construction Phase Two (Build)

WRNMMC DB – a construction project delivery system where, in contrast to "traditional design-bid-build", the design and construction aspects are contracted with a single entity known as the design-builder or design-build contractor.

WRNMMC Cancer Centers and Integrated Cardiac Health Project

As an example of the mission responsiveness and flexibility of the DB process, the Department has managed to accommodate evolving concepts of patient care and practice such as the concept of providing a comprehensive cancer care center which was not part of the original Program for Design (PFD). The Department was able to make over 10,000 square feet of space available to accommodate the previously unconsolidated cancer centers on Level 3 of Building A at WRNMMC. This allowed for the realignment of these centers so that Women's Care functions (Ovarian Cancer and Breast Cancer) are aligned with common support amenities. A cosmetics boutique for Chemotherapy patients, a meditation room, a patient education room, and counseling rooms were added as part of a new concept organized around patient-centered comprehensive cancer care.

Walter Reed National Military Medical Center

The new WRNMMC will consist of two new Buildings A and B, which will be predominantly patient care areas. Building A will include mostly ambulatory care, primary and specialty care. Building B will include imaging, diagnostics and critical care beds. Other inpatient and surgical service renovations will occur in Buildings 9 and 10. See Figure 36 and Figure 37 below for an overview of the future state and clinical facilities of the Walter Reed National Military Medical Center.

Walter Reed
National Military Medical Center

345 Inpatient Beds
Square Footage:
Addition: 637,000
Alteration: 321,000
Support Facilities: 590,000

FIGURE 36 - FUTURE STATE: WALTER REED NATIONAL MILITARY MEDICAL CENTER

WRNMMC Clinical Facilities Overview
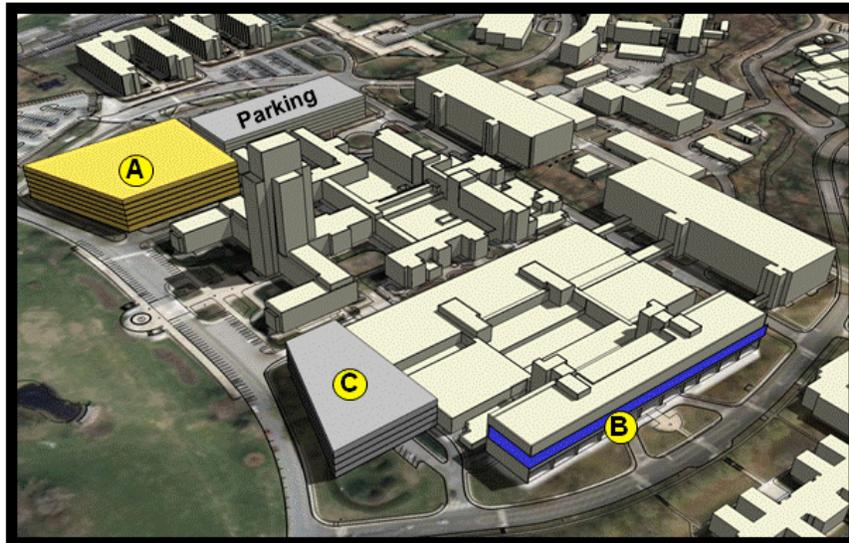
(A) Ambulatory Care Center Addition:
Tentative Construction Start May 2008
Tentative Construction Finish Sep 2010

(B) 66 Single Patient Beds (Renovation):
Tentative Construction Start May 2010
Tentative Construction Complete May 2011

(C) Warrior (Inpatient) Care Addition:
Tentative Construction Start May 2008
Tentative Construction Finish May 2010

FIGURE 37 - WRNMMC CLINICAL FACILITIES OVERVIEW

WRNMMC will also consist of several enhancements for wounded warrior care including new Joint Warrior Support Facilities (see Figure 38 below). Services will include a Warrior Clinic, a Warrior Housing Complex and non-medical support including fitness center and parking garage.

WRNMMC Enhancements for Joint Warrior Support Facilities

FIGURE 38 - WRNMMC ENHANCEMENTS FOR JOINT WARRIOR SUPPORT FACILITIES

Fort Belvoir Community Hospital

The new Fort Belvoir Community Hospital as shown in Figure 39 below, will be a 120 bed inpatient community hospital (Building C) with four attached clinic buildings, an attached utility plant, helipad and two parking garages.

Fort Belvoir Community Hospital

FIGURE 39 - FUTURE STATE: FORT BELVOIR COMMUNITY HOSPITAL

A design, construction and outfitting milestone schedule for WRNMMC and FBCH is provided in Appendix G the geographic IMS. The DoD expects construction and renovations to be completed between the beginning of 2010 and June 2011. All efforts continue to be made to meet the deadlines imposed by the Defense Base Realignment and Closure Act of 1990, as amended. See Figure 40 below for an overview of the future FBCH clinical facilities.
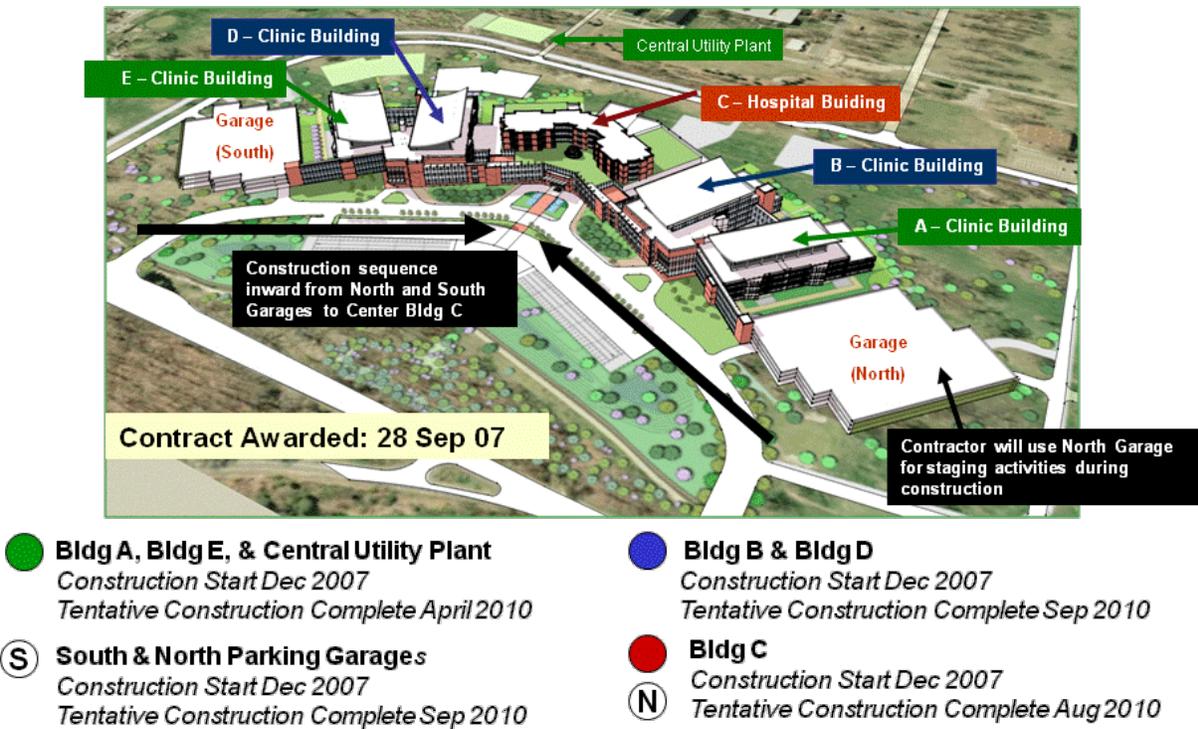
FIGURE 40 - FBCH CLINICAL FACILITIES OVERVIEW

Detailed Construction Plans and Milestones for the future WRNMMC

The capital improvements to the WRNMMC campus for BRAC have been broken up into two major construction pieces, RFP1 and RFP2 as demonstrated in Figure 41. Other construction projects on campus are being coordinated with the BRAC projects. Other construction projects on campus are being coordinated with the BRAC projects. The overall timeline for RFP1 and RFP2 are show in Figure 42.

WRNMMC Construction Overview

General Information
Scope: ~2M square feet of new construction and renovation

	Current	Projected
Base Population	8,000	10,500 (BRAC + Non-BRAC)
Patients/visitors	1860 per Day	Double Per Day

RFP 1

Scope of Clinical Work:
- 682,000 sq ft of new construction
- 320,000 sq ft of renovation (60% of existing clinic)

Scope of Non-Clinical Work:
- 327,000 sq ft of new construction (parking structure)
- 18,000 sq ft of renovation

Major Projects:
- 6-story, 520K sq ft Outpatient Facility
- 4-story, 162K sq ft Inpatient Facility
- 944 space Patient Parking Garage
- Clinic and Administration Renovation

RFP #2 Work

Scope of Work:
- 533,000 sq ft of new construction
- 80,000 sq ft of renovation

Major Projects:
- Fitness Center with pool
- Administration Facility (new and renovate)
- Barracks (152 plus suites and galley)
- 565 space Parking Garage

Other Work

- National Intrepid Center of Excellence
- Fisher House(s)
- 1200 space Multi-Use Parking Garage
- Main Operating Room Upgrade
- Traffic & Security Upgrades
- Vision Center of Excellence

FIGURE 41 - WRNMMC CONSTRUCTION AND PROGRAM OVERVIEW
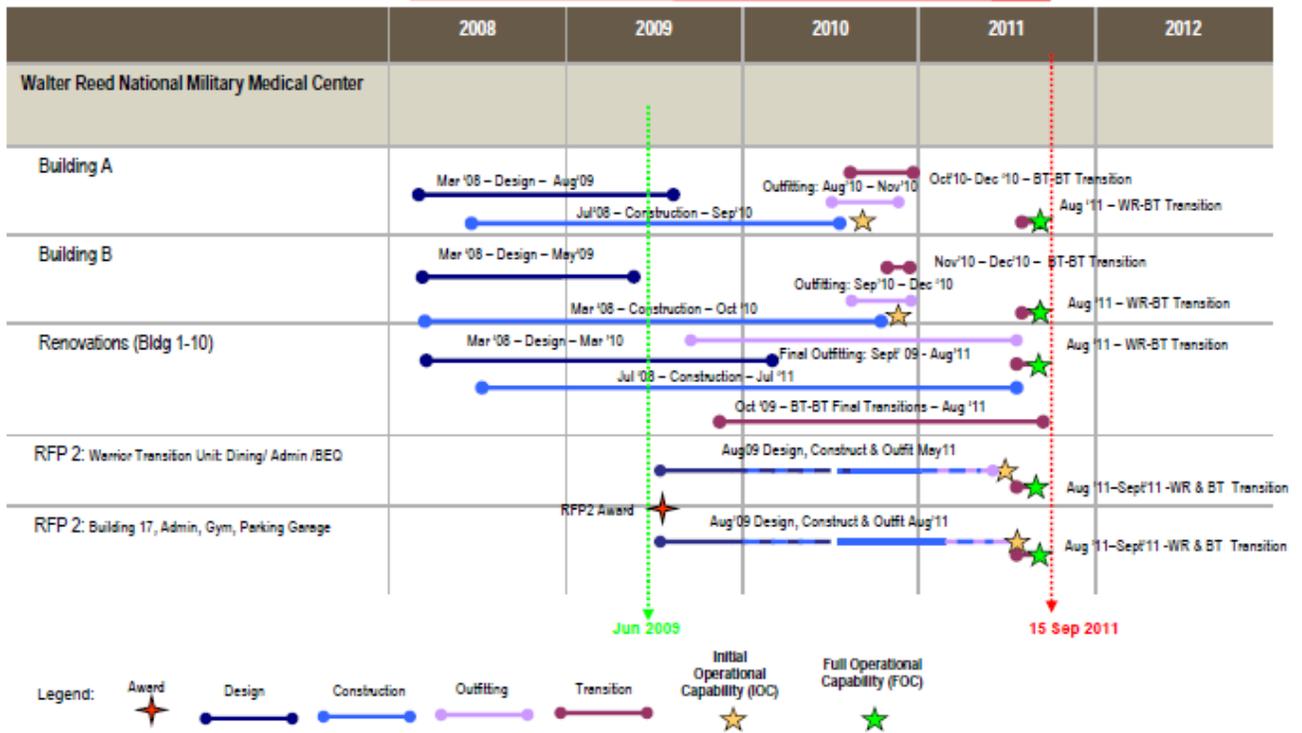
FIGURE 42 - BETHESDA BRAC CONSTRUCTION TIMELINE

Development of RFP1 & Design

The process of hospital construction evolved significantly in the last several years to achieve cost efficiencies by overlapping the traditional components of a sequential Design Bid Build process in the Design Build process. In a traditional Design Bid Build project, the client hires an architect/engineer to complete the 100% design prior to issuing a separate contract for construction. In a Design Build project, the owner hires one contractor to oversee both design and construction. The Design Build process is commonly adopted in the private sector and affords flexibility in design to allow for advances in technology and practice while still maintaining control of the project budget and schedule. This introduces several efficiencies. First, administration costs are reduced because there is only one contract to monitor. This is contrary to more traditional approaches where design, construction and other needs are covered by several contracts. Second, design changes can be implemented more efficiently. When unexpected design changes are needed, it is easier and less costly to alter the design during the design phase rather than ordering a change once the design phase is completed. Also, when using a single contract for both design and construction, the Government does not have to coordinate the activities of the designer and builder since one entity is responsible for both functions.

The concept design for WRNMMC was prepared by an independent A/E design firm joint venture of HSMM/HOK (Hayes, Seay, Mattern & Mattern/Hellmuth, Obata and Kassabaum), designers of award-winning state-of-the-art medical facilities across the country. The one million square foot Barnes-Jewish Hospital in St. Louis, Missouri which won the Modern Healthcare/AIA Design Award and the 2.1 million square foot Northwestern Memorial Hospital in Chicago, Illinois, which won the Building Design and Construction (BD&C) Building Team Project of Year, are two recent examples. Although NAVFAC uses the Design Build method extensively for the majority of their projects, this is the first time that DB methodology has been undertaken for a major medical project.

In developing the design for the new WRNMMC, HSMM/HOK, working with architects, engineers, and health care specialists from NAVFAC, collaborated and consulted with the medical staffs from both NNMC and WRAMC, Wounded Warriors, patients and their families. A series of iterative design meetings were held with all stakeholders. The end product was a set of floor plans depicting a solution for architectural layout of the clinics and supporting facilities that included adjacencies, sizes, and required functional spaces. This corresponded to a 35% architectural design solution. HSMM/HOK also included the government's required construction timeline and phasing plan in order to meet statutory BRAC deadlines with minimal disruption to ongoing healthcare operations. Figure 43 is an example of the floors plans produced by HSMM/HOK as the basis for the Design Build contract.

Existing Plan: Level 04
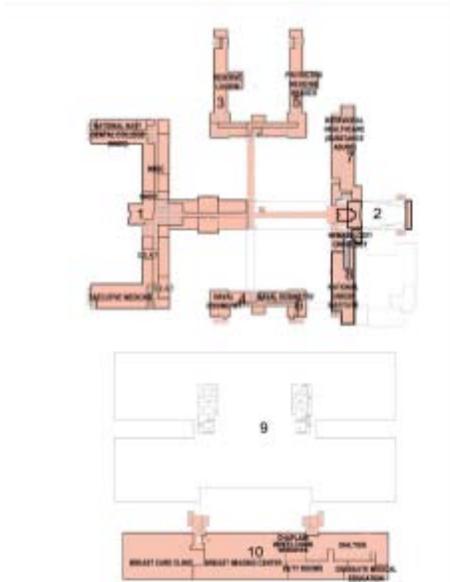
New & Renovation Plan: Level 04
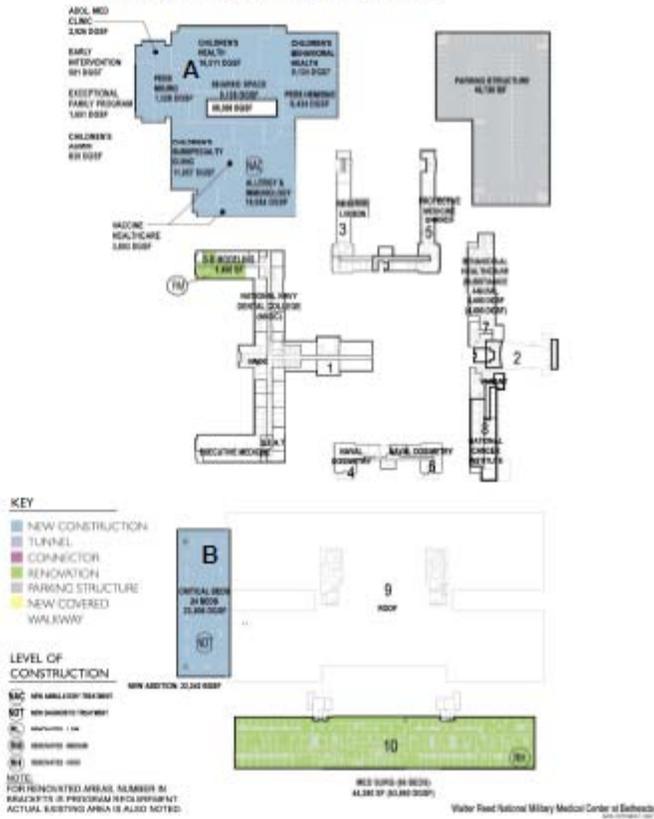
FIGURE 43 - BETHESDA LEVEL FOUR RFP DRAWING

This package became the basis for soliciting and awarding the Design Build contract. The contract was awarded to the design building team of Clark/Balfour Beatty, Joint Venture (CBB), Bethesda, Maryland and their design partners on March 2008. CBB selected and hired the Architect/Engineering firm of HKS, Inc., which is also an award winning healthcare design firm. The Navy's experts in healthcare design and construction maintain control and oversight of the designers and construction contractors throughout the planning, design and construction process. This ensures that the Government team remains in control of the process and responsive to its customers.

This project has been fully vetted through the National Capital Planning Commission (NCPC) which in turn coordinates with various other applicable local and state agencies within the National Capital Region projects. Concurrence was also received from Maryland's State Historical Preservation Office (MD SHPO). Coordination with NCPC and MD SHPO began in the fall of 2005, with the initiation of the Environmental Impact Statement.

Overview of RFP1 Scope

FIGURE 44 - BETHESDA BUILDING A, OUT-PATIENT AMBULATORY CARE PAVILION

RFP1 contains the clinical renovation scope which includes:

- Building A, as shown in Figure 44, is a new construction, out-patient Ambulatory Care Pavilion of over 520,000 square feet across six floors and a basement.

- Building B, a new construction, inpatient addition to the existing Building 9 of over 162, 000 square feet across four floors and a basement.

- A new Patient Parking Garage made of pre-cast concrete panels with over 900 parking spaces.

- Renovations of up to 379,000 square feet within Buildings 1-10.

- An upgrade to the existing Central Utility Plant.

- An underground logistic tunnel running from Building A to Building 54 for material handling and the electrical and data system.

- Connectors between new and existing buildings to improve patient access.

The Ambulatory Care Pavilion (Building A) to the north will provide outpatient services to including ,but not limited to, the Cancer Center, Neurology, Physical Therapy, Children's Health, and Internal Medicine spaces all clustered in one new building. In addition, outpatient services are supported by satellite laboratory, pharmacy and imaging stations. Table 10 - Bethesda Building A Service Units shown below contains a list of all services programmed for Building A. It will have a drop off area and adjacent outpatient parking structure to facilitate patient flow and way finding.

TABLE 10 - BETHESDA BUILDING A SERVICE UNITS

WR=New service originating from WRAMC. BT.AA.04 = Bethesda, Building A, 4th Floor			
Service Unit ID	**Name**	**Initial Locn**	**Final Locn**
2-01-01-01	Amputee Care	WR	BT.AA.00
2-02-02-01	Occupational Therapy	BT.09.00	BT.AA.00
2-02-03-08b	Physical Therapy - Out Patient	BT.09.00	BT.AA.00
2-04-02-04	Radiation Oncology	BT.09.00	BT.AA.00
2-02-03-03	Chiropractics	BT.09.00	BT.AA.01
2-01-01-09	Clinical (Satellite) Pharmacy	BT.09.02	BT.AA.01
2-02-02-06b	Orthotics Prosthetics	WR	BT.AA.01
2-04-02-02	Clinical Pathology Lab	BT.09.02	BT.AA.01
2-02-01-99a	Physical Medicine and Rehabilitation (PMR)	WR	BT.AA.01
2-01-01-05	Internal Medicine	BT.09.01 & BT.07.01	BT.AA.02
2-02-02-06	Orthopedics	BT.09.01	BT.AA.02
3-06-01-01a	Podiatry	BT.09.01	BT.AA.02
2-03-02-04	Satellite Diagnostic Radiology (Imaging)	BT.09.00 & BT.09.01	BT.AA.02
2-01-02-02	Breast Care	BT.10.04	BT.AA.03
2-03-01-03	Dermatology	BT.09.02	BT.AA.03
2-02-02-06c	GYN Oncology	WR	BT.AA.03
2-02-02-02	Hematology Oncology/ Cancer Center	BT.08.04	BT.AA.03
2-02-03-12	Prostate Cancer Center	WR	BT.AA.03
2-01-03-03	Rheumatology	BT.09.01	BT.AA.03
2-02-03-08	Adolescent Medicine	BT.09.01	BT.AA.04
2-01-01-07	Adolescent Psychology/ Children's BH	BT.10.07	BT.AA.04
2-01-03-09	Allergy	BT.09.01	BT.AA.04
2-02-03-05	Early Intervention	BT.10.07	BT.AA.04
2-03-02-03	Exceptional Family Program	BT.10.07	BT.AA.04
2-01-01-03	Immunization/ Vaccine Healthcare	BT.09.01	BT.AA.04

WR=New service originating from WRAMC. BT.AA.04 = Bethesda, Building A, 4th Floor			
Service Unit ID	Name	Initial Locn	Final Locn
2-03-03-02	Pediatric Hematology Oncology	WR	BT.AA.04
2-02-02-04	Pediatric Subspecialties	BT.09.01	BT.AA.04
2-01-01-02a	Pediatrics Primary Care	BT.09.01	BT.AA.04
2-01-03-13b	Audiology	BT.09.02	BT.AA.05
2-01-03-09a	Endocrinology	BT.09.02	BT.AA.05
2-02-03-09	ENT: Ear Nose & Throat/ Otolaryngology	BT.09.02	BT.AA.05
2-04-02-06	Speech Pathology	BT.09.02	BT.AA.05
2-02-03-13	Behavioral Health Outpatient	BT.07.03	BT.AA.06
2-01-01-04	Behavioral Health Partial Hospitalization	WR	BT.AA.06
9-03-03-00	Neurology	BT.09.02	BT.AA.06
2-01-01-06	Traumatic Brain Injury (DVBIC)	WR	BT.AA.06

The addition west of Building 9, the Inpatient Addition (see - Figure 45) will provide the required new ICU beds, the Emergency Department and additional diagnostic and treatment areas. Table 11 - Bethesda Building B Service Offerings lists the Building B service offerings. Connectors will be provided between the new Ambulatory Care Pavilion (Building A) to the main campus and a logistics tunnel will connect the Pavilion with Building 54 in the basement. Both new buildings are programmed to be LEED Silver Certified.

Figure 45 - Bethesda Building B Inpatient Annex

TABLE 11 - BETHESDA BUILDING B SERVICE OFFERINGS

WR=New service offering at Bethesda originating from WRAMC. BT.AA.04 = Bethesda, Building A, 4th Floor			
Service Unit ID	Name	Initial Locn	Final Locn
2-01-03-01	Emergency Dept/ Room	BT.09.01	BT.BB.01
2-01-03-10b	Diagnostic Radiology (Imaging)	BT.09.00 & BT.09.01	BT.BB.01
2-02-03-02d	Cardiac Catheter	BT.09.03	BT.BB.02
2-01-03-05	Radiographic Procedures / Multi Interv Imaging	BT.09.03	BT.BB.02
2-01-02-01	Cardio Thoracic (CT) Surgery	BT.10.03	BT.BB.02
2-01-02-04	Cardiology	BT.09.02	BT.BB.02
2-03-02-05	Vascular Surgery	BT.09.02	BT.BB.02
2-01-03-10	ICU	BT.09.03	BT.BB.03
2-01-03-10	ICU	BT.09.03	BT.BB.04
2-02-03-02	Anesthesia - Surgical (In Patient)	BT.09.03	BT.BB-03

Along with the medical additions, a large portion of the existing medical space will be renovated to meet the BRAC requirements. Portions of buildings 1, 2, 7, 8, 9 and 10 will be renovated. The west end of the basement of Building 9 is will be renovated for Pathology to include Anatomic, Clinical and Infectious Disease Labs. The first floors of several building are anticipated to receive renovation to accommodate a variety of functions: Infectious Disease Clinic in Building 7; the relocation of the Library to accommodate the Ophthalmology's Laser Eye Center in Building 8; and Pulmonary, Transplant, Nephrology, Neurosurgery, General Surgery, and Imaging in Building 9. Imaging will extend to the new addition west of Building 9 on this level. Pending the receipt of additional funds, Building 2 will be renovated for Optometry.

The second floors are also to receive some renovation in multiple buildings: Dental Readiness in Building 2 and 7; and Women's Clinics, Sleep Lab, Plastic Surgery, Cardiology, Cardio Thoracic, Cardio Pulmonary, Vascular Surgery, Oral Maxillofacial Surgery, Cardiac Rehab, Pharmacy Research, and GME

On-Call rooms and offices in Building 9. Cardiology will expand into the Building B from the second floor of Building 9.

On the third floor the renovations include areas in Buildings 9 and 10. Building 9 renovation will include the Main Operating Room, Anesthesia, Post Anesthesia Care Unit (PACU), Women's Invitro Procedures, Pain Clinic, Pain Block , Pediatric Sedation & Procedures, APU Check-in Center, and Stone Center; and portions of Building 10 will be renovated for Pediatric Ward, Medical/Surgical beds, and Inpatient Physical Therapy.

The fourth floor renovations include a new Medical/Surgical ward across all of Building 10 and 3-D Modeling in Building 1. Figure 43 is the architectural layout plans developed for the Design Build.

No renovations are anticipated on floors 5 and 6. Floor 7 of Building 10 will be renovated to expand the Behavior Health inpatient unit, some Psychological preventive and consultative services, and GME.

The construction completion dates of clinical services areas being provided with new or renovated space under RFP1 is provided in Table 12 - Bethesda RFP1 Renovation Service Offerings.

TABLE 12 - BETHESDA RFP1 RENOVATION SERVICE OFFERINGS

info			
WR=New service offering at Bethesda originating from WRAMC. BT.AA.04 = Bethesda, Building A, 4th Floor			
Service Unit ID	**Name**	**Initial Locn**	**Final Locn**
2-03-01-01	Anatomical Pathology	BT.09.03	BT.09.00
2-01-03-08	Clinical Pathology	BT.09.02	BT.09.00
2-02-03-04	Infectious Disease Lab	BT.09.01	BT.09.00
2-01-03-13	General Surgery	BT.09.02	BT.09.01
2-01-03-10b	Diagnostic Radiology (Imaging)	BT.09.00 & BT.09.01	BT.09.01
2-02-03-01	Pulmonary	BT.09.01	BT.09.01
2-04-02-08	Nephrology/ Dialysis	BT.10.04	BT.09.01
3-06-01-04	Neurosurgery	BT.09.02	BT.09.01
2-01-03-04a	Organ transplant	BT.01.04	BT.09.01
2-01-02-01	Cardio Thoracic (CT) Surgery	BT.10.03	BT.09.02
2-01-02-04	Cardiology	BT.09.02	BT.09.02
2-03-02-05	Vascular Surgery	BT.09.02	BT.09.02
2-02-03-06	Cardiac Rehab	BT.10.03	BT.09.02
2-02-05-01	General OB/GYN	BT.09.02	BT.09.02
2-02-01-02	Neuro Sleep Lab	BT.10.07	BT.09.02
3-06-01-05	Repro. Endo and Infertility	WR	BT.09.02
2-01-03-04	Uro/Gynocology	BT.09.02	BT.09.02
3-03-01-00	Urology	BT.09.02	BT.09.02

	WR=New service offering at Bethesda originating from WRAMC. BT.AA.04 = Bethesda, Building A, 4th Floor		
Service Unit ID	**Name**	**Initial Locn**	**Final Locn**
2-04-02-01	Women's Invitro Exam/ Admin	WR	BT.09.02
3-04-01-01	Pharmacy Research	WR	BT.09.02
5-02-05-99	09-02 GME On-Call Rooms	New	BT.09.02
2-01-02-03c	Oral Max Facial Surgery / Hospital Dentistry	BT.09.02	BT.09.02
2-01-03-12	Plastic surgery	BT.09.02	BT.09.02
2-02-01-99	Ambulatory Procedure Unit Check-in	BT.10.03	BT.09.03
2-02-03-02	Anesthesia - Surgical (In Patient)	BT.09.03	BT.09.03
2-01-02-03d	Post Anesthesia Care Unit (PACU)	BT.09.03	BT.09.03
2-03-02-04	Stone Center	WR	BT.09.03
2-01-03-07	Anesthesia Pain Clinic (Out Patient)	BT.09.03	BT.09.03
2-02-03-01c	Main Operating Room (MOR)	BT.09.03	BT.09.03
2-02-03-02b	Pediatric Sedation & Procedures Unit (Peds Partial Hospitalization)	WR	BT.09.03
2-02-02-06a	Women's Invitro Procedures	WR	BT.09.03
3-01-01-00	10-03 Medical/Surgical Ward	BT.10.03	BT.10.03
5-01-02-00	Pediatrics Inpatient Units	WR	BT.10.03
2-01-01-02b	Physical Therapy-In Patient	BT.10.05	BT.10.03
2-01-03-11	10-04 Medical/Surgical Ward	New	BT.10.04
2-01-02-03	In Patient Behavioral Health (Adult Inpatient Psychiatry)	BT.10.07	BT.10.07
5-01-02-00	10-07 GME On-Call Rooms	New	BT.10.07
2-04-04-99	Psychology: Preventive & Consultative	WR	BT.10.07
2-05-01-03	Infectious Disease Clinic (07-01)	BT.05.02	BT.07.01
2-01-03-02	Ophthalmology (08-01)	BT.08.01	BT.08.01
2-03-02-02	Dental Readiness (07-02 & 02-02)	BT.02.02	BT.02.02
2-02-03-02c	Health Physics (08-03)	BT.09.00	BT.08.03
4-03-99-99	3-D Medical Applications (01-04)	WR	BT.01.04
2-03-01-02	Family Advocacy Program (01-11)	WR	BT.01.11

The construction completion dates of clinical services areas being provided with new or renovated space under RFP1 is provided in Figure 46.

WRNMMC Internal Move Schedule

1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr

4th Qtr '09
General Surgery

2nd Qtr '10
Clinical Pathology
Dental Readiness

Buildings A & B Comp Sept' 10 & Oct '10

4th Qtr '10
Adolescent Psych
Allergy/Immunization
Anesthesiology
APU Check-in
Audiology/ Speech Pathology
Behavioral Health
Breast Care & Imaging
Cardiology
CT Surgery/Vascular Surgery
Dermatology
Early Intervention
Emergency Dept
Endocrinology
Ear, Nose, & Throat
Hematology Oncology (Cancer Center)
Intensive Care Unit
Imaging/Nuclear Med
Internal Medicine/Family Health Center
Multi-Interventional Radiology/Cardiac Cath
Neurology
Orthopedics & Podiatry
Post Anesthesia Care Unit
Pediatrics/Adolescent Med
PT/OT & Chiropractics
Radiation Oncology
Rheumatology
Satellite Pharmacy & Lab

1st Qtr '11
Behavioral Health Inpatient
Cardiac Rehab
Diagnostic Radiology
Infectious Disease Clinic
Neuro Sleep Lab
OB/GYN
Pulmonary
Repro. Endo and Infertility
Urology/Gynocology

3rd Qtr '11
Clinical Pathology
Infectious Disease Lab
Main Operating Room
Med/Surgery Inpatient
Nephrology
Neurosurgery
Oral Maxilliofacial Surgery
Ophthalmology
Pain Clinic
Physical Therapy Inpatient
Plastic Surgery
Transplant

Dept moves to final locations following renovations and new construction Schedule as of 5 May 2009

FIGURE 46 - WRNMMC INTERNAL MOVE SCHEDULE

RFP1 Construction Methodology

Much effort has been placed in isolating the daily operation of the medical campus from the construction work. For RFP1, a separate entrance has been established for construction workers and material delivery. The construction site has been cordoned off with fencing and jersey barriers. Construction traffic has been routed through a one way, dedicated construction path to facilitate the numerous daily deliveries. On-site construction parking has been limited and public transportation is encouraged. Construction activities and deliveries not confined to this construction zone have been coordinated with the hospital and are often performed after hours or on weekends to minimize impact to existing patient care.

FIGURE 47 - BETHESDA BUILDING A CONSTRUCTION PROGRESS AS OF JUNE 2009

The construction schedule has been compressed by the use of a design/build contract. Design risks have been mitigated by the segmenting the design into several design packages. The early design packages were fast-tracked to allow site, foundations and utilities work to begin. The schedule developed for new construction also considers the impacts on the renovation activities. For example, much of the renovation work is predicated on completion of Buildings A &B (see Figure 47 and Figure 48), services transitioning to their final location and vacating existing spaces for renovation to begin. Wayfinding and interior fit out designs have been coordinated between new construction and renovations.

Another construction management technique has been the use of a Short Interval Production Schedule (SIPS) to create accurate durations. The work is broken down into 10,000 square feet work areas which are to be worked by a single trade (Fire Proofing, HVAC, Electrical etc), and then turned over in a specific time. The trade then moves to a different work area and continues work, allowing another trade to move into the completed area. This method requires the subcontractors to provide the level of manpower required to perform the tasks and dedicates the area to a specific working group.

FIGURE 48 - BETHESDA BUILDING B CONSTRUCTION PROGRESS AS OF JUNE 2009

Potential delays to the construction schedule from design or external factors can be mitigated by re-sequencing the work areas.

In renovations, the phasing developed for the RFP as described in Figure 49 has been further refined and improved. Operability of the hospital during construction, construction access, availability of resources, adjacent work, the capacity of the government to outfit and transition to completed areas in a given period, necessary shift work (5 p.m. to 5 a.m.), working overhead, and available funding have been considered in the revised phasing plan. To facilitate the renovations, two temporary external medical swing spaces have been constructed for a total of 50,000 square feet. Numerous internal moves and shifts are required to vacate space for renovation.

FIGURE 49 - RFP PHASING NODE DIAGRAM

Development of RFP2 & Design

Overview of RFP2 Scope

Phase 2 of RFP2 was released for bid on April 2, 2009. This design, build and outfit contract is scheduled to be awarded fourth quarter of fiscal year 2009. It consists of largely non-clinical BRAC related construction on the Bethesda campus primarily for warrior transition support facilities. The programs include:

FIGURE 50 - BETHESDA BUILDING 17, FUTURE SITE OF ADMIN BUILDING

- A multi-story building combining Bachelor Enlisted Quarters (BEQ), Dining Facility, and Warrior in Transition (WTU) Administrative Center offices of approximately 280,000 square feet with the capacity of up to 306 residents

- Administration building on the site of Building 17 of 145,000 square feet over multiple floors. The historic Building 17 will be renovated and incorporated into this structure (see Figure 50 - Bethesda Building 17, Future Site of Admin Building)..

- Fitness Center of 70,000 square feet including a fifty-meter pool, gymnasium, fitness and training area, running track, volleyball/basketball and racquetball court, Integrative Cardiac Health Project, and ancillary facilities.

- Parking Garage of 565 parking spaces.
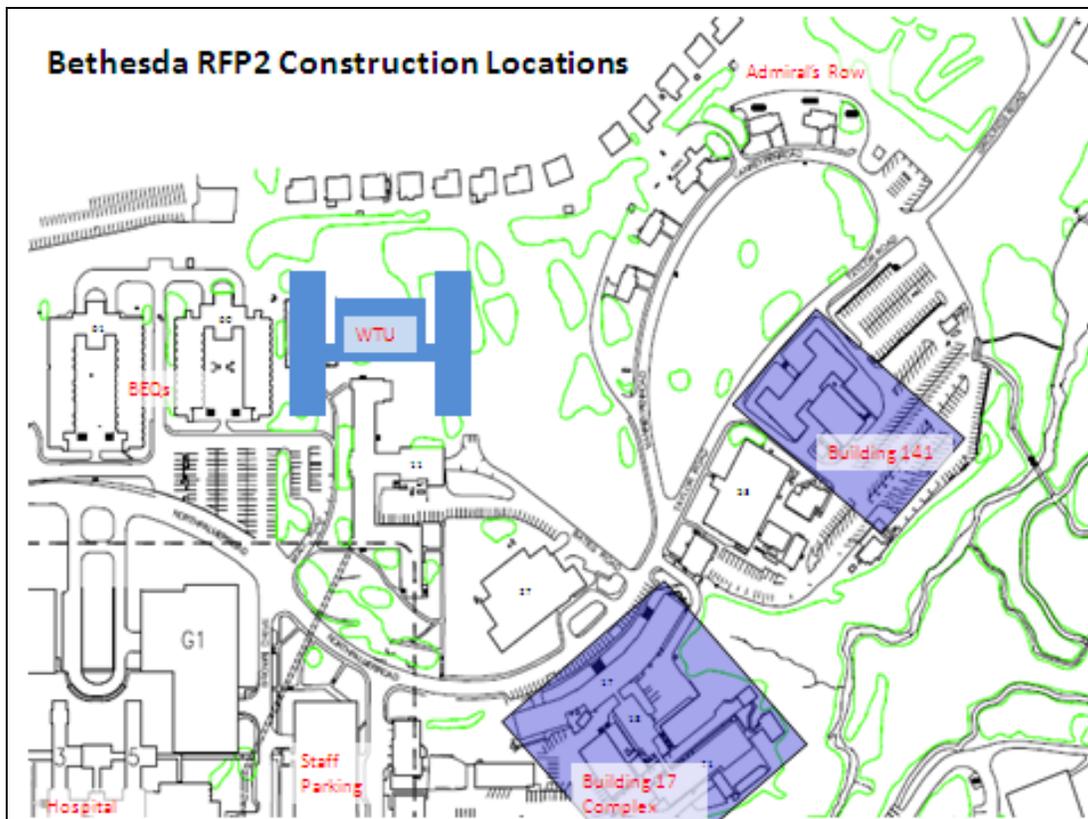
FIGURE 51 - BETHESDA RFP2 SITE MAP

As shown above in Figure 51, RFP2 has been designed to maximize value by allowing flexibility in the design. The contractor has the option of demolishing several buildings and using some or all of Building 17. In addition, the admin building, fitness center and parking garage may be combined into a single complex or constructed as stand-alone buildings. RFP 2 is a design, build and outfit contract. The WTU complex is to be completed by 3rd Quarter FY11 to support the transition of WRAMC to WRNMMC. The remaining, facilities: the admin building, fitness center and parking garage have a proposed due date of 4th Quarter FY11.

The BEQ & Dining facility commonly called the Warrior Transition Unit (WTU) will be located east of Building 60 and north of Building 11 as shown in Figure 52. The notional building plan follows an "H" design and will include housing, a dining facility and admin space. The 153 1+1E "Strickland" suites will meet all Americans with Disabilities Act requirements and include balconies. Each suite will house two warriors or residents. These suites are to be located in the wings of the "H". The dining facility in the center of the "H" will include a full service kitchen and will seat 240 occupants at a time. The WTU Administration Center will staff approximately 300 employees to provide services to Wounded Warriors and their families. Tenants of the WTU will include JWTC Brigade HQ, Individual Service Warrior Admin Spaces, Warrior Family Assistance Center, and TRICARE Operations.
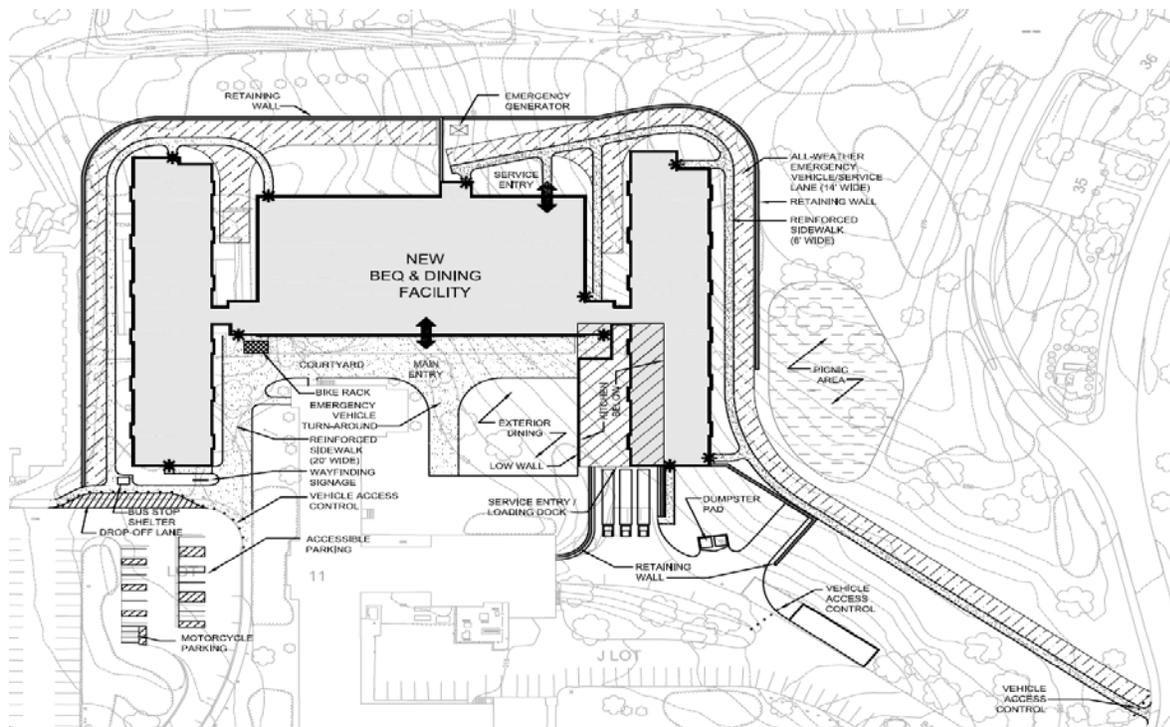
FIGURE 52 - WTU NOTIONAL LAYOUT

The administration building is to be built on the site of the historic Building 17 as shown in Figure 50. While the majority of this unoccupied building may be demolished, the facade and ends will be protected, reinforced and restored in accordance with National Capital Planning Commission requirements. The use or demolition of the interior of Building 17 is flexible.   The administration building will provide administrative office space relocated from Buildings 3 and 5, the Security and Public Safety Offices for the WRNMMC, as well as other support functions, including approximately 12,000 square feet of laboratory space for the Clinical Investigation and Tissue Bank departments. The demolition of Buildings 18, 21, 29, 49, 139, 150, 146, 174, 176 and 219 is required per contract.

Also on the Building 17 site is the Fitness Center. The 70,000 square foot facility will include a fifty-meter pool, gymnasium, fitness and training area, volleyball/basketball and racquetball court, Integrative Cardiac Health Project, and ancillary facilities.

The Parking Structure provides 565 parking spaces and is approximately 208,000 square foot in size. The Parking Structure may be constructed on the Building 17 site or on the site of existing Building 141.

The RFP-2 programs, with the exception of the parking garage, will meet USGBC Leadership in Energy and Environmental Design (LEED) Silver level certification.   Construction traffic will be routed into the University Road gate, along Perimeter Road and out the North Wood road gate. Improvements to the perimeter road on base are planned to support and separate the construction traffic from the patient traffic.

Multi Use Parking Garage

RFP1 included an option for a second multi use parking garage located near the site of the Fisher Houses. The option was not executed due to lack of funds and expired in March 2009. The program office is still pursuing additional funds to construct this third new parking garage on the Bethesda campus.

Other Capital Improvements on Bethesda Campus

Construction of the National Intrepid Center of Excellence (NICoE) for Psychological Health and Traumatic Brain Injury on the Bethesda campus has begun. The NICoE will provide intensive outpatient evaluation, advanced diagnostic, initial treatment plans, and long term follow-up for patients suffering from Traumatic Brain Injury and Psychological Health issues. Between one and three additional Fisher Houses are programmed to be added to the Bethesda campus and will provide housing for visiting families of wounded warriors. Figure 53 is an artist's rendering of the NICoE facility.

FIGURE 53 - BETHESDA - RENDERING OF NICOE

NNMC is pursuing upgrading the existing operating rooms in parallel with construction of new ORs per the RFP1 Renovation scope. The IT data center is also being expanded to provide additional capacity. Finally in 2010 construction is planned to begin on the expansion of the Navy Exchange.

Other BRAC related projects are the improvement to the Perimeter Road, entry control points, commercial vehicle inspection station, Visitor's Center, and intersection improvements. In addition, plans are in place to update the perimeter fence, add lanes, and install crash beams and cable barriers. Improvements to intersections and bike and pedestrian access are being considered and in some cases designed by State Highway Administration, Montgomery County and the Washington Metropolitan Area Transit Authority.

Construction of BRAC and other capital improvements on the Bethesda campus are being closely coordinated with NNMC facilities, maintenance contractor, NAVFAC, NAVMED NCA, and the construction agents to align operations and scope across the projects. Additional long term planning and projects are discussed in NNMC's campus Master Plan. Figure 54 is an extract from NNMC's Master Plan indicating areas of construction and improvement on campus.

FIGURE 54 - NNMC MASTER PLAN UPDATE 2008

Internal NNMC to NNMC Transition Moves

Working closely with the contractor, NAVFAC, the NNMC transition team, and representatives from the NAVMED NCA Health Facilities Planning Office are coordinating the internal department moves at Bethesda.
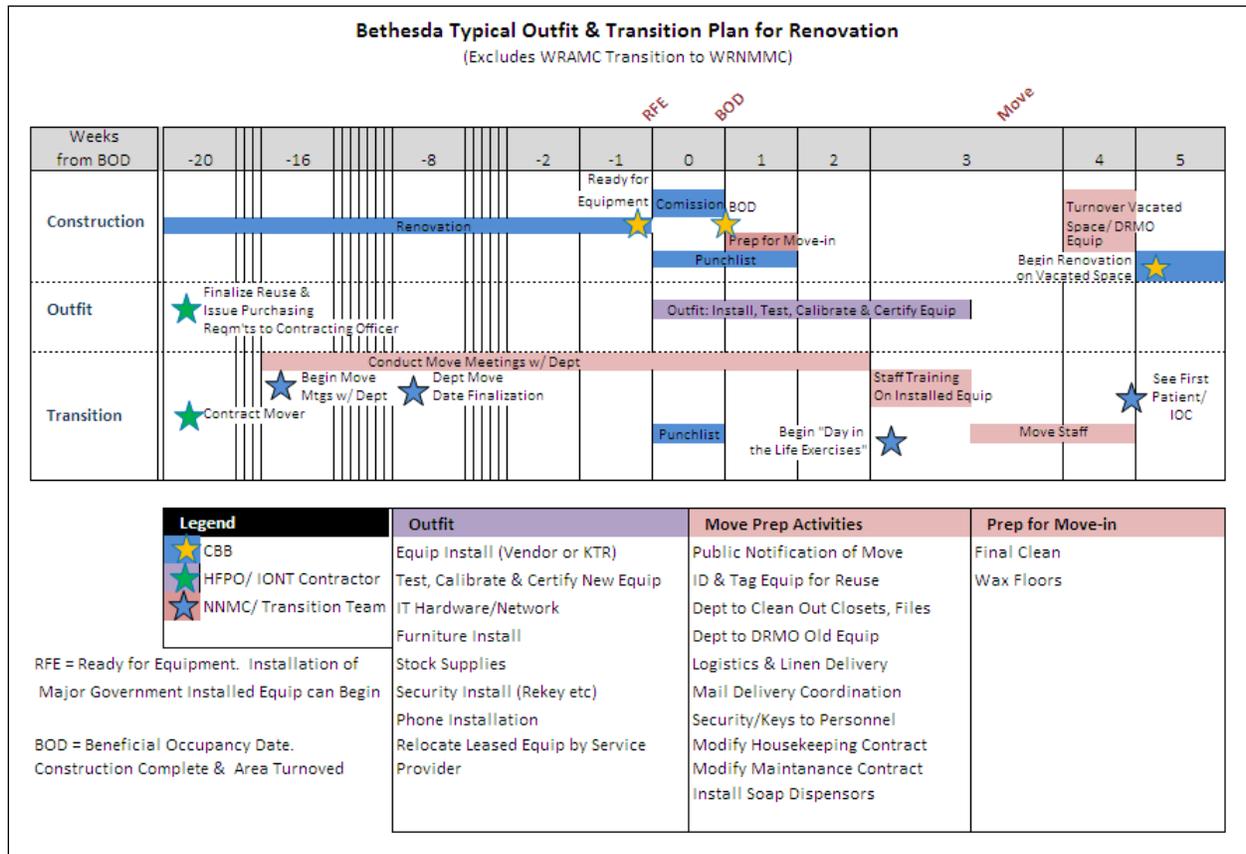
FIGURE 55 - TYPICAL BETHESDA TRANSITION TIMELINE FOR RFP1 RENOVATIONS

Figure 55 charts the process of a typical department move for renovations work. Once an area has been commissioned and accepted by the government, the area is deemed acceptable for transition and is outfitted with new or reused medical equipment, furniture, fixtures and supplies. Other government responsibilities include installation of information technology and telecommunications services. In some instances, early installation of government installed equipment may be permitted by the contractor prior to area turnover. The medical equipment may require calibration, certification, testing, and staff training prior to use. Equipment is installed in sufficient time to conduct "Day in the Life" scenarios and/or department training on installed medical equipment.

Coordination for a departmental move begins well in advance of the physical move date. Weekly transition meetings begin with the department heads and the transition team approximately five months in prior to the move date. The move date is established eight weeks in advance in order to appropriately schedule patient appointments. Prior to the move, the department personnel can perform walk-throughs of their space and verify that the space is ready for move-in and operations. Staffs are responsible for packing their personal belongings and the contracted movers physically transport the items.

Representatives from Logistics, IT, security, marketing, department operations, administration, and infection control coordinate the details of each transition. The May 2009 transition of the Pediatrics and Adolescent Medicine departments to the modular swing space occurred over a weekend. Patients were seen in the old location up until noon on Friday. At noon, the following Monday, the first pediatric patient was seen in the new location. In the prior month, the Emergency Department transitioned to a new location over a period of less than six hours while maintaining continual operations. While it may not be possible to keep all transitions this short, the hospital staff and transition team will strive to achieve the best results possible. These early Bethesda moves provide the opportunity to fine-tune the transition and communication process in advance of the WRAMC relocation to Bethesda.

Transition Planning Based on Construction Milestones

The DoD anticipates beginning outpatient healthcare service delivery at the new FBCH by April 2011. The building opening is planned for June 2011. The new space at Bethesda, Buildings A and B should be available for care in part or in total between November 2010 and August 2011. This window of time is dependent on resolution of the later stage renovations, which subsequently will affect the duration of transition time.

Ideally, five months of unfettered transition time would be available; however, the realities of the schedule's critical path may require overlapping transition activities across the end stage ("red zone") of construction. Figure 56 - WRNMMC and FBCH Outfitting and Transition Process, is a transition and outfitting process mock-up.
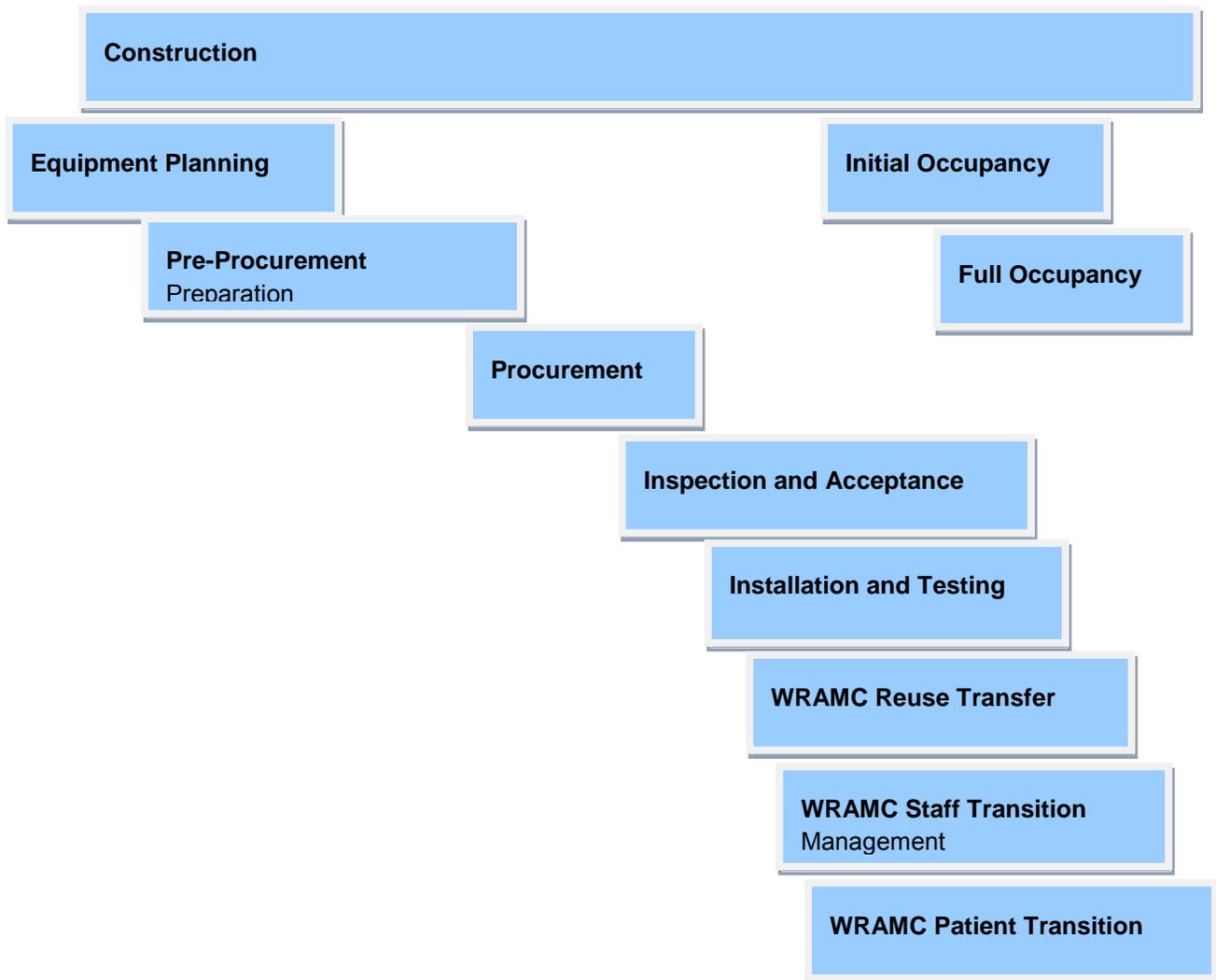
FIGURE 56 - WRNMMC AND FBCH OUTFITTING AND TRANSITION PROCESS

NNMC to New WRNMMC

Setting up WRNMMC for FOC by the BRAC deadline of September 2011 will involve two distinct transition efforts. The first is the coordination and transfer of resources from the present NNMC in Bethesda to the new and renovated facilities at WRNMMC and the second is the transfer of resources and patients from the present WRAMC to the new WRNMMC (a portion of these resources are also transferring to the future FBCH). At Bethesda, the transition plan is relatively straightforward. As each clinical and/or administrative area is completed (in either new or renovated space), the respective NNMC function will move in. Many clinics will vacate their space and move to temporary space to allow for renovations in the clinical vacated space. Thus, the NNMC transition to WRNMMC is governed by the construction schedule. Figure 47 is a high level schedule of the major moves that will be occurring as a part of the internal transition from NNMC to the new WRNMMC. The following dates refer only to the transfer of the clinical capabilities and are non-inclusive of predecessor activities associated with the transition of the service.

The newly expanded facilities at WRNMMC will predominately contain patient care areas; Building A and Building B. Building A will include mostly ambulatory, primary and specialty care, while Building B will include imaging, diagnostics, and critical care beds. Figure 57 contains a list of the clinical services, by location, that will be offered at the future WRNMMC.

WRNMMC Clinics List

Building A:

Adolescent Medicine
Adolescent Psych/Children's Behavioral Health
Adult Outpatient Behavioral Health
Allergy
Amputee Care
Audiology Speech
Breast Care
Chiropractics
Dermatology
Early Intervention
Endocrinology
ENT or Otolaryngology
Exceptional Family Program
Family Health
GYN Oncology
Hematology Oncology
Hematology Oncology/Cancer Center
Immunization/Vaccine Healthcare
Internal Medicine
Neurology
Occupational therapy
Optometry
Orthopedics
Orthotic Prosthetics
Outpatient Pharmacy
Partial Hospitalization
Pathology Blood Lab
Pediatric Primary Care
Pediatric Subspecialties
Physical Therapy (Outpatient)
Podiatry
Prostate Center
Radiation Oncology
Rheumatology
Satellite Radiology

Building B:

Cardiac Cath
Cardio Thoracic Surgery
Cardiology
Critical Care/Intensive Care Unit
Diagnostic Imaging
Emergency Department
Radiographic Procedures
Surgical Anesthesia
Vascular Surgery

Renovated Buildings 1-8:

3-D Medical Apps
Family Advocacy
Health Physics
Infectious Disease
Ophthalmology

Renovated Building 9:

Anatomical Pathology
Anesthesia Pain Clinic
APU, MOR, PACU, Women's Invitro
Cardiac
Clinical Investigations Pharmacy
Clinical Pathology
Graduate Medical Education
Infectious Disease Lab
Nephrology/Dialysis
OB/GYN
Pulmonary
Stone Center
Surgery (Gen, Neuro & Organ Transplant, Plastic, Urology, Oral)

Renovated Building 10:

Behavioral Health Inpatient
Medical/Surgical Wards
Pediatric Inpatient
Physical Therapy Inpatient
Preventive & Consultative Psych
Secure Inpatient

Freestanding:

Warrior Transition Unit

FIGURE 57 - WRNMMC CLINICS LIST

WRAMC to WRNMMC and FBCH

The clinical transition from WRAMC to WRNMMC and FBCH is more complex than the moves previously described. In most cases, WRAMC services will move to both receiving locations. Any significant transition out of WRAMC is dependent on the delivery of new space at FBCH and WRNMMC. Thus, the WRAMC transition requires the completion of FBCH, the new additions at WRNMMC and construction of other supporting services, i.e., administration and parking at Bethesda. As the schedule in depicts in Figure 59, this complex patient transition and relocation of service capabilities will be carried out using the quick, end move strategy (i.e., over a consolidated period of time) fleshed out at the JTF CAPMED simulation.

WRAMC Move Schedule

3rd Qtr
CY 2011

3rd Qtr '11 (August)

3-D Medical Applications
Adolescent Medicine
Adult IP Psychiatry
Adult Neurology
Adult OP Behavioral Health
Allergy Immunology
Ambulatory Procedure Unit (APU)
Amputee Care
Anatomical Pathology
Anesthesia
Audiology Speech
Behavioral Health
Breast Care Center
Cardiology
Cardiothoracic Surgery
Care Unit (PACU)
Child Partial Hospitalization
Chiropractics
Clinical Pathology
Dental Readiness
Dermatology
Diagnostic Radiology (Imaging)
Emergency Ambulance Services
Endocrinology
ENT Otolaryngology
Environmental Health
Family Advocacy
General Surgery
GI & Virtual Colonoscopy
Graduate Medical Education

Health Physics
Infectious Disease
Internal Medicine IP
Internal Medicine OP
Medical Oncology
Nephrology
Neurosurgery
Nuclear Medicine
OB/GYN
Occupational Health
Occupational Therapy
Ophthalmology
Optometry
Organ Transplant
Orthopedics
Orthotics & Prosthetics
Partial Hospitalization
Pediatrics OP
Pediatrics IP
Physical Therapy OP
Physical Therapy IP
Plastic Surgery
Post Anesthesia
Prostate Center
Pulmonary
Radiation Oncology
Repro. Endo and Infertility
Rheumatology
Substance Abuse Prevention
Urology

FIGURE 58 - WRAMC MOVE SCHEDULE

Existing DACH to New FBCH

Setting up FBCH for FOC by the BRAC deadline of August 2011 will involve two distinct transition efforts. The first is the coordination and transfer of resources from the present DACH to the new FBCH and the second is the transfer of resources and patients from the present WRAMC to the new FBCH (a portion of these resources are also transferring to the future WRNMMC). The DACH transition to the new FBCH is relatively uncomplicated. When the FBCH is completed, services from DACH can readily move in. Some services could potentially transition in advance as individual buildings and/or floors become available; however, this approach will not provide great benefits. As described further (under WRAMC to FBCH), Building C, the main hospital (including the ER, ancillary support, and inpatient beds) will be the last building to be completed at FBCH. It is estimated that the existing DACH to FBCH transition will occur between April and June 2011. Outpatient services would come on line in April, while the inpatient tower is readied for occupancy. Inpatients would then move over in June. Figure 59 shows a high-level schedule of the major moves that will be occurring as a part of the internal transition from DACH to the new FBCH.

FBCH Internal Move Schedule

2nd Qtr
CY 2011

2nd Qtr '11 (April)

Allergy & Immunology
Audiology & Speech
Pathology
Behavioral Health
Cardiology
Community Health Nursing
Dermatology
Endocrinology
Ear, Nose & Throat
Family Practice
General Surgery
GI & Virtual Colonoscopy
Internal Medicine
Occupational Health
Occupational Therapy
Ophthalmology
Optometry Services
Orthopedics & Podiatry
Orthotics & Prosthetics
Pediatrics
Physical Medicine and Rehab
Physical Therapy
Sports Medicine
Urology

2nd Qtr '11 (June)

Anesthesia
Blood Donor Center
Breast Care Center
Central Sterile
Clinical Pharmacy
Emergency Amb. Services
Environmental Health
Graduate Medical Education
Health Physics & Radiation Safety
Industrial Hygiene
Main Operating Room
Main Radiology Suite
Nuclear Medicine
Nursery
OB/GYN
Obstetrics
Pharmacy
Radiology
Surgical
Transfusion & Pheresis Services

FIGURE 59 - FBCH INTERNAL MOVE SCHEDULE

When completed, the 120-bed FBCH main facility will provide a robust array of primary and secondary health services while highly specialized, tertiary-level services will be provided at the new WRNMMC. Figure 60 contains a list of the clinical services, by location, that will be offered at FBCH.

FBCH Clinics List

Clinic A:

Admin (Behavioral & Children's Health Services)
Children's Behavioral Health
Chiropractics
Family Advocacy
General Internal Medicine
Occupational Therapy
Outpatient Integrated Adult
Pediatric Partial Hospitalization
Pediatrics (General & Sub-Specialties)

Clinic B:

Allergy & Immunology
Cardiology
Cardiothoracic Surgery
Cardiovascular & Pulmonary Admin
Community Health Nursing
Family Practice
GI & Virtual Colonoscopy
Occupational Health
Orthopedics & Podiatry
Orthotics & Prosthetics
Physical Medicine & Rehabilitation
Physical Therapy
Sports Medicine

Hospital C:

Anesthesia
Behavioral Health
Breast Care Center
Chapel and Pastoral
Care Clinical Care ICU & IMCU
Emergency Ambulance Services
Environmental Health
Fast Track Clinic
General OB/GYN
Health Physics & Radiation Safety
Hematology Oncology Pharmacy
Industrial Hygiene
Inpatient/Outpatient Pharmacy
Investigational Research
Labor & Delivery
Main Operating Room
Main Radiology Suite
Medical Library
Medical Oncology
Medical Surgical
Multidisciplinary Interventional Imaging
Nuclear Medicine
Nursery
Pediatric Inpatient
Preventive & Consultative Services
Residential Treatment Facility, Substance Abuse
Transfusion & Aphaeresis

Hospital C:

Admin
Blood Donor Center
Clinical Pathology & Infectious Disease Lab
Clinical Pharmacy
Hospital Dentistry

Clinic D:

Audiology & Speech
Breast Care Center
DVBIC
ENT Otolaryngology
General Surgery
Nephrology
Neurology
Neurosurgery
Plastic Surgery
Radiation Oncology
Urology
VA Clinic

Clinic E:

Dermatology
Endocrinology Service
Infectious Disease
Ophthalmology
Optometry
Pulmonary
Respiratory Services
Rheumatology
Vaccine Healthcare Centers

FIGURE 60 - FBCH CLINICS LIST

Logistics and Equipment

Initial Outfitting and Transition Strategy

The physical infrastructure plans are not limited to construction alone, but also the outfitting of the new clinical spaces with the equipment necessary to provide world-class healthcare. This equipment must be in place prior to moving patients and staff. JTF CAPMED has developed an Initial Outfitting and Transition (IO&T) strategy consisting of three key elements: a central performance based service contract, procurement contracts for long lead items, and contracts to support the reuse of current assets from Walter Reed Army Medical Center (WRAMC) and DeWitt Army Community Hospital (DACH).

Central Performance Based Service Contract

The central performance based contract is scoped to support the WRNMMC Request for Proposal 1 (RFP1) and the FBCH MILCON projects with a comprehensive suite of equipment acquisition and transition services. . The contract will be managed by the Government to purchase equipment and services for both projects, and is designed to achieve unity of effort, economies of scale (i.e. cost savings through quantity purchases), and patient safety through interoperability and standardization of equipment across the NCA. The objective of the single contract is to allow the Government centralized control over all acquisition activities associated with simultaneously standing up the two new facilities. It leverages the experience, management, skills and marketing power of civilian contract sources for which this is their "core business".

Unlike most other BRAC moves, the relocation of sensitive medical equipment, staff and supplies cannot be undertaken by a series of "garden variety" move contractors. A comprehensive, deliberate approach must be achieved to minimize the myriad possible risks to the schedule and to patient care. Not only does the NCA BRAC program cross Service lines, it also crosses geographical and state and local boundaries. Most DoD medical treatment facility moves have taken place within the confines of the single DoD installation. DoD has no direct authority over state and regional transportation networks, and has extremely limited inherently governmental experience in the logistics, storage, synchronization and move permitting associated of such a relocation. Placing all these logistical activities into a single contract minimizes risk to the move process by placing the government in a position of contract management, versus the many details of move management.

Although the DoD has equipped and outfitted major medical facilities in the past, this initiative is far more complex than any previous undertaking, merging the equipment and staff of four existing medical treatment facilities into two new facilities, while maintaining world class health care in a wartime scenario. This type of contract approach was successfully executed in support of the transition to the Walter Reed Army Institute of Research/Naval Medical Research Center in 1998. During this transition process, every detail of the move was flawlessly accomplished, without any unforeseen impact to medical research, loss of property or code violation. The healthcare delivery mission of must be paramount to the staff of the existing MTF operations, and "day to day" management of the details of this complex move could lead to mission failure.

For purposes of the contract, the equipment requirements are divided into four categories: medical, non-medical, IM/IT, and furniture and furnishings. In addition to providing equipment, hardware, materiel and supplies to outfit each of the projects, this contract will also provide transition services (planning and execution) to support the overall acquisition and equipping process. Support for establishing this central performance based service contract is being provided by two DoD contracting organizations: the U.S. Army Medical Research Acquisition Activity (USAMRAA) and the TRICARE Management Activity (TMA)

Acquisition Team. The required pre-procurement documents for the contract were developed by the JTF Program Manager and the JTF/JOA Acquisition Team Members, based on the following inputs:

- USAMRAA/TMA submitted Draft Acquisition Plan for Approval
- NNMC/DACH submitted performance based service contract requirements
- USAMRAA/TMA submit Final Acquisition Plan for Approval
- Acquisition Team submitted final procurement documents to USAMRAA/TMA

Although the identified critical milestone to award this contract is January 2010, the specific equipment procurement strategy will not be determined until the central performance service based contract is awarded. Prospective contractors will be encouraged to propose their own "best" strategies for delivery timetables, working within the parameters of the construction schedules, and move, activation, and transition services based on expertise. As discussed below, long lead items and efforts to support the reuse of equipment from WRAMC and DACH are purposefully not included in this central contract. Appendix J is the Equipment Performance Solicitation Work statement.

Procurement Contracts for Long Lead Items

Long lead items are generally defined as medical equipment items costing over $100K and require more than 6 months to procure. The long lead items consist of equipment such as linear accelerators, diagnostic imaging equipment, pharmacy equipment and robotics, laboratory equipment, ophthalmic lasers, 3-D applications equipment, and surgical robotics. Due to the cost and technical complexity of procuring and installing such long lead items they are being procured via other existing contracting vehicles, to mitigate risk to the central performance based service contract. Additionally, this assures the medical equipment items critically linked to building design and construction is available when needed. Requirements for long lead items are being supported by several contracting offices based upon agency contracting mission, available capacity, and experience in contracting for capital expense equipment items. The MILCON funded long lead items for the FBCH are being procured by the U.S. Army Corps of Engineers. The majority of long lead items for FBCH and WRNMMC are being supported by the Defense Supply Center Philadelphia (DSCP). Equipment that is not within the scope of the DSCP mission will be supported by the Naval Medical Logistics Command (NAVMEDLOGCOM). One unique requirement is the da Vinci Surgical Robotic System required at both MILCON sites. Since NAVMEDLOGCOM has purchased this item recently, they will support this item for both projects. The following actions have been completed to set the conditions for the long lead strategy:

- DSCP identified long lead items they can support.
- FBCH coordinated and finalized long lead items with U.S. Army Corps of Engineers.
- NAVMEDLOGCOM assigned all other long lead items to a contracting activity.
- Long lead reuse and standardization decision was determined.

Contract to Support Reuse Items from WRAMC and DACH

The Acquisition Team is exercising due diligence to reuse major investment equipment items From 10 March – 3 April 2008, the Joint Technology Assessment and Requirements Analysis (JTARA) Team conducted assessments of current equipment and technology used at Walter Reed Army Medical Center (WRAMC), DeWitt Army Community Hospital (DACH), National Naval Medical Center (NNMC), and Malcolm Grow Medical Center (MGMC) in the areas of diagnostic imaging, pharmacy, laboratory, monitoring systems, and central materiel service. In a final report released in September, 2008, the JTARA Team recommended that certain items, systems and technologies be considered for reuse. Since

the release of this report, the two MILCON project teams have assessed the JTARA recommended items for reuse. (See Appendix I for JTARA report executive summary). Although equipment and systems under $100K were not evaluated by the JTARA Team, assets under $100K at WRAMC and DACH were reviewed by both MILCON project teams for reuse

A Diagnostic/Ancillary Services Group was created to drive the final reuse decisions and to obtain the joint approvals and coordination actions needed for the reuse items. As both MILCON projects reached 100% design in the April- May 2009 timeframe, the decisions regarding reuse of these JTARA items are being finalized. Reuse of items is also balanced and coordinated with constructions schedules, equipment standardization objectives, and clinical transition plans. Reuse of the major equipment items and systems requires contracts to de-install, move, reinstall, test, and in some cases recertify the equipment's installation and operation. NAVMEDLOGCOM has routinely supported such service contract efforts and will support contracts for equipment reuse that require these services.

Initial Outfitting and Transition Budget

BRAC funding has been allocated to the project, based upon programming estimates used in the DoD for Medical Military Construction projects. The budget for initial outfitting and transition (IO&T) was originally projected as a percentage of the total construction cost of both facilities, as estimated using the Unified Facilities Criteria DoD facilities pricing guide prepared by the U.S. Army Corps of Engineers. This funding is used primarily in two areas: Initial Outfitting and Transition Support.

Initial Outfitting

BRAC funding is the primary funding source to procure replacement equipment, or to install new or relocate existing equipment into the new facilities. The standard exception to this funding source is high value, technology intense installed imaging and clinical equipment, which are procured with MILCON funding (identified on the DD 1391 as "Category E"). Every effort should be made to reuse and relocate existing equipment, and Initial Outfitting funds should be reserved to only procure equipment either supporting expanded capabilities, or to replace equipment that cannot be relocated. Also, dependent upon equipment life cycle management, some additional equipment items may be procured with O&M funding in the MTFs base budget. For example, if an equipment item reaches the end of its useable life immediately before the transition to the new facility, it should be replaced using normal equipment replacement funding, as opposed to utilizing Initial Outfitting funds.

Transition Support

Normal MTF resourcing is based upon the execution of their mission: providing healthcare. The design, construction and transition to a new facility adversely impacts the ability of the MTF to achieve that mission due to the many demands on staff, space and other resources. Therefore, Transition Support funding allows for the temporary augmentation of MTF resources mitigate that impact. For example, additional property management staff and equipment maintenance support could be added, and warehouse space rented, to support the procurement, receipt, testing and installation of equipment. Additionally, manpower could be contracted to support the development of Concepts of Operations, staff orientation and training plans prior to the move, and additional security guards to protect government resources during the transition process. At the end of the transition period (which extends beyond initial start up) the intent is that this temporary augmentation of staff or space is curtailed, and that the continued operation of the MTF is through its programmatic base budget. "One time costs" could also be eligible for Transition Support funding. Examples of "one time costs" include: initial cleaning of the new

facility prior to occupancy, costs of the physical moves and initial provisioning of a "basic load" of supplies and disposables that mitigate any supply shortage upon initial start up.

IO&T Funding Management

During the construction and transition process the JTF J-8 manages the allocation and distribution of IO&T funding. Data calls to the MTFs, through their Component Commands, systematically identify the various transition funding requirements, and JTF J-8 subsequently releases funding for approved activities to the MTFs for execution. Periodic In-Progress Reviews are held to determine the status of funds and to anticipate additional requirements, or to mitigate shortfalls.

One of the unique aspects of the NCA BRAC program is that many of the transition activities typically performed by MTF staff augmentation will be the responsibility of the Central Performance Based Service Contract (see above). Rather than each MTF independently contracting for additional services, economies of scale and synergies will be achieved by central management. Additionally, given the dynamic, yet interrelated, nature of relocating activities to two separate projects with independent delivery schedules, the burden of synchronization and coordinating falls to the contractor. Although the Government retains management oversight, professional civilian move management contractors are far more experienced and adept at such activities. The Government has experience in moves to new, large MTFs, but it is neither recent, nor a skill/experience set that is inherently governmental in nature. Often, experience gained on a single project is lost upon completion, as there is no continuity of opportunity to deploy that experience at a follow on project. Therefore, through the Central Performance Based Service Contract, the burden of delivering the appropriate skill sets and support contracts required for execution of the outfitting and transition process becomes the responsibility of the contractor.

Equipment Design Process

The DoD Space and Equipment Planning System (SEPS) develops the Program for Design. The equipment planning module of SEPS produces a by-room listing of every piece of equipment required for the new facility called the Project Rooms Report (PRR).

The PRR is provided to the A/E for incorporation into the facility's designs, and to the Transition Team/HFPO to coordinate with the local medical activity.

During the succeeding phases of design submittals the A/E will coordinate equipment requirements with the different engineering disciplines. This is to ensure the electrical/mechanical designers have provided appropriate utility support, the structural engineers have included floor loading considerations, and architects have integrated these restrictions into space which is properly sized and located. During this same time, equipment planners will meet with the local medical activity staff to review the PRR and ensure that all of the necessary equipment considerations have been addressed, and that any additions/deletions in equipment are promptly transmitted to the A/E for this action. After all changes have been integrated into the designs and a 100% submittal is completed, the A/E will prepare the final contract documents. An updated PRR will also be prepared. Once the final documents are released the Equipment Design Process is concluded. During the Equipment Validation Process responsibility for procurement, installation and any further design changes associated with the new facility's equipment is assumed by the local medical activity.

Campaign Plan Framework

The purpose of including the Campaign Plan framework is to ensure that the reader understands the framework of the Campaign Plans and the commander's strategy for transforming healthcare delivery in the NCR JOA.

Figure 61 below is a conceptual framework for the Campaign Plans, and outlines the campaign planning construct. Each campaign plan has goals and objectives focused on the end state of each time horizon.

JTF CAPMED Campaign Plan Framework

Strategic Guidance

DEPSECDEF memos, QDR 2006, NSS

Strategic Plan

JTF CAPMED Strategic Plan

Campaign Plan 1

Re-align and Transform

Present – Oct 2012
"Define the JTF (ourselves)"

Near-Term

Campaign Plan 2

Find efficiencies and refine sustainable solutions
Oct 2012 – Oct 2017
"Demonstrate our Value"

Long-Term

Campaign Plan 3

Demonstrate the JTF as Joint MHS Center of excellence
Oct 2017 – "Lead Strategic Change"

Vision 2023

FIGURE 61 - JTF CAPMED CAMPAIGN PLAN FRAMEWORK

The Campaign Plan framework describes how the JTF CAPMED will provide the highest quality of healthcare in the Military Health System, and is a strategy to create a legacy of world-renown healthcare.

Strategic Context

The 2006 Quadrennial Defense Review provides a context for the delivery of healthcare in the NCR with respect to the requirements for transformation. Specifically it states,

> New breakthroughs in science and health, and new innovations in prevention and wellness, offer the opportunity to develop a 21st century Military Health System that will improve health and save both lives and money. This transformation in health and healthcare parallels other transformations in the Department of Defense. It is the Department's goal to have a lifetime relationship with the entire Department of Defense family which maximizes prevention, wellness and personal choices and responsibility.

As with other areas related to the Department enterprise, the QDR recommends aligning medical support with emerging joint force employment concepts. Building on recent improvements in new purchased care contracts and the streamlining of regional TRICARE management structures, the QDR recommends continuing to shift toward a market-driven, performance-based investment program. It also recommends improving planning processes and the transparency of information, while leveraging the recent launch of the Department's electronic health record system. This new system is needed to effectively manage MHS by adopting a more flexible financing process. Above all, the Department's military and civilian senior leaders endorse the need to modernize the TRICARE benefit structure for those customers who are not on Active Duty. The intent is to promote longer and healthier retirement lives by encouraging self-responsibility for their own and their family's health and the use of health resources to achieve the longest, healthiest lives at the lowest cost. Doing so will require changes in legislation and rules to adjust TRICARE cost-sharing features so that they restore the balance Congress created in establishing the TRICARE program in the 1990's and also to seek authority for Health Savings Accounts.

New concerns regarding the current state of the economy, while growing the defense budget added another level of power on the microscope above us. The Defense Health Program is a specific target for budget reduction as a huge part of the Department of Defense budget is on military healthcare. This year, $47 billion is budgeted for the military healthcare for over 9 million beneficiaries. As the 2010 Quadrennial Defense Review is written and published, there is no question that the JTF CAPMED will be directed to demonstrate efficiencies and find areas for cost reduction. Doing this while also transforming into two joint facilities, amidst a $2.4 billion construction project is a daunting task. The JTF shall take the direction of our civilian and military leadership to continue to be good stewards of our resources, demonstrate our capabilities, and find efficiencies. There is an expectation that the creation of the JTF will force cost reduction and reduce inefficiencies and redundancies in the NCR medical delivery systems. The highest levels of the Department of Defense and Congress are interested in our progress in providing the best care to service members and their families, while forging ahead in a new direction of joint, integrated military healthcare delivery.

The JTF faces large expectations for success. In order to gain success, the JTF recognizes that transformation is inevitable and applies focused energy to this main effort. At the same time, the JTF is a maturing organization. While the JTF and its facilities execute the daily tasks of a Joint Task Force headquarters and treatment facilities, the JTF headquarters is also growing into its own processes and systems. The JTF will continue to focus on establishing processes so that they endure external system challenges and internal transformational requirements. All systems that the JTF establish will be joint and must meet a requirements oversight lens that ensures sustainment viability and interoperability of systems.

NCR JHSS Current and Future State
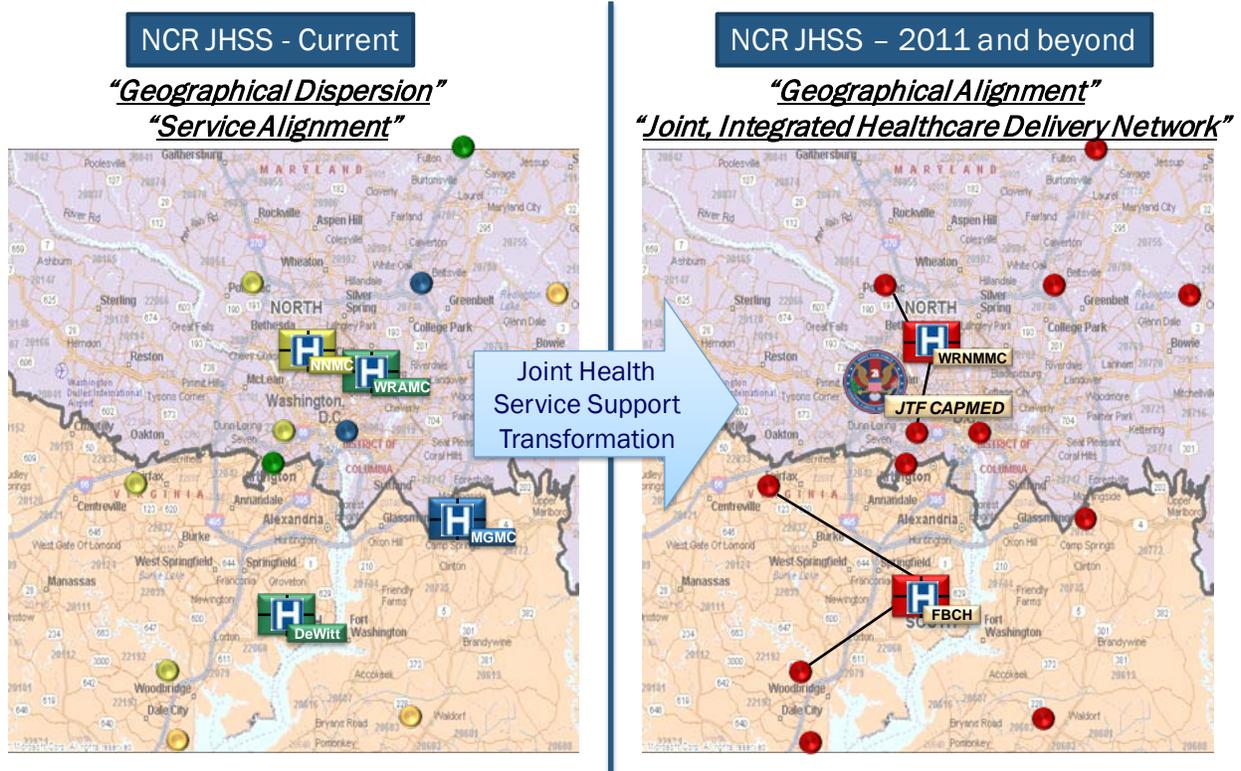
FIGURE 62 - NCR JHSS CURRENT AND FUTURE STATE

Campaign Plan I – Present Day to October 2012

Purpose

The purpose of Campaign Plan I is to outline and describe the goals, objectives, and actions required to take JTF CAPMED through the most important portion of the transformation into a Joint Task Force of medical units. The Campaign plan provides the rough outline of the requirements directed by the Commander, Joint Task Force (CJTF) CAPMED, and aligns CJTF vision to JTF action in the strategy for accomplishment of the transformational changes required to achieve the end state of this campaign.

Concept of the Operation

The JTF CAPMED describes its plan by looking at what it must accomplish in a specified timeline, from now through October 2012. The timeline goes one year past the current BRAC requirement (which disestablishes WRAMC and establishes WRNMMC and FBCH by 15 September 2011) because there are transformation tasks that must be sustained one year past the BRAC suspense date to solidify transformational changes.

The JTF CAPMED conducted a mission analysis and developed courses of action to determine the best way to transform the JTF CAPMED JOA from its current state of four, Service-specific inpatient facilities into two joint inpatient facilities and one ambulatory surgery facility. The CJTF decided that the JTF CAPMED will accomplish this task by creating necessary conditions for establishing the joint commands, WRNMMC and FBCH, NLT 01 October 2010. Other requirements and tasks for creating proper conditions are outlined in CJTF Decision Memo #001, and incorporated into the Transformation Road Map (See Figure 1 below) and the details of the Integrated Master Schedule (IMS).

Timeline

A key step to setting the conditions for JTF transformation is the approval for obtaining Operational Control (OPCON) earlier than the 15 September 2011 BRAC-required date. Meanwhile, the JTF must also make deliberate decisions regarding the timing of closure of three facilities: DeWitt Army Community Hospital, Walter Reed Army Medical Center, and National Naval Medical Center. The timing of these closures is contingent upon several requirements, one of which is the plan for sustaining our accreditations, certifications, privileging, Graduate Medical Education (GME), Health Profession Education, and clinical research programs. Once the JTF accomplishes these major objectives and establishes operational joint commands, the JTF must continue the momentum of transformation by solidifying processes, documenting lessons learned, and continuing patient care improvements and health promotion initiatives.
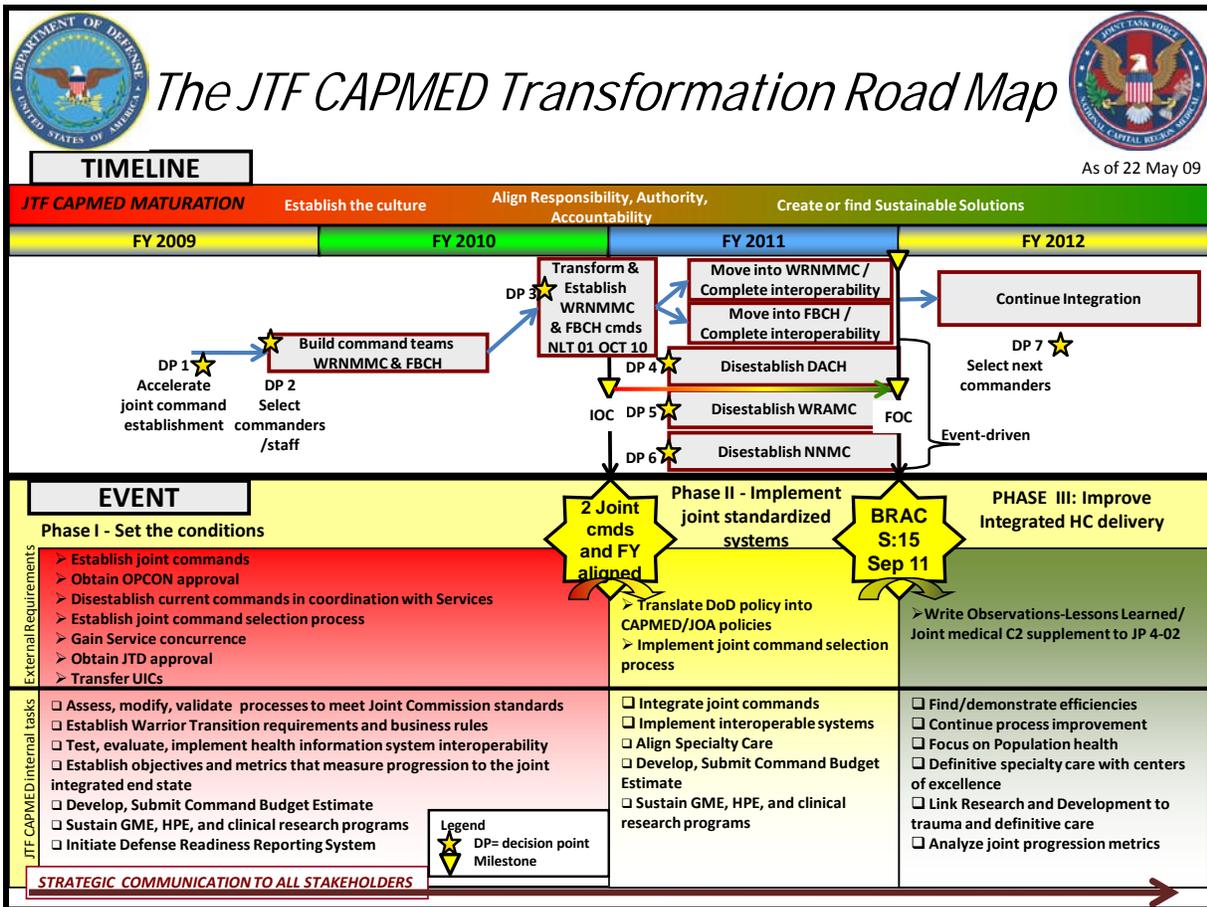
FIGURE 63 - JTF CAPMED TRANSFORMATION ROAD MAP

Phasing Construct

The JTF CAPMED further describes the timeline by the events required during each of three phases:

Phase I – Set the Conditions (current through 1 October 2010)

The JTF CAPMED is in Phase I. This phase ends when the joint commands, WRNMMC and FBCH are established on 01 October 2010.

Phase II – Implement joint standardized systems (1 October 2010 – 15 September 2011)

Phase II begins upon the establishment of the two joint commands and ends with the Full Operational Capability of WRNMMC and FBCH by 15 September 2011. Full Operational Capability includes the integration of people and process into the two joint commands and the functional interoperability of key

healthcare network systems (clinical information systems, human resource systems, and administrative and logistics systems).

Phase III – Improve integrated healthcare delivery (15 September 2011 – 1 October 2012)

Phase III begins upon completion of FOC of WRNMMC and FBCH, and ends when lessons learned and key observations are codified and formalized into a comprehensive history of the transformation of the JTF CAPMED JOA.
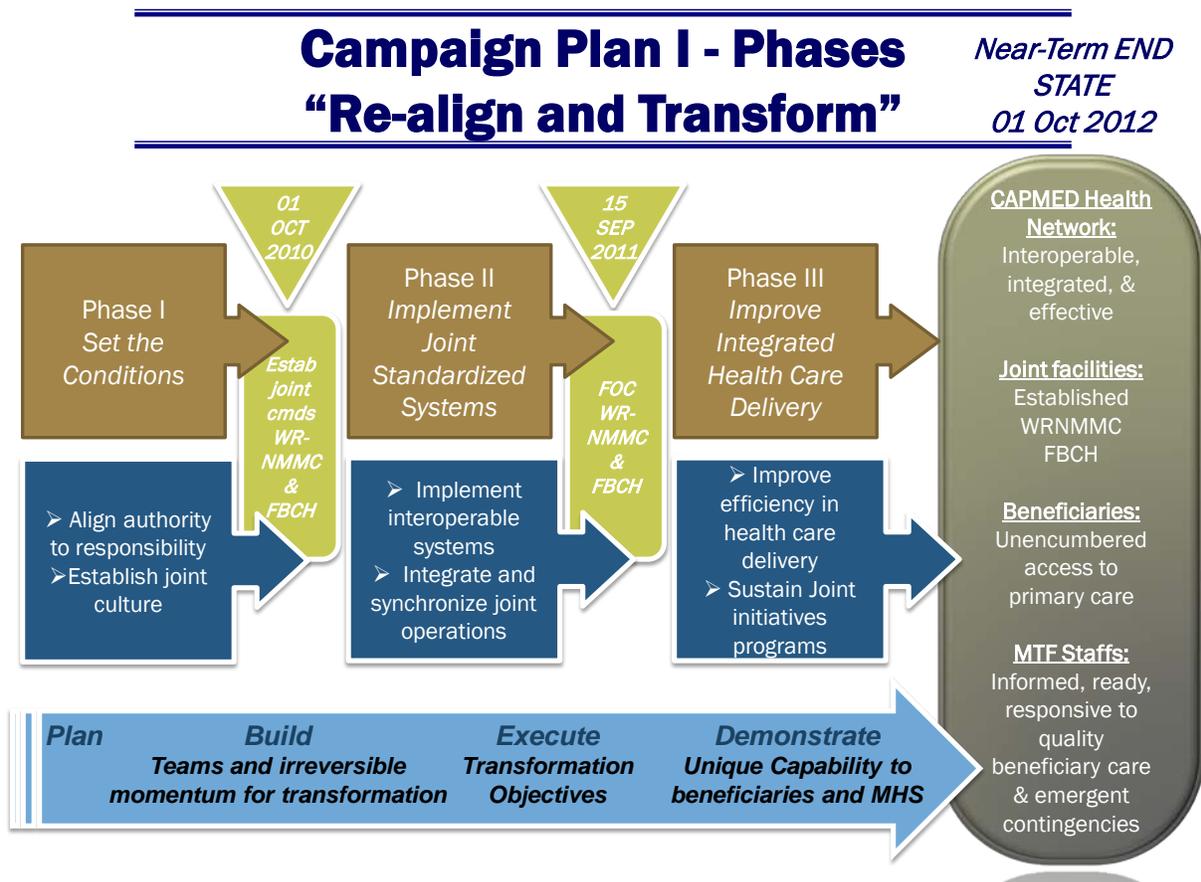
FIGURE 64 - CAMPAIGN PLAN I

The JTF CAPMED Campaign Plan I conceptual map describes the major objectives and effects that lead the JTF toward accomplishing the stated end state.

End State

The JTF CAPMED end state for Campaign Plan I can be described in terms of how it envisions the health network, its facilities, its beneficiaries, and its people (medical treatment facility staff).

Health Network

The network of healthcare delivery must have interoperable systems whether personnel, information systems, or logistics. These systems must be able to talk to each other to form the overlapping, interoperable system throughout JTF CAPMED MTFs. The patient care services must be integrated to provide comprehensive and continuous care for each beneficiary for each episode of care. The healthcare the JTF delivers must also be effective, and based on evidence of quality processes and treatments. The JTF CAPMED will be able to provide a menu of services that follows a continuous stream of treatment and instills pride and confidence in the JTF CAPMED integrated healthcare delivery network.

Joint Facilities

The Walter Reed National Military Medical Center's facilities will be fully functional and ready to provide care to contingency requirements and responsive to all wounded warriors. Fort Belvoir Community Hospital will also be ready to provide care to its beneficiaries with an emphasis on primary care, while increasing capability to include inpatient services.

Beneficiaries

Beneficiaries will have unencumbered access to primary care throughout the transition of people and equipment, and the construction of facilities in the JOA. The JTF CAPMED must maintain and strive to improve access to care during this transition and transformation period to fulfill the Department of Defense promise to its service members and families.

Medical Treatment Facilities (MTF) Staff Members

MTF staff members will be informed of transition and transformation activities, requirements, and changes. An informed staff instills initiative and spurs independent thought for actionable contributions to the JTF CAPMED team. The staff will continue to be ready and responsive, while JTF CAPMED leverages the full power of the medical resources in the JOA to respond to any emergent contingency. Finally, the JTF CAPMED and MTF staff members will always be dedicated to the highest quality in beneficiary care and services.

Key Tasks by Phase

Phase–I – Set the Conditions – Present Day to 1 October 2010

Key Tasks (external)

- o Establish joint commands on 1 October 2010 (prior to BRAC requirement) to enable the commands to be immediately affective upon activation on 15 September 2011.
- o Obtain OPCON approval NLT 1 October 2010 to align authority of the new joint commands with their responsibilities for healthcare delivery.
- o Disestablish current commands in coordination with Services to properly transfer facilities and manpower to other agencies or commands.
- o Establish joint command selection process to create an enduring process for joint medical leadership in the JOA.
- o Gain Service concurrence on actions affecting the JOA in order to sustain good relationships and transparency of decisions.
- o Develop plans to execute JTD to solidify our manning authorizations and link human resources to our operational requirements.
- o Transfer UICs to complete the transfer and transition of the previous organizational structure to the future structure.

Key Tasks (Internal)

- Assess, modify, validate processes to meet Joint Commission standards to ensure continued quality services and care during the transition of people, equipment, and facilities.
- Establish Warrior Transition requirements and business rules to sustain the legacy of superior care to those who sacrifice through service.
- Test, evaluate, implement health information system interoperability to enable patient-centered healthcare services, and service-oriented human resource management.
- Establish objectives and metrics that measure progression to the joint integrated end state to manage and monitor how we are accomplishing our goals.
- Develop, Submit Command Budget Estimate to acquire resources required for successful healthcare delivery, and funding of Centers of Excellence, research and development, Graduate Medical Education, Health Professional Education, and other command directed initiatives.
- Sustain GME, HPE, and clinical research programs to sustain the MHS with qualified and educated professionals.
- Initiate Defense Readiness Reporting System to ensure we are constantly assessing and improving our capability to support contingencies directed by the Department of Defense.

Phase II – Implement Joint Standardized Systems – 1 October 2010 – 15 September 2011

Key Tasks (external)

- o Translate DoD policy into CAPMED/JOA policies to provide guidance alignment from DoD down through each clinic.
- o Implement joint command selection process to select the first joint leaders of WRNMMC and FBCH.

Key Tasks (internal)

- Integrate joint commands (established 1 October 2010) to provide authoritative alignment of geographical healthcare delivery responsibilities and JTF initiatives/programs.
- Implement interoperable systems to enable patient-centered services.
- Align Specialty Care services to a comprehensive and connected referral process to allow access from any point of service in the JOA.
- Develop, Submit Command Budget Estimate for the 2012 Program Objective Memorandum to accomplish JTF near-term objectives and posture long-term goals.
- Sustain G"E, HPE, and clinical research programs to sustain the MHS with qualified and educated professionals.

Phase III – Improve Integrated Healthcare Delivery – 15 September 2011 – 1 October 2012

Key Tasks (external)

- o Write Observations-Lessons Learned/Joint Medical C2 supplement to JP 4-02 to capture and disseminate observation and lessons of creating a JTF with a focused medical mission in a geographical area of responsibility.

Key Tasks (internal)

- Find/demonstrate efficiencies to joint, integrated healthcare delivery compared to service-aligned and un-integrated services.
- Continue process improvement to sustain the highest quality and access to healthcare services.
- Focus on population health to improve the health status, reduce disease prevalence, and promote healthy lifestyles.
- Link and define specialty care with centers of excellence to leverage the full complement of the resources in the JOA.
- Combine Research and Development in trauma and definitive care with current practices to be at the forefront of medical innovation.
- Analyze joint progression metrics to ensure continued process improvement.

The JTF CAPMED will operationalize the task force by successfully transforming into two joint commands by 15 September 2011. This is our main effort during this first campaign. While we cannot let our current healthcare mission falter, the majority of our organizational effort will focus on transformation, establishing the JTF CAPMED identity, and aligning responsibility, authority, and accountability. We will define ourselves through the successful completion of this transformation, and continue to build our momentum in demonstrating our unique value to the Military Health System.

Conclusion

When JTF CAPMED was initially stood-up, it was expected to deliver integrated healthcare in the National Capital Region (NCR), ensure readiness, and execute BRAC business plans that would ultimately lead to the stand-down of four Service-centric MTFs within the NCR and stand-up two new, joint MTFs. Those joint MTFs, the Walter Reed National Military Medical Center in Maryland and the Fort Belvoir Community Hospital in Virginia; will serve as the centerpiece for integrated healthcare throughout the NCR.

The closing of two iconic hospitals (WRAMC & NNMC), both with rich histories, determining overall JTF governance and establishing the right balance between Service-owned installations and joint hospital tenancy has had a profound impact on planning efforts for our Service medical departments as well as the JTF staff. Clear direction and support from the most senior levels of the DoD helped make clear what the overall expectations were for not only the JTF, but for all medical personnel NCR-wide. Jointly-manned hospitals, reporting to a Joint Task Force commander is the new reality and timelines to get there remain tight.

Service-centric paradigms play a role in most JTF planning actions. Balancing deliverables necessary to ensure product success while blending Tri-Service cultures into a fully joint endeavor is not unique to the line; to medics though, it is ground-breaking. Despite these challenges, progress is being made and work groups comprised mostly of personnel assigned at the clinic level (in additional duty capacity) continue to move forward. Work group challenges are faced when transition planning deliverables meet the day-to-day realities of healthcare delivery. As NCR healthcare professionals move forward, they continue to work closely with Service component (Army, Navy, Air Force) leadership to minimize the impact the BRAC-directed mission is having on their ability to provide world-class, day-to-day healthcare. Service cultural integration and integrated planning efforts remain a challenge, but what once seemed like an insurmountable obstacle has slowly been replaced by Airmen, Soldiers and Sailors working together for the common good of our patients and our missions.

The JTF and its subordinate commands hit the ground sprinting. The architects of the Master Transition Plan have made tremendous strides in their planning efforts, producing flexible documents capable of change and as a result, will pay huge dividends throughout future, quarterly action plans. Measuring process/progress effectiveness and quality of performance will provide data that will serve as the basis for these quarterly MTP updates and as those updates are completed appropriate commander's guidance and staff vector checks will follow.

Authorship of Master Transition Plan

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Acronym List

Acronym	Definition
A/E	Architect/Engineer
ACGME	Accreditation Council for Graduate Medical Education
ACS-COT	American College of Surgeons Committee on Trauma
ADA	American Dental Association
ADSM	Active Duty Service Member
AFAP	Family Action Plan
AFB	Air Force Base
AFMS	Air Force Medical Service
AFHLTA	Armed Forces Health Longitudinal Technology Application
AF/SG	Air Force Surgeon General
AIR FORCE COMPASS	Clinical Optimization for Military Provider AFHLTA Satisfaction Survey
AMBUS	Ambulance Bus (Air Force-specific term)
AMEDD	Army Medical Department
ARMY MAPS	MEDCOM AFHLTA Provider Satisfaction (a provider satisfaction survey for AHLTA)
ARTS	Army Medical Department Resource Tasking System
ATLS	Advanced Trauma Life Support
BCA	Business Case Analysis
BGWG	Business/Governance Work Group
BHD	Behavioral Health Department
BKA	Bailey K. Ashford
BPT	Business Process Team/Business Planning Tool
BRAC	Base Realignment and Closure
BUMED	Bureau of Medicine and Surgery
C&A	Certification & Accreditation
C3i	Command, Control, Communications, Intelligence
C4I	Command, Control, Communication, Computers and Intelligence
CBB	Clark/Balfour Beatty, Joint Venture
CCIR	Commander's Critical Information Requirements
CDS	Civilian Drug Screening
CFO	Chief Financial Officer
CHR	Civilian Human Resources
CHRA	Civilian Human Resources Agency
CI	Counter Intelligence
CID	Chief of Integrated Department
CIO	Chief Information Officer
CIS	Chief of Integrated Services
CITI	Collaborative Institutional Review Board Training Initiative
CJCS	Chairman, Joint Chiefs of Staff
CJTF	Commander, Joint Task Force
COA	Course of Action
COCOM	Combatant Command
CODA	ADA Commission on Dental Accreditation
COE	Center of Excellence
CONOPS	Concept of Operations
CONPLAN	Contingency Plan

Acronym	Definition
COOP	Continuity of Operations Program
COR	Contracting Officer's Representative
COS	Chief of Staff
COSC	Combat and Operational Stress Control
CPX	Command Post Exercise
CSA	Commander Special Assistants
CTO	Chief Technical Officers
CY	Calendar Year
DACH	DeWitt Army Community Hospital
DB	Design Build
DCA	Deputy Commander for Administration
DCI	Deputy Commander for Integration
DCIO	Deputy Chief Information Officer
DCJTF	Deputy Commander, JTF CAPMED
DCOE	Defense Center of Excellence
DCSP	Deployment Cycle Support Program
DEPSECDEF	Deputy Secretary of Defense
DFAS	Defense Finance and Accounting Service
DHP	Defense Health Program
DIO	Designated Institutional Official
DMHRSi	Defense Medical Human Resources System internet
DMIS	Defense Medical Information System
DoD	Department of Defense
DOTMLPF	Doctrine, Organization, Training, Materiel, Leadership, Personnel and Facilities
DP	Decision Point
DRO	Department of Research Operations
DRRS	Defense Readiness Reporting System
DSCA	Defense Support of Civil Authorities
DSCP	Defense Supply Center Philadelphia
DTF	Dental Treatment Facility
DVBIC	Defense and Veterans Brain Injury Center
EAIM	Accreditation Inspection Milestones Project
EBD	Evidence-Based Design
EDIS	Electronic Data Information System
EEO	Equal Employment Opportunity
EFMP	Exceptional Family Member Program
EIA/TIA	Electronics Industries Alliance/Telecommunication Industry Association
EIS	Environmental Impact Statement
EMMA	Electronic Medication Management Assist
EMR	Electronic Medical Record
ERSA	External Resource Sharing Agreements
FAD	Funding Authorization Documents
FAP	Family Advocacy Program
FBCH	Fort Belvoir Community Hospital
FECA	Federal Employees' Compensation Act
FFP	Firm Fixed Price
FHP	Force Health Protection
FMR	Financial Management Regulations
FOC	Full Operational Capability
FTDTL	Forensic Toxicology Drug Testing Laboratory

Acronym	Definition
FWS	Federal Wage System
FY	Fiscal Year
GAFS	General Finance and Accounting Systems
GDE	Graduate Dental Education
GME	Graduate Medical Education
GPP	Guaranteed Placement Program
GS	General Schedule
GWOT	Global War on Terror
HEDIS	Healthcare Effectiveness Patient Information Set
HFPA	Health Facility Planning Agency
HFPO	Health Facilities Project Office
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPE	Health Professional Education
HR	Human Resource
HRD	Human Resource Department
HRIS	Human Resources IM/IT Systems
IA	Information Assurance
IAWG	Information Assurance Work Group
ICW	In Coordination With
IDBB	Integrated Design Bid Build
IM/IT	Information Management/Information Technology
IMR	Individual Medical Readiness
IMS	Integrated Master Schedule
IO&T	Initial Outfitting and Transition
IOC	Initial Operational Capability
IPR	In Process Review
IRB	Institutional Review Board
IS	Information System
IT	Information Technology
J1	JTF CAPMED Manpower and Personnel Directorate
J3	JTF CAPMED Operations
J4	JTF CAPMED Logistics and Facilities
J5	JTF CAPMED Plans and Policy
J6	JTF CAPMED Communications Support
J7	JTF CAPMED Education, Training and Research
J8	JTF CAPMED Resources
JCIT	Joint Commands Implementation Team
JCS	Joint Chiefs of Staff
JFCOM	Joint Forces Command
JDIR	Joint Director of JTF CAPMED
JFHQ-NCR	Joint Forces Headquarters – National Capital Region
JIT	Joint Integration Team
JMETL	Joint Mission Essential Task List
JOA	Joint Operations Area
JOC	Joint Operations Center
JOPP	Joint Operation Planning Process
JPC	Joint Planning Cell, Joint Pharmacy Center, Joint Pathology Center
JPG	Joint Planning Group
JTARA	Joint Technology Assessment and Requirements Analysis
JTD	Joint Table of Distribution

Acronym	Definition
JTF CAPMED	Joint Task Force National Capital Region Medical
JTPB	Joint Transition Planning Board
KM	Knowledge Management
LEED	Leadership in Energy & Environmental Design
LMS	Learning Management System
LOO	Line of Operation
LRMC	Landstuhl Regional Medical Center
MAC	Medical Affirmative Claims
MAN/LAN	Metro Area/Local Area Network
MCIT	Medical Center Integration Team
MCSC	Medical Care Support Contractor
MDG	Medical Group
MDSHPO	Maryland State Historical Preservation Office
MDW	Medical Wing
MEB	Medical Evaluation Board
MEPRS	Medical Expense and Performance Reporting System
METC	Medical Education and Training
MGMC	Malcolm Grow Medical Center
MH	Mental Health
MHS	Military Heath System
MHSLearn	Military Health System E-Learn
MHSSI	Military Health System Support Initiatives
MILCON	Military Construction
MILPER	Military Personnel
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSA	Military Services Account
MSMO	Multi-Service Market Office
MTF	Medical Treatment Facility
MTF	Military Treatment Facility
MTP	Master Transition Plan
NARMC	North Atlantic Regional Medical Command
NAVFAC	Naval Facilities Engineering Command
NAVMEDLOGCOM	Navy Medicine Logistics Command
NAVMISSA	Navy Medicine Information Systems Support Activity
NCC	National Capital Consortium
NCM	Nurse Case Manager
NCO	Noncommissioned Officer
NCPC	National Capital Planning Commission
NCR	National Capital Region
NDAA	National Defense Authorization Act
NICOE	National Intrepid Center of Excellence
NIH	National Institutes of Health
NIPR	NIPRNet Non-Classified Internet Protocol Router Network
NKO	Navy Knowledge Online
NLT	No Later Than
NMS	National Military Strategy
NNMC	National Naval Medical Center
NRF	National Response Framework
NSPS	National Security Personnel System

Acronym	Definition
NSSE	National Special Security Events
O&M	Operations and Maintenance (relates to budget)
OASD/HA	Office of the Assistant Secretary of Defense (Health Affairs)
OIPT	Overarching Integrated Product Team
OML	Order of Merit List
OPCON	Operational Control
OPORD	Operation/Operational Order
OTSG	Office of the Surgeon General
PAD	Patient Administration
PC	Personal Computer
PD	Position Description
PEB	Physical Evaluation Board
PFD	Program for Design
PH	Psychological Health
PIP	Personal Injury Protection
PMO	Program Management Office
POC	Point of Contact
POM	Program Objective Memorandum
PPP	Priority Placement Program
PR	Program Review
PRR	Project Rooms Report
PSD	Personnel Services Division
RDT&E	Research, Development, Test and Evaluation
RFE	Ready for Equipment
RFP	Request for Proposal
RFT	Ready for Turnover
RMSC	Resource Management Steering Committee
RMSTR	Referral Management System Tracking Reports
RRC	Residency Review Committee
RS-BUX	Resource System Bucks
SA	Situational Awareness
SDM	Spiral Development Model
SECDEF	Secretary of Defense
SEL	Senior Enlisted Leaders
SEPS	Space and Equipment Planning System
SERMC	Southeastern Regional Medical Command
SIPS	Short Interval Production Schedule
SME	Subject Matter Expert
SMMAC	Senior Military Medical Advisory Committee
SOP	Standard Operating Procedure
STARS-FL	Standardized Accounting and Reporting System–Field Level
STRATCOMM	Strategic Communication
SUPPLAN	Supporting Plan
SWS	Social Work Service
TBI	Traumatic Brain Injury
TIWG	Technical Infrastructure Work Group
TMA	TRICARE Management Activity
TPCP	Third-Party Collection Program
UME	Undergraduate Medical Education
USACOE	United States Army Corps of Engineers

Acronym	Definition
USAMEDCOM	United States Army Medical Department
USAMRAA	United States Army Medical Research Acquisition Activity
USU	Uniformed Services University
VCE	Vision Center of Excellence
VIWG	Visual Information Work Group
WFAC	Warrior Family Activity Center
WiT	Warrior in Transition Cell
WRAMC	Walter Reed Army Medical Center
WRNMMC	Walter Reed National Military Medical Center
WT	Warrior Transition
WTB	Warrior in Transition Brigade
WTU	Warrior Transition Unit
WW	Wounded Warriors

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Joint Medical Manpower Development Model

The Consolidation and Realignment of Medical Manpower within the National Capital Region (NCR) by the Joint Task Force, National Capital Region Medical (JTF CapMed)

April **22**[th]**, 2009**

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Introduction

In May 2005, the Base Realignment and Closure (BRAC) Commission recommended relocating patient care activities from the Walter Reed Army Medical Center (WRAMC), Washington, D.C., to the National Naval Medical Center (NNMC), Bethesda, MD., and Ft. Belvoir, VA. The new Walter Reed National Military Medical Center (WRNMMC) would be established on the Bethesda campus and would provide primary, subspecialty, complex and tertiary medical services. At the same time, a new community hospital would be created at Ft. Belvoir (FBCH) to provide comprehensive primary and subspecialty patient care services. Malcolm Grow Medical Center, Andrews Air Force Base would down size to an ambulatory care clinic. BRAC law was subsequently passed in August 2005 mandating the closure of Walter Reed Army Medical Center, Washington, D.C., by September 15, 2011.

In Aug 2006, the Infrastructure Steering Group approved the Walter Reed Business Plan (Comm 169); details and authority were provided to ensure the execution of the closure directive. The Assistant Secretary of Defense for Health Affairs (ASD/HA) was made responsible for overseeing execution of all clinical operations in accordance with the approved Business Plan. Efforts built upon prior guidance from the Medical Joint Cross Service Group (MJCSG) were directed by the Commander, Multiple Service Market under the management of the Multi-Service Market Office (MSMO) and later supported by the National Capital Area (NCR) BRAC Integration Office. Attention was focused on the development of requirements for two new Service Military Treatment Facilities (MTFs) with multi-Service staffing.

In September 2007, the Deputy Secretary of Defense (DEPSECDEF) signed a memorandum establishing the Joint Task Force - National Capital Region/Medical (JTF CapMed). JTF CapMed was aligned directly to the DEPSECDEF and merged the assets of the NCR BRAC Integration Office and MSMO. Its mission was "to ensure the effective and efficient delivery of world-class military healthcare within the National Capital Region (NCR) using all available military healthcare resources with the Joint Operating Area (JOA)." At this time, focus shifted to the development of two new Joint MTFs and an integrated healthcare system within the Joint Operational Area (JOA).

In September 2007, the Military Health Service (MHS) Issue Team reviewed prior analyses and provided specific guidance for future JTF CapMed manpower planning of the Joint MTFs.

From October through November of 2007, the Commander, JTF (CJTF) CapMed provided further planning guidance in the form of Vision, Mission, Principles and Regional Healthcare Delivery Concept of Operations (CONOPS) statements. Key priorities were established: Casualty Care, Care for the Caregiver, Be Ready Now, Regional Healthcare Delivery, and Common Standards and Processes. Critical to these tenets was the principle of Interoperability – a blending of Service competencies and establishment of common operational concepts/systems within the JOA.

In October 2008, CJCS recommended that manpower requirements for the new WRNMMC and FBCH be documented as jointly coded billets on a Joint Table of Distribution (JTD). In addition, he recommended the identification of Critical billets, continued support of the Global Force Management (GFM) process and Service Readiness requirements, provision of fair opportunities for the Services to share Senior Leadership positions, and the utilization of Component Commanders and Service elements to support the Administrative needs of assigned military members. These recommendations were subsequently endorsed by the NCR OIPT.

In January 2009, DEPSECDEF accepted the recommendation and in an action memo directed the establishment of Joint Commands at WRNMMC and FBCH, and documentation of Joint billets at both facilities on a JTD.

In Dec 2007 through current date, JTF CapMed began developing a joint manning document that reflected the consolidation and realignment of existing medical care resources per initial BRAC directive, built from prior NCR Integration analyses, incorporated MHS Issue Team and CJTF CapMed Joint guidance, and addressed Environmental Impact and Civilian Guaranteed Placement requirements. This paper summarizes the methodology employed and results produced by JTF CapMed's efforts to consolidate and realign medical manpower from four existing Service MTFs to two new Joint facilities.

Methodology

Background

Initial estimates of manpower requirements were developed in 2005-2007 to assist in defining spatial requirements, or Program for Design (PFD), for the new Navy (WRNMMC) and Army (FBCH) facilities. Tri-Care Management Activity's (TMA) NCR BRAC Integration Office initially contracted the services of Noblis, Inc. (formerly Mitretek Systems) to assist in the planning the realignment of medical services and resources pursuant to BRAC law. Delivered 1 February 2007, the work reflected a comprehensive, collaborative effort involving multiple Federal agencies and organizations. Initially, several relevant staffing models were reviewed including OT/SG's Automated Staffing Assessment Model (ASAM), Navy SG's REDE, AF/SG's Product Line Analysis and Transformation Team's (PLATT) model, draft Tri-Service Manpower model, Medical Group Management Association (MGMA), California Nurse Staffing Model, Association of Operating Room Nurses (AORN), the 2007 Technology Assessment and Requirements Analysis (TARA) report, various administrative and professional standards. Results were adjusted to reflect the professional judgment of nurses, MDs, hospital administrators, manpower experts and other members of the development team. In addition to TMA, the agencies included the NCR Multi Service Market Office (MSMO), Service representatives and over 150 working groups and more than 700 subject matter experts. Throughout the effort, results were compared with

available authorized and staffing levels to ensure that that the solution set would realign and operate within currently existing resources. The outcomes were summarized in CONOPS documents.

Figure 1 depicts the NCR Military Health System (MHS) initial integration organization that was involved in the PFD development.
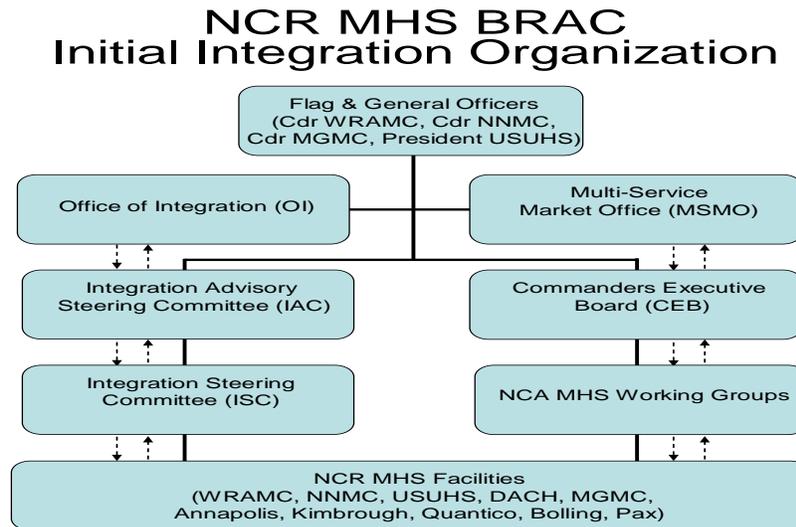
Figure 1: NCR MHS BRAC Initial Integration Organization (circa 2006)

Spiral Development Process

Following the establishment of the JTF CapMed, rapid refinement and finalization of a Joint manning document became a critical concern as facility design, budget and personnel management decision-makers needed to take definitive action. JTF CapMed elected to draw upon the experience and results of the TMA/Noblis collaboration and Noblis' services were retained by JTF CapMed. Prior analyses and results were subsequently refined to reflect the directives/realities of JTF CapMed's mission, the availability of additional information, and inclusion of new missions. Key among these: Service MTFs would become Joint; would address prescribed requirements (i.e. Service Equities, Business Plan, EIS, Guaranteed Placement, and Readiness); and would use existing resources. Functional communities would be challenged to develop strategies to mitigate risk.

To address the complexity of factors surrounding the task, Noblis recommended the use of a Spiral Development Model (SDM) as that model would provide focus and procedural direction. SDM is tested and proven – most frequently employed in software engineering. Boehm (1988) explains that the spiral model evolved with experience and incorporated refinements to the waterfall model. The spiral model is defined as an iterative process of incremental development with a focus on identifying and managing risk. Although tied closely to software development, it has been applied

successfully to a variety of industries addressing challenges such as rapid development, integration, and new technologies. Boehm's SDM was adapted for JTD document development as depicted in Figure 2 below.
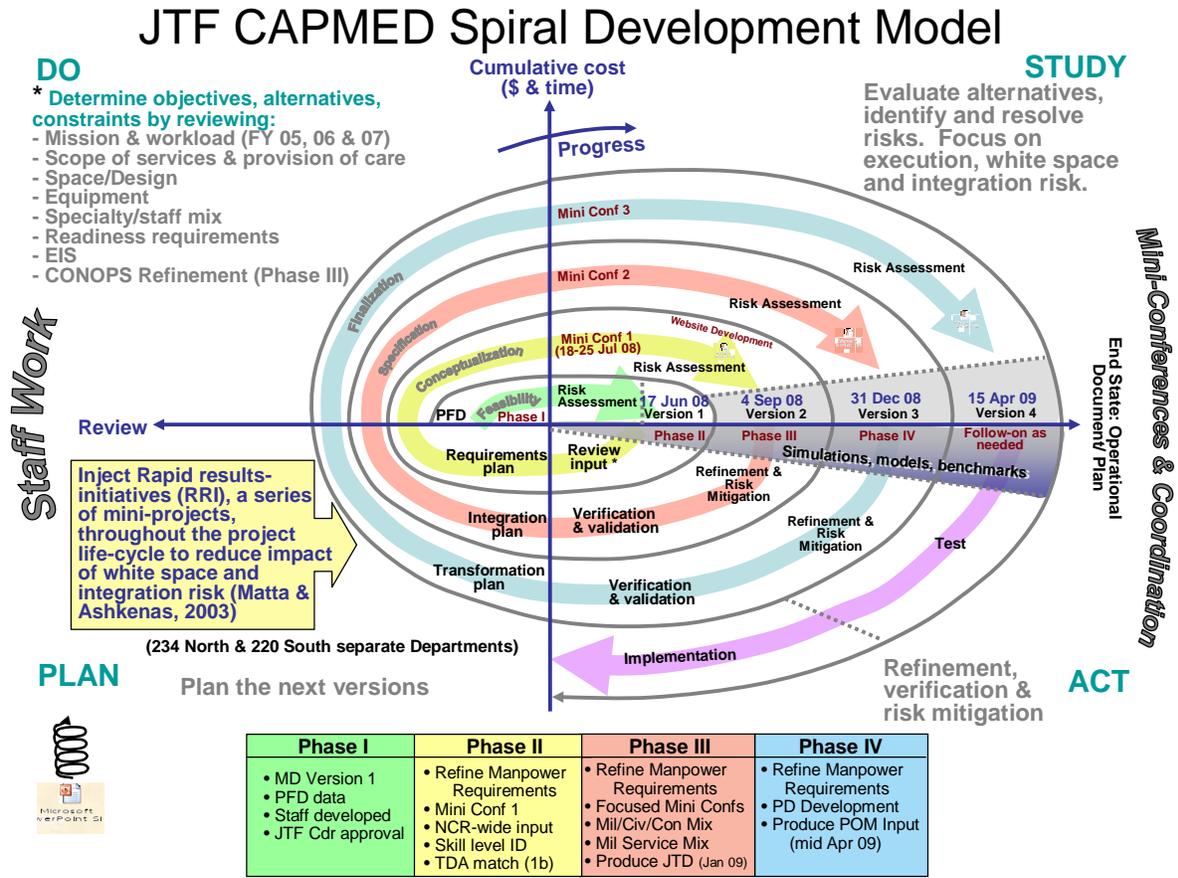
Figure 2: Spiral Development Model

A total of four phases were planned and managed for this effort. The four phases were specifically adapted to meet the JTD development goal. A model developed for each of the four phases is at Appendix A. Additionally, to enhance the SDM framework, the Deming (2000) Plan, Do, Study and Act (PDSA) cycle was employed to provide continuous quality improvement within each phase.

Throughout the development, careful scrutiny was given to identifying and managing risk. Matta and Askensas (2003) point out that even though tremendous efforts are provided to promote success in large and complex undertakings such as this JTD development, the majority of projects deliver disappointing results over half of the time. To further hedge against less than optimal outcomes, rapid results initiatives (RRI) and specific in-depth risk management practices as proposed by both Boehm and Matta and Askensas were incorporated into the JTD SDM. The process for including RRI within the SDM is depicted in the model above. The identified risks and mitigation techniques proposed for JTD document development are depicted in Table 1 below.

Risk Assessment & Mitigation

| Section: All | | Date: 1 Jan 08 |
| Iteration: 1 | | |

Risk Item	Risk Management Techniques
1. Insufficient time.	Carefully developed and implemented lock step plan; resist giving in to 'hurry up' pressures.
2. Lack of necessary participation & buy-in.	Provide sufficient time to plan and schedule staffing events to ensure wide participation. Focus on accommodation of stakeholders & staff.
3. Space & design shortfalls.	Verify space requirements for each service and sub organization from current design plans; monitor A&E timeline.
4. Organizational design & governance issues.	Arbitrate and sufficiently staff organizational design to ensure standardization, functional effectiveness & agreement.
5. EIS challenges.	Establish a tiger team to focus on EIS requirements and actively solve and mitigate challenges.
6. White space risk (Matta & Ashkenas, 2003).	Watch out for requirements not identified in advance and the resulting gaps & unintended consequences in the project plan. Conduct pilot projects (Rapid Results Initiatives-RRIs).
7. Communication & coordination failures.	Focus on communication and coordination to ensure all stakeholders are aware of planning, issues, ongoing activities and changes. Establish a Communications Plan (Info Ops).
8. Continuing stream of requirement changes.	Establish a means to identify and track requirement changes. Create a management system to anticipate and respond to changes in an orderly and efficient means (change management).
9. Changes due to Service level disagreements & political involvement.	Establish a means to identify and track Service & political level issues impacting on manpower objectives. Focus on anticipation and mitigation.
10. Avoid focus shifts from end product to development of recommendations, new technologies and partial solutions (Matta & Ashkenas, 2003).	Focus on the end product. Establish a leadership team to review progress and avoid focus shifts.
11. Integration risk (Matta & Ashkenas, 2003).	Continuous monitoring of activities to enhance coordination and agreement to avoid incongruent disparate outcomes.

Table 1: Risk Assessment and Mitigation

Throughout the development of the Joint Manning Requirements, user defined staffing requirements in the written concepts of operation were used as the foundation. The concepts of operation were revised in Summer/Fall of 2008 by end users following conferences to review the planned requirements.

Assumptions

The following list of assumptions was applied in deliberations concerning the development of the Joint Manpower Requirements:

1. The population served would remain static from 2004.
2. The clinical workload to be met would be based on 2004.
3. The 2004 missions would remain constant; additional missions added since would be acknowledged and annotated.
4. Synergies and efficiencies would occur from merging 3 hospitals into 2.
5. There would be overlapping manpower requirements between hospitals and base support which would require resolution through the development and approval process.
6. The manpower requirements would be defined by DoD Occupational Code and description and not diluted by current job description.

7. Skill type codes 1 through 5 addressed the skill mix: 1- Provider, 2 – Licensed Independent Practitioner, 3 – RN, 4 – Technician, Medic, 5 – Administrative.
8. Military readiness platforms and military unique functions would be maintained as reflected in current manning.
9. Manpower requirements are counted as full time equivalents (FTE) available 1740 hours per year.
10. Current command grade allocation would remain consistent.

The JTF Manpower Database/Tool

In order to manage the myriad data, i.e. skill type, skill type suffix, DoD Occupational Code, DoD Occupational Description, Generic Occupational Description, para & line number, BIN number, personnel category, grade, etc., required to create a Joint Manning Document, a database was created. The database is a workgroup tool for managing the organizational structures and manpower requirements of the new Walter Reed National Military Medical Center (WRNMMC) and the new Ft. Belvoir Community Hospital (FBCH). The primary output of the database is a Joint Table of Distribution (JTD). The database contains the following major components:

- The organizational structures for the North and South Medical Facilities
- The future manpower requirements for the North and South Medical Facilities
- The current manpower data from the following sources:
  - Oct 2008 Army TDA for WRAMC and DACH, ASAM Sep '05 study 0104
  - Nov 2008 Navy AMD for NNMC, REDE of Oct '08
  - Jan 2009 DMHRSi for NNMC
  - Oct 2008 Overhires for WRAMC
  - Jun/Jul 2008 Contractor FTEs for WRAMC and DACH
- An algorithm for matching the current manpower with the future manpower requirements
- A report for generating a JTD for the North and South MCs

The database is developed in MS Access 2003 and is hosted on a network share folder for multi-user analysis.

Establishing the Baseline

The first step in moving toward the final manpower requirements was redistributing the workload and manpower projections made during the 2006-2007 facility requirements determination into the new, proposed Joint Organizational Structure for the new facilities. Similar to each other, WRNMMCs organization structure is broader and deeper than FBCH, as would be expected given the scope of services to be provided and the size of the facilities.

Baseline volume metrics for the Joint Manning Requirements are:

Enrollment in Inpatient Facilities			
Enrollment Category	North	South	Total
Total Enrollment	39,004	40,412	79,416
AD	10,061	7,097	17,158
ADFM	13,923	17,978	31,901
Ret & RFM<65	7,684	10,090	17,774
OTHER<65	122	171	293
Ret & RFM>=65	7,105	4,984	12,089
OTHER>=65	109	92	201
ENROLLED PRIME	31,658	35,269	66,927
ENROLLED PLUS	7,346	5,143	12,489
AVERAGE	39.4	36.4	
Total Eligible Population in AREA	218,882	220,803	439,685
Patient Encounters			
Volume Category	North	South	Total
Projected Admissions	17,933	10,082	28,015
Projected Outpatient Encounters	936,617	649,281	1,517,325
OBD (Adjusted patient days)	102,122	38,474	140,596

Table 2: Volume Metrics for Inpatient Facilities

The framework for determining the manpower requirements will be described for each of the functional areas.

Clinical Manpower Requirements

Reallocating the clinical requirements was performed primarily through the use of mathematical formulas. The outpatient workload, i.e. encounters, was compared across the years of 2004-2008 to ensure that demand had not changed appreciably. Increases were seen in the clinical specialties of neurology, physical therapy, occupational therapy and behavioral health. Appropriate adjustments were made in the staffing requirements of both provider and support staff, to meet the calculated workload. A primary care visit was assumed to require 15 minutes; a specialty exam would require 30 minutes.

The staffing was calculated using the following formula:

$$\frac{\text{Annual workload by service}}{\text{Provider workload factor per year}} = \text{\# of FTE providers req for service}$$

A cross-check was calculated to ensure a rational workload requirement for each provider within the service:

$$\frac{\text{Annual workload by service}}{\text{250 workdays}} = \frac{\text{\# of visits per day in service}}{\text{\# of FTE providers required}}$$

The support staff for each provider delivering care was then determined. Each military service has defined its own ratio of support staff to provider; the draft (2006) Joint Medical Manpower model set a ratio which blended Navy, AF & Army standards. The Joint Manpower requirements analyzed the user requirements and allocated staff within the range of the Services models. Professional judgment adjusted the skill mix of RNs, technicians and administrative staff using the Concepts of Operation as a guide. The support staff of registered nurses and technicians was determined to be required to support the workload as calculated above.

Additional administrative support was similarly balanced to minimize duplication of functions. Early manpower projections called for receptionists/front desk clerks for each and every clinical service. As the manpower projections matured, duplications of front desk clerks and other administrative support were minimized with architectural design information regarding combined services working from the same reception desk, i.e. plastic surgery working with general surgery. In a number of instances, clinical departments submitted requests for medical record coders. These requests were reconciled with requirements allocated to the central Patient Administration office to avoid duplication. The standard allocation for support staff in clinical areas included: 2-4 front desk personnel depending on expected workload/number of services; 1-2 medical support assistants and an administrative specialist or officer. Larger services received additional staff; smaller clinical services were programmed to share resources.

Following the calculation of the clinical requirements to support the patient workload, the Graduate Medical Education (GME) requirements were added. Careful scrutiny ensured adequate faculty would be present within each residency program as defined by the 2004 Residency Review Committee (RRC) requirements provided by the GME Chair, National Capital Consortium. The faculty requirements were met predominantly through the staffing already allocated for the encounter workload. Additionally, the GME Program administrative requirements consisting of a Program Director (included in total faculty requirement), a Clerk and secretary were provided in the clinical service supporting the residency program. The smaller GME programs were consolidated with larger, similar programs that were thought to be able to share clerks and secretaries.

The Health Professions Education requirements for one year or longer training programs were addressed via a similar manner. Full-time faculty and student requirements are included in the manning document if those positions are not carried on other documents, i.e. USUHS or AMEDD Center & School.

Ancillary Manpower Requirements

Ancillary staffing requirements were determined primarily through user input and on-hand staffing information. The TARA report and current literature references were used as additional data points for analysis and adjustments in staffing determinations.

Radiology

The 2007 TARA report provided ASAM III workload benchmarks for utilization of radiologists and radiology support staff. These benchmarks were used to validate and adjust user defined requirements. Those benchmarks are:

Academic exams/procedures per radiologist	7,919
Non-GME exams/procedures per radiologist	12,316
Technologists and administrative support per radiologist	6-7

Pathology

Benchmarks for pathology from Valenstein, et.al. (2005) are as follows:

Anatomic Pathology Management FTE	7.6
Tissue blocks – histology – per FTE	6,908
Cytology accessions per FTE	4,067
Chemistry, hematology, immunology management FTE	11.6
Total billable tests per FTE	42,674
Microbiology Management FTE	8.0
Total billable tests per FTE	9,276
Transfusion Medicine management FTE	5.5
Units transfused per FTE	1,574
Cross matches and/or type and screens per FTE	3,339

Pharmacy

Pharmacy requirements were provided according to user defined input. Careful analysis assured no growth beyond current staff.

Nursing Manpower Requirements

The inpatient nursing staffs from the three existing hospitals were consolidated then distributed to follow the inpatient workload to the new WRNMMC and the new Fort Belvoir inpatient units. The nursing staff requirements were calculated using the 2005 California Standard Model of 5 patients to 1 med-surg nurse; 1 ICU patient to 1 ICU nurse for 40% of available beds & 2 ICU patients to 1 ICU nurse for 60% of the

projected inpatient beds. Additionally, a head nurse and senior enlisted were programmed for each inpatient unit. The skill category mix on the inpatient units was generally held at a 65% RN to 35% tech ratio on med-surg units with ICUs having a 90% RN staff with 10% tech staff. Additionally, each inpatient unit was programmed to have 3 receptionists/ward clerks to provide support for day and evening shift. Additional specialized nurses such as clinical nurse specialists, infection control nurses and the remaining administrative staff were programmed.

Operating room and central sterile/central material services user defined requirements were validated using 2005 AORN standards of 1 circulating RN and 1 scrub tech per OR for standard operating rooms and 2 RNs and 2 scrub techs for high acuity procedures.   Call coverage was added to the requirements of two teams of 2 RNs and 2 scrub techs. Indirect staff to support central sterile and administrative requirements was calculated at 1 requirement per 2 OR staff.

The outpatient nursing requirements are included within each clinical service as discussed above. Finally, the nurse staffing requirement projections for FY 2011 were compared with actual FY 2004 requirements and on-hand staffing to ensure the total requirements did not exceed the current staffing for WRAMC, NNMC and DACH.

Dental Manpower Requirements

Dental manpower requirements were based on populations of 10,788 active duty (AD) military members at Fort Belvoir (includes 5,426 Non-Army AD) and 6,000 AD Military at WRNMMC (includes 1,121 Army AD). For Army providers only, the ratio of on-hand to projected future requirements varied from 1 dentist: 1,200 patients to 1:800. Future projections included providers and support staff in the South (Logan Clinic and the New Fort Belvoir Community Hospital) and North (WRNMMC and Readiness functions), although the final Joint Manpower Requirements exclude the staffing requirements for the Ft. Belvoir Logan Dental Clinic. Additionally, the Navy Post-Graduate Dental School staffing is not included in the Joint Manpower Requirements.

Administration, Education and Research, Strategy/Future Operations Manpower Requirements

As the intent is to deliver patient care across an integrated delivery system in the NCR, the necessity of providing duplicative administrative support at the MTFs was under continual scrutiny to support the unique missions and future primarily joint functions of supporting the hospitals. User defined requirements were obtained and analyzed based on expected efficiencies and synergies from merging three hospitals into two new facilities. Limited standardized or previously accepted Service manpower formulas for administration were found, necessitating a dependence upon on-hand staffing numbers along with reviewing current industry standards and professional literature for other data

points. Information from Solucient[1] was used as a benchmark from the civilian community for several hospital administrative functions.

Solucient data provides operational cost and staffing benchmark data from 850 healthcare organizations from across the U.S., including approximately 100 major teaching and 200 non-teaching hospitals and is provided in percentiles or in a comparative group average. We used the group of Standard Major Teaching Hospitals with the group average as the data point for the selected benchmarks. The benchmarking focused on labor productivity rates including hours worked per adjusted discharge, hours worked per adjusted patient days and departmental specific ratios, such as hours worked per case managed; hours worked per patient record.

Following the organizational structure, each Deputy Commander and Director was allocated 4 personnel – a director, a senior enlisted specialist, an administrative officer and a secretary/clerical support. Clinical administrative support was programmed as defined above. Close scrutiny continued to ensure that the remaining administrative requirements provided under the Deputy Commander for Administration did not exceed current on-hand staffing, and in fact showed a reduction assuming future efficiencies.

Added Missions

Since the BRAC announcement in 2005, numerous missions have been added to the healthcare requirements in the NCR. Requirements to staff those missions in some instances are included in the identified requirements in the Joint Manning Requirements document. In others, the manning requirements are not included.

New Mission	Future Activity	Partial Manning Reqts included in
Traumatic Brain Injury (TBI)	NiCOE	Neurology
Psychological Health (PH)		Behavioral Health
Advanced Wound & Limb Care	General Surgery/Amputee Care	General Surgery
Advanced Ophthalmological Care		Ophthalmology
Trauma Care	ER	ER, Critical Care, Clinical Sub-specialties

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[1] Thomson Reuters Action O-I Database, Benchmark data pulled 3/24/09 for Teaching Hospitals with 10+ Clinical Researchers

New Mission	Future Activity	Partial Manning Reqts included in
WTU	Base Support	Readiness

Table 3: NCR New Missions

Allocation of Available Resources

Beginning with the original staffing requirements through the subsequent analysis and confirmation with User Groups, identification of the personnel category and military service were ignored. The same availability factor was used for all personnel and the occupational description was chosen based on the function required. After the manpower requirements appeared to be at a 90% solution, the challenge was to match the existing staff – authorizations, on-hand, and overhires – to the manpower requirements for the facilities. The goal continued to be preservation of missions while demonstrating the ability to maximize Guaranteed Placement opportunities for civilian employees and meeting EIS constraints, particularly on the North campus.

Aligning service job codes with DoD Occupational Codes was a necessity across the provided manning documents in order to have a common reference between requirements and authorizations. One of the biggest hurdles to ensuring maximal utilization of existing staffing was the differences in occupational job descriptions for like functions between the military services shown in the TDAs/UMDs. There was inconsistent application of occupation codes/descriptions from facility to facility. A specific example was the function of Nursing. Most of the current registered nurse authorizations, on-hand staff and over hires, particularly those positions filled by civilian employees, are identified as Series 509, General Nurse. The requirements for nurses vary across the new facilities requiring much more specificity, i.e., critical care, neonatal, pediatric, clinical nurse specialists, medical-surgical, psychiatric, etc. Finding the right authorization for the right requirement was overcome through the use of similes[2] or occupational substitution. Additionally, there appeared to be a mix of licensed independent practitioners and technicians, a skill classification conflict, filling the same function at the occupational code level. The use of similes was used to facilitate the maximal use of existing staff to fill functional requirements.

Matching existing authorizations to requirements was a task for automation. Using the capabilities inherent in the Access Database, an extensive algorithm involving over 60 matching sequences for 28 separate rounds addressing military, civilian and then contractors across each of the 3 existing facilities was developed. Over 56 separate courses of action were developed to meet various scenarios to meet the requirements for the two new hospitals.

All of the Courses of Actions (COA) included:
1. Matches were based on DoD Occupancy Code and Skill Type

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[2] Similes in this case represent matching equivalents, such as similar occupational codes that could be used fulfill the requirements.

2. Matching sequence
    a. DoD Code Pairs: Authorized position to Requirement
        i. Exact match
        ii. Simile match
    b. Match at the lowest organizational level first
        i. Service
        ii. Department
        iii. Directorate
        iv. Command
        v. Activity
3. Authorization were sorted by Grade (high to low)
    a. Officer
    b. Enlisted
    c. Civilian
4. Military Authorization were sorted by Service: Navy, Army, Navy, Army

Added Steps

Continual concern was voiced by all end users of the numbers of positions identified for delivery of services across the clinical, clinical support and administrative services for the new facilities. Acknowledgement by the leadership was made to the shortfalls in documented workload, differences in service delivery of administrative functions in particular and ever-evolving mission requirements. As a result, the Deputy Commanders of Integration and Administration reviewed Phase III requirements and submitted changes which were incorporated into the Phase IV JTD. Those changes were independent of the above methodology and reflect in many instances significant increases in manpower.

Additionally, the Air Force staffing requirements to meet their readiness mission were added at a very late date. This necessitated a change to the programming as a new site, Andrews AFB, was included.

Analyses

Results

The final COA used to develop the Joint Manning Requirements for the NCR identifies the Manning requirements for WRNMMC and FBCH JTDs (including AAFB and the Pentagon clinics). This COA aptly named Readiness 1, Continuity 1 (R1C1), sorts the military resources of the Navy to ensure that the hospital ship Comfort readiness mission minimally impacts the continued delivery of patient care at in the JOA in the event of mobilization. Likewise, the Army PROFIS mission divided between the North and South campuses to enable continual health care delivery. It appears from the course of action selected that the Civilian Guaranteed Placement Program will maximize the utilization of existing staff and fully operationalize the Joint platform for the

future. The EIS constraint on the North campus is addressed through the authorizations provided by the Services; the requirements to staff a robust, world-class medical center and region are met.

Conclusion

A systematic, process driven methodology involving multiple interfaces with hundreds of stakeholders and users assisted the development team in identifying and documenting the manpower requirements for the future. The continuous application of best practices and civilian benchmarks achieved a staffing requirement which took the existing staff and adapted it for a Joint healthcare system to meet the demanding requirements for the military's premier Integrated Healthcare Delivery System hospitals. The Joint Manpower Requirements Document reflects an effort that is unique in its methodology and meets the myriad military and healthcare missions in the NCR for WRNMMC and FBCH while maintaining a regional focus. Finally, this development process may serve as a model for future Joint military medical manpower development efforts.

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Appendix A – List of Acronyms

AMEDD – Army Medical Department

AORN – Association of Operating Room Nurses

ASAM – Automated Staffing Assessment Model

BRAC – Base Realignment and Closure

CEB – Commanders Executive Board

COA – Course of Action

CONOPS – Concept of Operations

DACH – Dewitt Army Community Hospital

DoD – Department of Defense

EIS – Environmental Impact Statement

ER – Emergency Room

FBCH – Fort Belvoir Community Hospital

FTE – Full Time Equivalent

GME – Graduate Medical Education

IAC – Integration Advisory Steering Committee

ICU – Intensive Care Unit

ISC – Integration Steering Committee

JOA – Joint Operating Area

JMD – Joint Manning Document

JTD – Joint Table of Distribution

JTF – Joint Task Force

MGMA – Medical Group Management Association

MGMC – Malcolm Grow Medical Center

MSMO – Multi-Service Market Office

MTF – Medical Treatment Facility

NICoE – National Intrepid Center of Excellence

NNMC – National Naval Medical Center

NCR – National Capital Region

OI – Office of Integration

OR – Operating Room

PFD – Program for Design

PH – Psychological Health

PROFIS – Professional Officer Filler System

RN – Registered Nurse

RRC – Residence Review Committee

RRI – Rapid Results Initiatives

SDM – Spiral Development Model

TARA – Technology Assessment and Requirements Analysis

TBI – Traumatic Brain Injury

TDA – Table of Distributions and Allowances

TMA – Tri-Care Management Activity

UMD – Unit Manning Document

USUHS – Uniformed Service University of the Health Sciences

WRAMC – Walter Reed Army Medical Center

WRNMMC – Walter Reed National Military Medical Center

WTU – Warrior Transition Unit

Appendix B – Spiral Development Phase Models

Manpower Development Flow Diagram (Phase Ia)
Predecisonal Draft
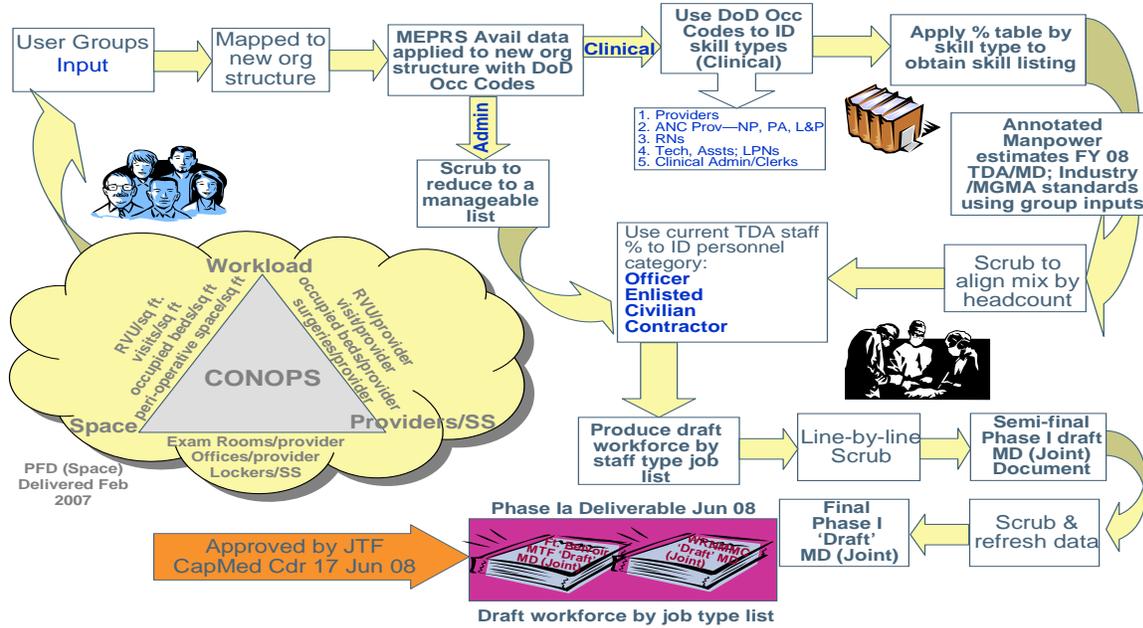
Figure 3: Manpower Development Flow Diagram (Phase Ia)

Manpower Development Flow Diagram (Phase Ib & II)
Predecisonal Draft
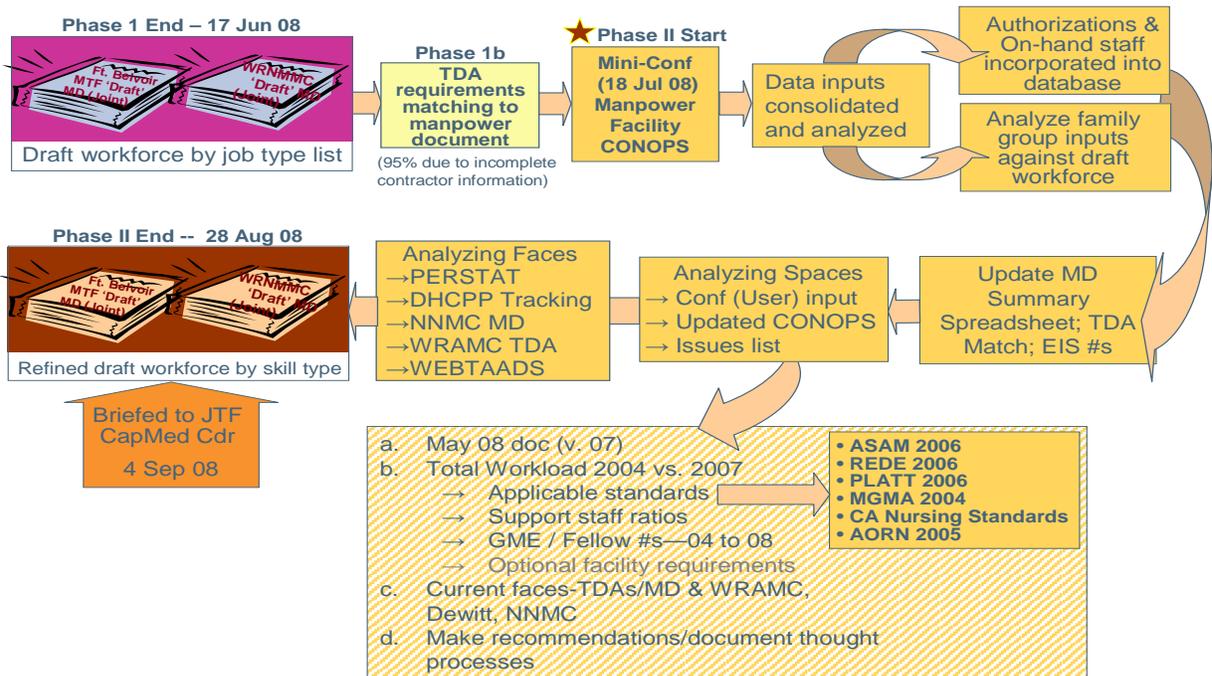
Figure 4: Manpower Development Flow Diagram (Phase Ib & II)

Manpower Development Flow Diagram (Phase III)

Predecisonal Draft

Phase II End
28 Aug 08

Map Contractors to Org Structure

Complete missing "Spaces"/Occ Descriptions

Correct Occupational Codes

Scrub! Scrub! Scrub!

Refinement
Admin
Clinical
Others

Adjust Spaces based on Approved Conops

Align Skill Mix

Validate
Workload
Space
Standards

Align current (2008) Authorizations & Contractor lists to ID % by personnel category & Service category:
Officer   Army
Enlisted   Navy
Civilian   Air Force
Contractor   Civilian

Brief to JTF CapMed Cdr Late Jan 09

Define Format for Manning Documents

Define Business Rules for Manning Realignment

Guaranteed Placement Program Document
POM Manning Document
EIS Manning Document
Facility Functioning Document

Phase III End (31 Jan 09)

Figure 5: Manpower Development Flow Diagram (Phase III)

Manpower Development Flow Diagram (Phase IV)

Predecisonal Draft

Phase III End
31 Jan 09

Development of PDs

CoA Selection for JTD/POM

Continued CoA Development

Continued Refinement

Coordinate and Validate Requirements with Services

Determine Readiness Requirements

Map Readiness Requirements to JTD

Coordinate Readiness Requirements with Services

Re-validate workload, space & standards

Refined JTD

Narrative & Model Refinement

Re-Align Skill Mix

Prepare for POM Submission

Continue to adjust Spaces based on Updated CONOPS

Brief to JTF CapMed Cdr Early Apr 09

POM Submission

Phase IV End
15 Apr 09

Figure 6: Manpower Development Flow Diagram (Phase IV)

Appendix C – Contributors

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MHS Human Capital Strategic Plan

2008 – 2013

November 2007

Interoperable and Agile –
A Total Medical Force that meets
missions defined by National
Security Strategy requirements

TABLE OF CONTENTS

MESSAGE FROM THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

It is my pleasure to present the Military Health System (MHS) Human Capital Strategic Plan for Fiscal Years 2008 to 2013. This comprehensive plan sets forth our vision, guiding principles, goals, and objectives that will shape the future direction of MHS human capital. This MHS Human Capital Strategic Plan will leverage joint capabilities and optimize resources across the Services to enable the MHS to deliver its mission more effectively and efficiently. We, the Services, MHS, and other Department of Defense (DoD) organizations are already implementing initiatives that directly support the achievement of this strategy, improving the services and care we provide to the warfighter. As a result we will be an interoperable and agile Total Medical Force ready to achieve both today's and tomorrow's missions during war and peacetime.

MHS is one of the most expansive healthcare organizations in the United States and the world's leading military medical care provider. Our people are our most valuable resource; they are called upon to provide medical care to our 9.1 million beneficiaries located around the world. We are facing numerous challenges in the upcoming years as we continue to fight a global war on terrorism, defend our Nation's homeland, and provide support around the globe for humanitarian efforts. Furthermore, changes in the demand for healthcare, national workforce shortages for medical providers, and increasing healthcare costs also demand that we strategically review and define our human capital plan for the future.

In response to the challenges we face, we have identified strategic goals and objectives that will help us successfully meet our missions and provide world-class healthcare to our beneficiaries. These goals and objectives include fostering a performance-based culture and building capabilities across the Total Medical Force to align recruiting, education, and workforce planning efforts. Significant results can be achieved in the next two years, with some already achieved, other activities underway, and still others about to launch. Integration of education and training across the Services and increased interoperability of Information Technology across the enterprise are examples of early success.

Additionally, our Human Capital Strategic Plan links to other DoD and MHS plans, including the DoD Human Capital Plan, the DoD Civilian Human Capital Plan, and the MHS Strategic Plan. Our approach and outcomes align with strategic initiatives at the DoD, MHS, and Service levels. Together, the medical components of the Army, Navy, and Air Force as well as members of the Joint Staff, National Guard, Reserves, and other DoD organizations have collaborated to ensure that this plan provides strategic direction for the Total Medical Force while respecting the unique Service cultures and practices that make our Services successful. The result is a comprehensive plan that promotes unity in mission without forced uniformity across Services.

I look forward to working with all components of the MHS in addition to our partners and stakeholders to support the initiatives and to achieve the results outlined in this Human Capital Strategic Plan.

Honorable S. Ward Casscells, MD
Assistant Secretary of Defense for Health Affairs

EXECUTIVE SUMMARY

MHS Human Capital Vision
Interoperable and Agile – A Total Medical Force that meets missions defined by National Security Strategy requirements

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In support of the DoD readiness mission, the Military Health System (MHS) ensures the Nation has a medically ready, healthy fighting force supported by a combat ready healthcare system that provides a health benefit to its broad customer base.

Analysis of the MHS operating environment and human capital data revealed several management challenges for the MHS. Medical resource gaps, lack of insight into human capital management across the Services, and limited coordination in planning, communication, and accountability result in workforce inefficiencies. In addition, stovepiped systems, programs, and practices limit the MHS' ability to close manning gaps and develop future leaders. Cultural differences between the Services also impact our ability to coordinate the management of the Total Medical Force.

MHS mission execution can be improved immediately with increased emphasis on planning, coordinating, collaborating, and developing human capital solutions across Services. These solutions require collaborative human capital systems, technologies, and programs that leverage economies of scale to improve performance across the Total Medical Force. Furthermore, the adoption of standardized performance management practices across the MHS will enable enterprise-wide decision making and analysis that will benefit all of the Services.

A vision statement drives the MHS human capital strategy and expresses what MHS human capital needs to be in the future to achieve its evolving MHS mission effectively. The vision and guiding principles are supported by five goals and 23 objectives. These goals and objectives create the foundation for the strategic direction in MHS human capital management. Our goals are as follows (the full list of goals and objectives can be found in Appendix D):

- ▸ **Goal 1:** Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management

- ▸ **Goal 2:** Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels

- ▸ **Goal 3:** Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission

- ▸ **Goal 4:** Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability

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- ► **Goal 5:** Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs

These strategic goals and objectives will help MHS personnel meet the challenges of both today and tomorrow. They reflect the collaboration of the Office of the Assistant Secretary of Defense / Health Affairs (OASD/HA), TRICARE Management Agency (TMA), and the medical components of Army, Navy, and Air Force as well as Joint Staff, National Guard, Reserves, and other DoD organizations. Together these organizations can create a proactive plan that will better recruit, develop, and retain a world-class medical force.

The MHS Human Capital Strategic Plan, directed by the DoD Chief Human Capital Officer (CHCO), guides the workforce toward becoming more interoperable and agile while providing medical services around the globe. Current MHS policies and programs support the outlined objectives, including the Defense Medical Human Resources System – Internet (DMHRSi) and the Health Professionals Incentives Working Group (HPIWG). Developing resource requirements and a collaboration design to support these goals including budgets, manpower, and technology will be critically important factors in action and implementation planning phases.

INTRODUCTION

The goal of the MHS Human Capital Strategic Plan is to bolster support and resources for the MHS human capital, the men and women providing medical assistance every day around the world. Improving the quality of care is critical and we are a Nation at war. We continue to provide international assistance to friends and allies around the world. Increasing threats within our national borders require preparedness to support our homeland defense priorities. In addition, we also maintain our healthcare services mission to the more than 9.1 million military beneficiaries. Serving beneficiaries through both combat service support and garrison care is challenging. It is necessary to change our human capital practices to address the following:

► It is proving challenging to retain our workforce over the long-term as our military and civilian men and women are proudly fighting a demanding war

► We are faced with an increasingly competitive healthcare industry job market

► The beneficiary population has grown and changed significantly in recent years bringing new health challenges, thus new and innovative healthcare solutions and a medical workforce capable of supporting those evolving needs

► While we maintain and respect our Service specific doctrines, we support evolving joint missions and need to continue to develop our workforce capabilities to succeed in those environments

► There are increasing pressures from Congressional and oversight bodies to demonstrate accountability

The MHS has a workforce of over 160,000 personnel to provide the support needed to face these human capital challenges. We are continuously improving the development of key medical skills and are aligning our workforce's capabilities to meet emerging medical needs. However, operating as we have historically has limited our potential for future success. We can no longer succeed to recruit, develop, train, reward, and retain our workforce solely through each Service independently. Instead, mission requirements demand that we work together to fulfill operational and combat missions. This involves increased collaboration and integration across the MHS to achieve interoperability and agility.

As the MHS embarks on the medical transformation established in the MHS Strategic Plan, we have developed a Human Capital Strategic Plan for FY 2008 to FY 2013. This plan lays the foundation for evolving our workforce and human capital management to meet MHS mission requirements effectively and efficiently. The plan establishes the vision to optimize the MHS workforce across the Services through increased interoperability, collaboration, and agility.

This MHS Human Capital Strategic Plan establishes the human capital management priorities for the enterprise. The strategic direction provided in this plan builds upon current MHS activities enabling the medical workforce transformation. The design, development and implementation of several initiatives are in process. For example, the Services are coordinating on Special Pays to increase collaborative recruiting initiatives. Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland, has been providing a joint education environment since 1976. The Medical Education and Training Campus (METC) in Ft. Sam Houston, Texas, currently remains in the development phase.

These institutions are examples of where combined training and education across the Services is already proving to be successful.

A methodical and systematic approach for developing this strategy brought together members of each of the Services, OASD for HA and TMA, the Joint Staff, the National Guard, the Reserves, and other DoD organizations. Under the scope of Title X of the U.S. Code they seek to identify and agree upon the priorities for MHS human capital management of the Total Medical Force. The flexibility provided to the Secretary of Defense for execution of Title X enabled constructive discussions and decisions that promote collaboration and integration across the Services in human capital management. This plan supports achieving MHS mission requirements while respecting Service-specific doctrine.

THE MILITARY HEALTH SYSTEM

The MHS has one mission: to enhance the Department of Defense and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care. The mission supports two areas - force health protection and beneficiary healthcare. The MHS supports DoD force health protection by ensuring the medical readiness of military forces. It also provides operational medicine, training, research, and Force Health Protection support across the spectrum of requirements resulting from the National Security Strategy. In fulfilling the needs of beneficiaries, the MHS provides healthcare benefits to the members of the Services, retirees, their family members, and other eligible beneficiaries through TRICARE, a healthcare plan using military healthcare as the main delivery system. The MHS promotes Total Medical Force medical preparedness in war and in peacetime.

As a DoD organization, the MHS is comprised of five entities: HA, TMA, and the medical components of the Army, Navy, and Air Force (Figure 1). Each of our MHS organizations perform unique but often similar functions in the execution of the MHS mission.

Figure 1. MHS Organizational Overview

Source: 9/11/07 - http://www.tricare.mil/pressroom_facts.aspx

MHS Strategic Direction

As the MHS continues its transformation into a health system that is exceptionally responsive to the changing national security environment, its components will need to provide more efficient and coordinated care to all service members. Critical activities associated with this transformation include restructuring the medical force, planning for shared services, implementing the decisions of the Base Realignment and Closure (BRAC) Commission, and executing the Quadrennial Defense Review (QDR). At the same time, we must continue to provide sustainable medical benefits to all of our beneficiaries.

MHS is committed to managing and delivering a high standard of care. The 2006 MHS Strategic Plan focuses organizational strategies to provide a medically ready and protected force and homeland defense for communities. It also aims to shape an integrated and seamless military health system characterized by an agile, flexible, and continually adaptable medical force – one that is joint and interoperable across all the Services and can deploy anytime, anywhere.

> **MHS Mission**
> To enhance the Department of Defense and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care
>
> **MHS Vision**
> A world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health

The MHS Strategic Plan outlines a five to seven year roadmap for enterprise-wide medical transformation. The plan includes system-wide goals and objectives that will result in achieving MHS goals through measurement and oversight.

The MHS Strategic Plan uses a balanced scorecard approach to define future success through a variety of performance indicators including financial, beneficiary, internal business processes, and learning and growth. The MHS balanced scorecard translates MHS's strategy into terms that can be easily understood, communicated, and implemented. Additionally, the MHS balanced scorecard is regularly updated and gives a complete picture of the status of goals and objectives. In using this approach, MHS developed a Strategy Map to foster a logical understanding of the key components of the future enterprise (Appendix A). In the near-term, MHS leadership will concentrate resources and management effort on achieving the following six goals:

> **MHS Strategic Goals**
>
> **Goal 1:** Enhancing deployable medical capability, force medical readiness and homeland defense by reducing the time from "bench to battlefield" for more effective mission focused products, processes, and services
>
> **Goal 2:** Sustaining the Military health benefit through cost effective, patient centered care and effective long-term patient partnerships
>
> **Goal 3:** Providing globally accessible health and business information to enhance mission effectiveness
>
> **Goal 4:** Transformation to performance based management for both force health protection and delivery of the healthcare benefit
>
> **Goal 5:** Development of our most valuable asset – our people
>
> **Goal 6:** Implementation of Base Realignment and Closure (BRAC) findings

MHS Components

Our organization has a wide and decentralized span of command and control divided between local, regional, and multi-service markets as well as medical research development. Our diverse personnel include senior leadership, facility commanders, regional and area office staff, healthcare professionals,

administrators, and researchers. Each of the Services and HA/TMA are responsible for the management of its own personnel. Each entity independently performs the full range of human capital functions, including recruitment, retention, training, and workforce planning. As a result, each of the MHS components plan and manage the human capital functions of their own medical force with different methods, systems, policies, and structures. Since the human capital management and procedural responsibilities of the HA and TMA are limited to the management of their own staff within their respective offices, the Services manage the majority of the MHS personnel and operate the majority of human capital functions within the MHS.

Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA)

The Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA) oversees the DoD's medical mission. The HA reports to the Under Secretary of Defense for Personnel and Readiness (USD/P&R) under the Office of the Secretary of Defense (OSD). HA issues policies, procedures, and standards for TRICARE. It also develops MHS initiatives to improve the quality of healthcare across the DoD and prepares the DoD healthcare budget.

TRICARE Management Activity (TMA)

In fulfilling the benefits mission, TMA manages and executes the Defense Health Program (DHP) appropriation and the DoD Unified Medical Program and supports the Uniformed Services implementation of the TRICARE program. TMA ensures that the DoD healthcare policy is implemented consistently, effectively, and efficiently across the MHS. In addition, it manages the TRICARE managed care program. Both HA and TMA work together to execute and manage healthcare policies and programs within the DoD.

TMA utilizes military healthcare as the main delivery system. It also uses a civilian network of providers and facilities that serves our uniformed services, retired military, and their

TMA OVERVIEW
Budget (2006)
▸ $37.1 billion for all DoD healthcare
Personnel
▸ 132,700 DHP personnel in the MHS
▸ 163,000 total active duty and civilian projected for EFY07
Beneficiaries
▸ 9.1 million Active Duty members, their families, select National Guard and Reservists, and others entitled to DoD healthcare under the authority of Veterans Affairs
Facilities
▸ 3 TRICARE Regional Offices (TROs)

families worldwide. Three TRICARE Regional Offices (TROs) and three TRICARE Area Offices (TAOs) support TMA's day-to-day functions. USUHS, the medical university that educates and trains medical officers for all three Services, is also aligned under TMA services. These institutions are responsible for dual mission of Force health protection and healthcare, as well as for medical education and medical services.

The Medical Components of the Services

Military healthcare within each of the Services is spearheaded by medical divisions within the Army, Navy, and Air Force through the Army Medical Department (AMEDD), the Navy Bureau of Medicine and Surgery (BUMED), and the Air Force Medical Service (AFMS), respectively. AMEDD and BUMED maintain command of the Medical Force, deploy mission support in theater, and provide beneficiary medical care. The Air Force manages and commands similar medical responsibilities throughout the line.

The Service medical components contribute to the MHS readiness missions by operating MTFs, recruiting, equipping, and training an able and ready Medical Force, and supporting operational readiness through Force Health Protection. The Army, Navy, and Air Force individually maintain Active Duty and Reserve officer and enlisted corps for deployment and staffing at the Service-specific MTFs. Each Service also maintains a Federal civilian medical workforce at the Service-specific MTFs. In addition to recruitment and retention, the Services provide education, leadership development, and other training programs to support MHS needs.

Army Medical Department (AMEDD)

AMEDD OVERVIEW
Budget (2006) ▸ $9.7 billion
Personnel ▸ 27,000 soldiers ▸ 28,000 civilians ▸ 20,000 Active Duty ▸ 30,000 medical soldiers as part of National Guard and Reserves
Beneficiaries ▸ More than 5 million Active Duty, retirees, and family members
Facilities ▸ 8 medical centers ▸ 26 medical departments (MEDDACs) ▸ Numerous clinics

AMEDD's mission is "to project and sustain a healthy and medically protected Force, to deploy a trained and equipped Medical Force that supports the Army transformation, and to manage the care of the soldier and the military family." AMEDD supports more than five million Army Active Duty service members, retirees, and their family members.

The Surgeon General of the Army simultaneously heads AMEDD and the Army Medical Command (MEDCOM). As the head of AMEDD, the Surgeon General is the medical expert on the Army staff and advises the Secretary of the Army on medical affairs. As the commanding general of MEDCOM, the Surgeon General commands hospitals and other AMEDD commands and agencies.

Within the Army, medical human capital management functions are centralized and are undertaken by three subcomponents of AMEDD: the Human Resources Directorate, which manages the people within the Army; the AMEDD Proponency Office, which manages billets, recruiting, and retention; and the Program Analysis & Evaluation within the office of the Secretary General, which plans for resource integration and transition, program analysis, and evaluation capabilities for effective resource management of enterprise-wide programs.

Navy Bureau of Medicine and Surgery (BUMED)

BUMED's mission is "to be ready to care for those in need, anytime, anywhere." BUMED personnel deploy with Sailors and Marines worldwide and provide critical mission support aboard ships, in the air, and on the battlefield.

Similar to the Army counterpart, the Navy Surgeon General serves as the Director of Naval Medicine and Chief of BUMED. His or her responsibilities include advising the Chief of Naval Operations on Naval health service programs, providing oversight of direct and indirect systems for providing health services to all beneficiaries in wartime and peacetime, and acquiring sufficient resources to provide health services.

BUMED OVERVIEW
Budget (2006) ▸ *$5.7 billion*
Personnel ▸ 56,000 officers, enlisted, and civilian personnel
Beneficiaries ▸ 2.6 million Active Duty, retirees, and family members
Facilities ▸ 22 hospitals ▸ 3 Naval Medical Commands ▸ 6 clinics ▸ 11 dental centers

Human capital management functions within Navy Medicine are centralized and carried out by the Human Resources Department of BUMED, which develops and directs Navy Medicine manpower plans and personnel policies. The department is responsible for developing staff standards, analyzing and evaluating Total Medical Force planning and programming for acquisition and alignment, developing proposals to achieve required Total Medical Force structure, coordinating Navy Medicine's personnel actions in relation to the DoD, and acting as the functional sponsor for manpower and personnel information systems.

Air Force Medical Service (AFMS)

AFMS's mission is "to provide seamless health service support to the Air Force and combatant commanders and to assist in sustaining the performance, health and fitness of every Airman." The AFMS promotes and advocates for optimizing human performance for the warfighters, including the optimal integration of human capabilities with systems.

AFMS OVERVIEW
Budget (2006) ▸ $6.9 billion
Personnel ▸ 40,000 officers, enlisted, and civilian personnel ▸ Additional 20,000 members as part of National Guard and Reserves
Beneficiaries ▸ More than 2.63 million Active Duty, retirees, and family members
Facilities ▸ 74 MTFs ▸ 11 hospitals, 3 medical centers, and 2 medical wings

The AFMS operates and manages a worldwide healthcare system capable of responding to a full spectrum of anticipated health requirements and arranges for healthcare capabilities that it does not possess. The AFMS directly supports Air Force operations and theater aeromedical evacuation of joint and combined forces. The Office of the Air Force Surgeon General also develops and implements medical programs and policies that provide for the healthcare of Active Duty and retired military personnel and their family members.

Air Force human capital functions are unique because they are decentralized and managed within the commands and MTFs. However, human capital strategy and direction on personnel requirements come from AF/A1, the personnel and manpower portion of the entire Air Force. When individuals join the AFMS they are assigned to specific MTFs by the Air Force Personnel Center. MTFs provide the decentralized human capital functions and administer human capital programs at a local level.

The MHS Workforce

Workforce Makeup

The Total Medical Force is comprised of approximately 163,000 personnel that includes 116,700 military personnel and 46,300 civilians. The Army, Navy, and Air Force medical forces are proportional to the overall distribution of the military workforce across the three Services (Figure 2).

Figure 2. Distribution of Workforce and Medical Workforce by Service
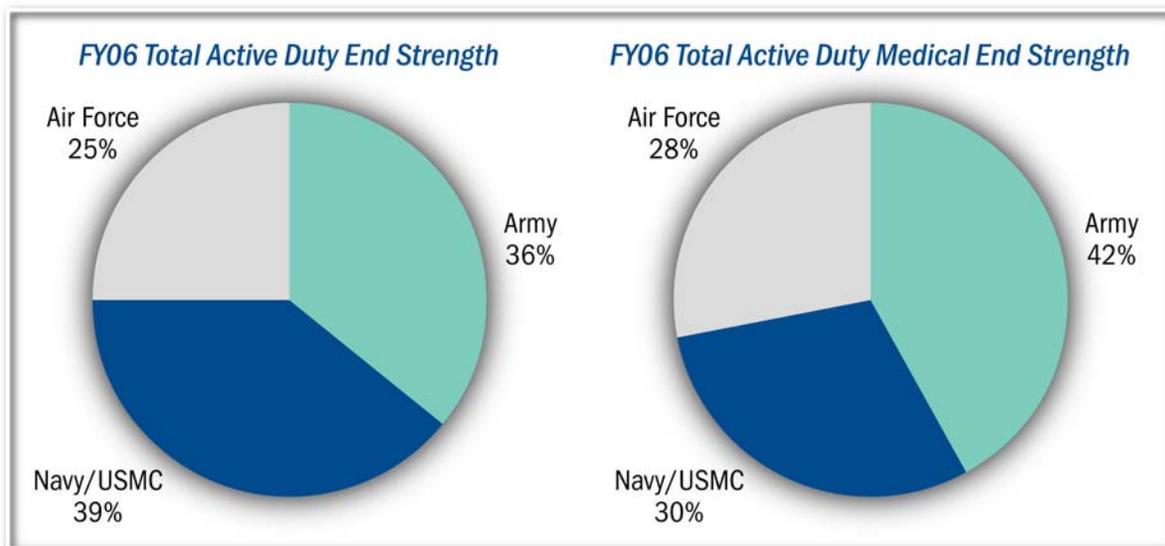
Note: The percentages above include only Active Duty and Reserve components of each Service
Source: Active Duty Military Strength Report for September 2006, Defense Manpower Data Center;
FY08 Defense Manpower Requirements Report (DMRR)

The MHS workforce is comprised of different populations including Active Duty, Reserves, and Civilians. In addition, the MHS Total Medical Force utilizes personal and non-personal service contract support for clinical and non-clinical mission support. Together the Active Duty and Reserve workforces make up approximately 80% of the Medical Force. Of that 80% the Active Duty comprises 53% and the Reserve comprises 28% (Figure 3).

Figure 3. Distribution of Total Medical Force
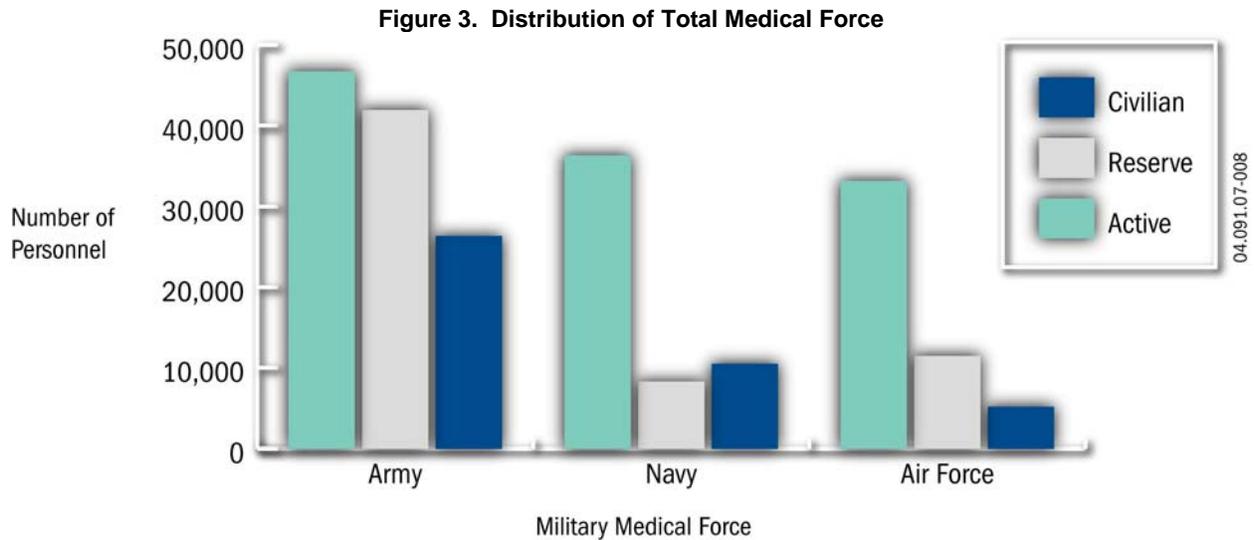
Source: FY 2007 Defense Manpower Requirements Report Template Workbook

Across the MHS, the medical workforce is comprised of several specialty medical corps including Medical, Dental, Nurse, Medical Service, Medical Specialist, Biomedical Sciences, Veterinary, Warrant Officers, Medical Enlisted, and Dental Enlisted. The largest corps is the Medical Enlisted Corps which consists of 77,058 individuals and makes up 65% of the Total Medical Force (Figure 4).

Figure 4. Distribution of Active Duty Medical Personnel by Corps
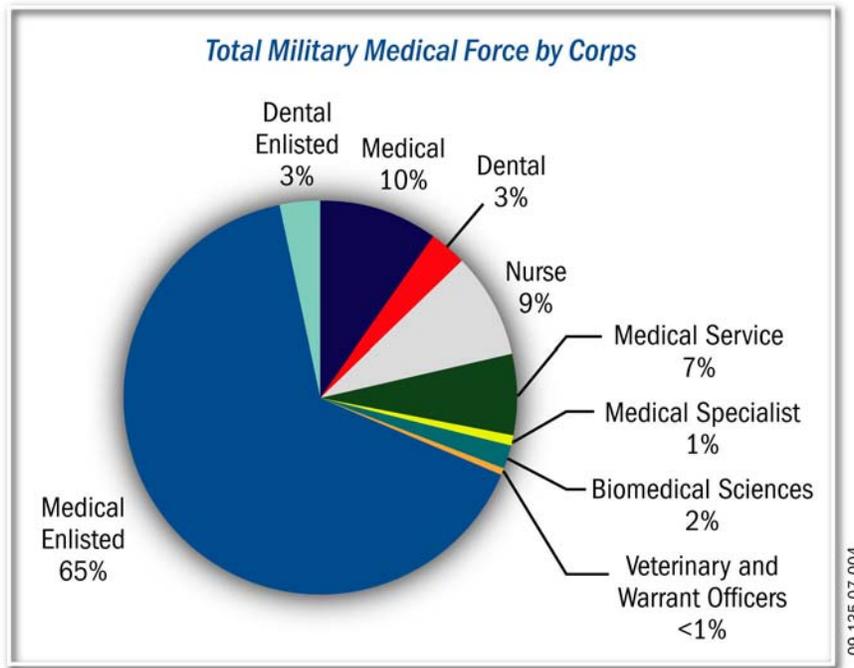
Source: FY 2007 Defense Manpower Requirements Report Template Workbook

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Civilians satisfy human capital requirements that do not require a uniformed member. The DoD civilian workforce contributes directly to the readiness of the Armed Forces by providing direction, continuity, and control. This civilian contribution frees uniformed personnel to perform military-essential tasks. While civilians are currently the smallest medical component, reliance on Federal Civil Service personnel is increasing. From FY 2005 to FY 2007 Federal civilians increased by over 3,500 and are expected to continue to increase as mil-to-civ conversions continue. Civilians have a separate human resources management system known as National Security Personnel System (NSPS), which is scheduled for full implementation by FY 2008. NSPS will govern basic pay, staffing, classification, labor relations, adverse actions, and employee appeals to ensure that the DoD human resources management and labor relations systems align with its critical mission requirements and protects the Civil Service rights of its employees.

Contractors also play a pivotal role in the execution of the MHS mission by providing:

▶ Coordination of medical services within the MTFs and the network of civilian hospital and providers within TMA

▶ Clinical and administrative support staff to the Services in local MTFs

▶ Support in the garrisons when military personnel are deployed to serve operational missions

▶ As-needed supplemental coverage for the military workforce where there are capability gaps

▶ Internal support services, program management, and product support through the TMA non-purchased care program

Additionally, there are thousands of volunteers who contribute their time and labor in support of our mission of caring.

Accession Sources

Medical personnel enter the military through a variety of different accession sources that include education and training scholarships and incentive pay programs. Enlisted medical staff enter a branch of the Services and are then assigned based on aptitude test scores and specialty staffing needs. Medical officers join their respective Service through a variety of sources: direct accession, Armed Forces Health Professional Scholarship Program (AFHPSP), Reserve Officers' Training Corps (ROTC), Health Service Collegiate Program (HSCP), Financial Assistance Program (FAP), and various enlisted commissioning programs. Civilians are hired through the General Schedule (GS) Federal program and Federal Wage System, but they remain eligible for many bonus programs as well.

USUHS is an additional source of accession for medical officers accounting for approximately 10% of total Medical Corps accessions. Established by Congress in 1972, USUHS is the Nation's federal health sciences medical university. It provides the Nation with health professionals dedicated to career service in DoD and scientists that serve the public good. USUHS provides health education with relation to military medicine, disaster medicine, and military medical readiness. Graduates represent all three Services and the United States Public Health Service. Students from each Service are educated by faculty representing the Total Medical Force. As a result of this joint environment, students have a better

understanding of the different Service terms and processes before engaging in their military medical career. This joint education and training leads to increased interoperability later in the service member's career as USUHS alumni have strong connections with one another that serve as an informal network. In addition, USUHS graduates have a higher retention rate than those accessing directly to the military or from financial assistance programs.

HUMAN CAPITAL STRATEGIC PLANNING

In September 2006, MHS launched the development of the MHS Human Capital Strategic Plan to identify human capital management opportunities across the MHS and optimally enable the medical transformation. The development of an MHS Human Capital Strategic Plan is critical to achieving an informed understanding of how the Services and HA/TMA can work together to achieve MHS' goals. Human capital strategy development also enables MHS to effectively integrate and advance key priorities across the enterprise. In particular, human capital strategic planning within MHS achieves six objectives:

► Establishes an integrated vision and set of priorities for MHS human capital

► Provides organizational and programmatic focus for both short-term and long-term organizational activities

► Improves human capital alignment across the Services and HA/TMA with the future direction of the MHS

► Anticipates and focuses MHS human capital to meet future DoD and national security needs

► Enables more informed decision-making to promote success

► Promotes accountability for the management of human capital

Additionally, it furthers the integration across MHS thereby improving collaboration within the organization and promoting interoperability across the Services and HA/TMA.

Figure 5. Human Capital Strategic Planning Framework

The MHS vision statement drives the Human Capital Strategic Plan, specifically regarding future MHS human capital initiatives needed to achieve the evolving MHS mission (Figure 5). Guiding principles describe shared values that form the basis for goals and objectives. These goals and objectives then direct how the vision will be achieved. For each goal and objective, performance measures establish agreed upon indicators of future success. They also inform prioritization of MHS human capital management activities.

Action plans will be developed to assign responsibility and set forth the steps and timing necessary to execute the strategy. Performance measures are found embedded within this Plan. The action plans will be published separately and will complement this plan. Based on these action plans, implementation plans will be developed and communicated in several phases to facilitate interoperability.

Critical to the entire development of our Human Capital Strategic Plan was a firm understanding of the current state of human capital and its management across the MHS. A detailed analysis was undertaken and served as an input in the strategy development process. Furthermore, a review of environmental trends helped shape our strategic direction (see page 14 for more on the environmental analysis).

Strategic Alignment

The MHS Strategic Plan establishes the foundation for medical transformation across the military medical enterprise. This MHS Human Capital Strategic Plan complements the MHS Strategic Plan and aligns directly with many of the MHS Strategic Plan's six goals and 27 objectives. Additionally, commonalities and linkages with other DoD- and Service-level human capital plans were identified as critical areas of alignment. These key plans included the DoD Human Capital Plan developed by the congressionally appointed DoD CHCO, the DoD Civilian Human Capital Plan, the QDR – Roadmap for Medical Transformation (fully staffed and approved by the Senior Medical Military Advisory Council (SMMAC) and the Military Health System Executive Review (MHSER), the Navy Human Capital Strategic Plan (2004), and the Air Force Human Capital Strategic Plan (2004-2009). The common themes leveraged for this Plan include the following:

- ► *Competencies and Competency-Based Planning* – We need to create a common framework or set of descriptions to define skills and vocational activities related to the people who possess and use them. The competencies have to be common across Services and components to promote understanding and to produce measurable performance results. Based upon the identification of competencies, the Services and Offices can begin to fill competency gaps through hiring, training, education, and career development programs or through other workforce planning efforts such as reassignments and restructuring efforts to ensure the right people are in the right job at the right time at the right cost.

- ► *Performance-Based and Results-Oriented Culture* – We strive to achieve success in line with stated goals. We plan to create performance-based management systems that align all of the processes and systems with one another to achieve results. Additionally, these systems must clearly link individual performance with organizational goals and provide incentives to reward high performance.

- ► *Interoperability* – We work to create interoperability between Services and programs. Joint capabilities and interoperability lead to greater agility and flexibility for the medical force. Interoperability pervades all elements of human capital from joint education and training and Graduate Medical Education (GME) to a seamless transition between Active Duty to civilian resources across disparate organizations.

- ► *Use of technology to improve efficiency* – We leverage technological resources to promote efficiency. Aligning technological capabilities with human capital processes and systems will help to define, collect, and manage data, decrease the recruiting cycle time, and increase the quality of service to beneficiaries.

Our MHS human capital strategy incorporates these common DoD human capital planning themes throughout our goals and objectives. It builds upon initiatives that are already being implemented across the enterprise. Initiatives such as the implementation of DMHRSi and Defense Integrated Military Human Resource System (DIMHRS) are promoting efficiency across the enterprise through the use of technology. Joint education and training at the METC and at USUHS enhance our ability to work in an interoperable environment. Specific areas of alignment with other Strategic Plans are highlighted in the particular goals and objectives. A cross-walk of the human capital strategy and the plans to which it aligns may be found in Appendix B.

Environmental Analysis

To deliver the healthcare benefit we need to understand the complete environment in which we operate and the critical factors that impact our success. Analyzing the environment allows us to proactively address potential challenges. Internal and external factors impact MHS and our strategic direction. External factors, such as the nationwide shortage of nurses, and internal factors to DoD, such as the QDR, have an impact on human capital decisions and were taken into consideration while developing the plan. The trends provide an understanding of the types of human capital initiatives that must be in place to address potential challenges and ensure that MHS has the right people with the right skills at the right time at the right cost.

Our organization is facing increased financial and strategic pressures. With medical care accounting for an increasing share of the DoD budget, we must examine ways of restructuring our workforce to control this rising cost. Coordination and planning for the optimal MHS workforce mix will help stem this rising cost. We must also work across the Services to streamline our operations in response to strategic initiatives such as BRAC, the QDR, and the increasing jointness of medical capabilities.

INTERNAL	
Key Trends	**Impact**
Rise in military health expenditures	*Fiscal pressures will place an increased budget constraint on MHS resulting in fiscal prudence. Our organization will need to examine ways of restructuring the healthcare workforce and the healthcare benefit to control this rising cost*
DoD strategic initiatives (BRAC, QDR, increasing jointness of medical capabilities) and increased support for humanitarian crises	*The Military medical capability must transform to respond to these initiatives. Doing so requires building a Medical Force of the right size and with the right mix of skills*
Staffing imbalances across the Services	*Services will need to work together proactively to plan for shortages and share resources across the Total Medical Force*

In addition to increased internal pressures, our organization faces significant external pressures. The healthcare industry is experiencing a significant shortage across its workforce, especially within the nursing field. The number of non-US citizen applicants to medical schools is increasing at the same time

the percentage of female students enrolled in medical schools is increasing. Traditionally, these populations have not chosen to serve in the U.S. military, which increases the challenge for MHS recruitment. We must work across the Services to find new ways to attract the highly skilled and increasingly growing population of medical school graduates that have not traditionally served. At the same time, we must also develop strategies that retain our top performers.

EXTERNAL	
Key Trends	**Impact**
National shortage of healthcare workers	*The dramatic shortage in nursing continues; demand will exceed supply even if there is a dramatic 90% increase in nursing school graduates*
Increase in preventable illnesses	*Lifestyle challenges such as increasing diabetes and obesity will contribute to increased utilization of MHS services which will put a strain on resources requiring MHS to invest more resources in preventive medicine*
Increased focus on workforce planning	*MHS will need proactively to examine ways in which its medical workforce can help support DoD's long term strategies and work to identify and plan for the optimal workforce mix*

We will need continuously to analyze our internal as well as our external environment to address these trends and challenges. We must be prepared to respond to the information gathered from this analysis by altering our strategies to meet mission requirements. While each of these examined trends impact the future of our workforce, the interplay could have a more significant impact if we do not proactively work to address these issues. Appendix C provides a comprehensive list of the trends identified in this assessment.

MHS HUMAN CAPITAL STRATEGY

Developing a comprehensive and integrated human capital strategic plan will enable our systems to address the challenges of managing the Medical Forces across Services and HA/TMA. The plan improves integration and interoperability between the human capital functions of the Services and HA/TMA by providing collaborative human capital direction. From this Plan, the MHS will be better able to address the needs of the Total Medical Force, from Active Duty, National Guard, Reserve, to Federal Civil Service personnel. We will better structure career paths and succession planning and ensure that they are tied to performance standards and training opportunities. The Plan will help us build incentives that reward the right behaviors. Transparency of data will allow the entire MHS to plan for, identify, track, and match available resources against changing mission requirements. The Plan will also enable accountability and improve the use of technology to support human capital functions.

Foundational Success Factors

The success of our human capital strategy is dependent on three critical factors: 1) understanding and executing human capital management as part of an integrated lifecycle; 2) creating a performance management system to enable us to achieve results through monitoring, reporting, and performance-informed decision making; and, 3) reliable information systems and supporting business rules.

Human Capital Lifecycle Management

Human Capital Lifecycle Management refers to systems and processes that support employees through every phase of their service with the MHS, from recruitment through training, development, retention, and ultimately release and separation. By requiring utilization and management of the Human Capital Lifecycle Management Framework (Figure 6), we will be able to find the best people, leverage their talent to meet mission requirements, align employee goals with corporate goals, maximize the impact of training, and retain top performers.

Figure 6. Human Capital Lifecycle Management Framework

Our Human Capital Strategic Plan was developed by focusing on the categories of this framework to ensure that all phases of MHS human capital management are addressed. The six segments that compose the Human Capital Lifecycle Management Framework incorporate the complete career development spectrum for our entire workforce.
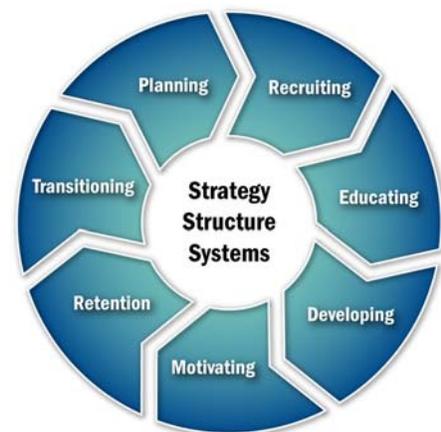
- ► **Planning:** Planning aligns the future workforce by aligning the MHS human resources to the MHS strategy, mission, and vision. MHS workforce planning would include determining the proper size of

the workforce, deployment across MHS, and the competencies needed to fulfill our mission. Examples of MHS planning include determining manpower requirements, the optimal mix, and budgeting. The different components currently have their unique workforce planning processes that are aligned to their individual strategies, missions, and visions. By developing an MHS-wide workforce planning process, this first step in the lifecycle will align human capital plans across components to support the MHS mission and common priorities.

- ► **Recruiting & Retention:** Recruiting activities seek out and attract people to fill positions using a variety of methods including enlistment, officer educational programs, and special pays. There are tangible and intangible benefits as part of the recruitiment process including professional liablitiy coverage and Service provided administrative support for providers. Retention activities provide incentives for current MHS members to remain within our organization. Examples of common retention strategies include flexible work schedules, telecommuniting, and job sharing. MHS currently offers comprehensive scholarships and special pays as recruiting and retention tools but these meet with varied success depending on the medical specialty and current market for that specialty. Currently, Services compete against one another for the same limited pool of resources. Relating Service recruiting and retention strategies across the MHS will help anticipate and close workforce competency gaps. This will build coordination and collaboration across the Services to share lessons learned, help identify available candidates, and maximize the positive impact on the Total Medical Force.

- ► **Educating & Training:** Education helps to develop and improve employee performance through formal and informal training and education. MHS education spans from formal degree-granting educational programs such as those offered at USUHS to on-the-job training to classroom and electronic learning through external institutions and partners. While MHS provides multiple educational opportunities, we can leverage the educational programs across Services to provide the best offering to all of our personnel. Examples of combined training and education include the METC at Ft. Sam Houston, San Antonio and USUHS in Bethesda. MHS can further enhance the educational experience of its personnel and enhance mission success by linking individual employee educational plans to core competencies and behaviors.

- ► **Developing:** Development of personnel occurs through performance-based assessment systems that align to strategic MHS needs. Development is based on building the right skills mix, instilling leadership development, and facilitating positive career movement. As a DoD organization, MHS provides a number of leadership opportunities for Active Duty members to rise through the ranks. Many Service components encourage local mentoring of promising staff to expand their skill set or take on new challenges to provide growth. Joint assignment opportunities is another method by which to develop the Active Duty and Civilian workforce. We can take these best practices to the enterprise level by developing a comprehensive leadership and succession planning strategy to develop the MHS leadership core and to ensure a pipeline of candidates, both military and civilian, are available for succession into vacant leadership positions. Additionally, workforce development plans would provide more opportunities for Federal civilian and other non-Active Duty advancement.

- ➤ **Motivating:** Motivating personnel is not just about financial incentives that reward performance and encourage future performance. Motivation includes benefits packages, award opportunities, quality of life programs, and assignment or housing opportunities. Increasingly, MHS personnel are citing quality of life as a top priority in remaining with our organization. For example, a Service member in Texas may want the flexibility to be assigned in California where his or her spouse is stationed. By taking these factors into account as well as creating MHS-wide strategies that enhance these policies and programs, MHS will become the employer of choice for medical staff.

- ➤ **Transitioning:** The transition of personnel spans beyond the separation of personnel and providing continuity of work and responsibility in his or her absence. Transitioning also includes knowledge management to ensure that the knowledge and skills of our highly capable medical staff are retained within our organization. This lifecycle phase is challenging with high turnover rates for some medical specialties but there are many opportunities for assisting in employee transitions. Services Reserve components, as well as Federal Civil Service organizations, often recruit from separating Active Duty populations. Providing information on upcoming separations to the Reserves and Federal Civil Services will help to retain that skilled worker and his or her critical knowledge within the MHS. MHS will also benefit from establishing succession plans that help to identify future skilled personnel to fill in positions left by separating members. Succession plans can be linked to MHS strategic needs and help to improve the continuity of work performed.

This framework addresses critical MHS human capital issues including critical skill shortages, evolving competency requirements, recruiting / retention / succession strategy decisions, and education / training / development programs needs. By viewing these activities as phases within the human capital lifecycle, MHS will be better prepared to identify the effect that one phase may have on another phase. For example, increasing recruiting efforts for skilled personnel may reduce training needs.

Performance Management

Establishing a performance management system will enable the MHS to make performance-informed decisions that achieve results and foster organizational accountability. MHS' implementation of an effective performance management system will achieve three key goals: 1) to align MHS' programmatic activities with its strategic goals and objectives; 2) to define measures to hold management accountable for achieving high performance targets; and 3) to promote optimal resources allocation to achieve desired business results.

MHS' human capital performance management efforts will integrate with other organizational management processes including strategy development, operational execution, budgeting activities, and most importantly with the MHS Balanced Scorecard. Any new personnel performance management systems would interface with the NSPS, which provides a results-oriented system for Federal civilians developed to value performance, reward contribution, and promote excellence. Performance measures will include both output measures (process-based quantifiable metrics) and outcome measures (goal-

based metrics). Additionally, MHS' performance management system will follow a disciplined approach of systematic collection, distribution, and use of performance metrics.

Implementing an effective performance management system will allow MHS to articulate both successes and areas for improvement accurately and objectively to both internal and external stakeholders across all facets of the human capital lifecycle. It will also promote a performance-based culture and focus on achieving results.

Vision

> *Interoperable and Agile – A Total Medical Force that meets missions defined by National Security Strategy requirements*

We have a demanding and challenging responsibility to support operational and combat missions. The missions that we support have recently evolved and will continue to change. As the DoD continues fighting the current war, maintains a primary role in the Global War on Terrorism (GWOT), and supports our allies, our Total Medical Force must be ready and capable of providing the necessary medical capabilities. The DoD has increasingly played a vital role in homeland defense and national security within our borders. Furthermore, our Nation's success and influence internationally is enhanced through humanitarian missions. We must maintain a critical capability in fulfilling our peacetime responsibilities in honoring the healthcare benefit and care promises made to our more than 9.1 million beneficiaries. All of these requirements are rooted in the National Security Strategy which has evolved into this broad spectrum of missions – requirements that the MHS must be ready and able to meet.

Each of these National Security Strategy requirements mandates that the MHS approach its human capital mission differently than it has in the past. These missions are executed jointly by our Soldiers, Airmen, Sailors, and Marines. From the medical human capital perspective, we must be able and ready to work collaboratively across our Services to support these joint missions successfully which equates to attaining a level of interoperability and agility across our Services. We will accomplish this by establishing common standards and programs that may be applied across the MHS, where appropriate, to increase interoperability and agility.

Guiding Principles

We will honor our commitments to the Nation by following a set of seven guiding principles in the development and execution of our human capital strategy:

- ► *Meeting our commitment to the mission***:** Our emphasis will be to shape the Total Medical Force for the purpose of ensuring our force is properly prepared to accomplish the current and evolving missions of force medical readiness, deployable medical capability, and healthcare delivery. Our focus is to best serve our customers and stakeholders.

- ► *Meeting our commitment to our people:* We must create and sustain a culture that values and recognizes each member's contributions to our missions. We will create an environment that is conducive to a productive and motivated Total Medical Force. This environment will provide challenging and rewarding career choices, continuous learning and improvement by maximizing one's potential, empowering personnel, recognizing and rewarding the contributions and sacrifices of our people and their families, and by ensuring a diverse and inclusive workforce.

- ► *Maintaining balance between mission and people:* We will ensure the vitality and capability of our people while ensuring mission requirements are met. This will include the integration of our human capital investment across our services, cooperative recruiting efforts, and obtaining and building our competencies to support the dynamic mission environment.

- ► *Establishing a culture of innovation and continuous improvement:* We will promote a culture of innovation challenging our people continuously to improve our work processes and procedures. We will provide our people with the tools, training, opportunities and incentives to increase mission effectiveness.

- ► *Establishing a performance-based culture within the MHS:* Our people will start each task with the end state clearly defined using a common set of terms and measures. Data driven, strategically aligned performance objectives will be communicated and understood and people will be recognized for meeting those objectives.

- ► *Ensuring transparency across the MHS:* Our processes and investments will be transparent across all organizations within the MHS. We will ensure that information is accessible to the Total Medical Force so leaders at every level can make informed decisions. To meet future challenges, an aligned enterprise approach is necessary to promote interoperability and unity without uniformity.

- ► *Ensuring an agile, flexible, and adaptive workforce capable of responding to the full range of military operations:* We will be joint and interoperable to ensure an agile and effective workforce that meets DoD's evolving mission needs. MHS positions will have defined competencies enabling capabilities-based planning. Joint education and training and a common lexicon will also support joint responses in a more effective and efficient manner.

Based upon the vision and these guiding principles, we have developed five goals with 23 objectives that establish the strategic direction for MHS human capital and MHS human capital management.

Goal 1: Information Management

> ### Goal 1:
> **Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management**

As Information Management (IM) is the backbone of informed decision making, we will develop a unified IM system that will provide us with human capital data that are available, consistent, collaborative, comprehensive, and globally accessible. Common data standards will ensure the Services and Offices can share and collaborate on data and decision making.

While some human capital data are currently coordinated and combined between Services, the process occurs only once a year and is extremely time consuming. Information is not published until long after the data collection, significantly limiting our ability to make informed and timely human capital decisions. The introduction of the DMHRSi is a great improvement over previous capabilities and is a critical factor in ensuring that we meet this goal. It will establish a common system to track training and education and executive skills and competencies among military and civilian personnel across the MHS. However, the system does not establish MHS-wide enterprise policy that supports implementation and utilization. As a result, local units may track different data or choose to use some functionality without using others. To coordinate across the MHS and ensure consistency in use and application of the system, a single center of data will be established. This entity will serve as a central point to create and retrieve reports, disseminate information, and use the information to enable better human capital decisions.

The information available through the common data exchange will provide insight into current capabilities and uncover capability gaps that need to be filled. It will also be used to identify the optimal workforce mix and human capital requirements needed to support different military scenarios. In an effort to foster a collaborative environment for the Service and HA/TMA, we need to build a culture of trust in regards to data sharing. It will be important for each data provider to feel comfortable sharing and aligning information in an environment of data privacy and security.

Building a successful information management capability is a hallmark in both DoD-level and MHS-level Strategic Plans. The DoD Human Capital Plan requires the identification and collection of human capital information to provide input to leadership decisions on force shaping and other workforce alignment activities. In addition, the QDR supports expanding MHS' current limited Enterprise Architecture (EA) and integrating it with process improvement and business planning methods to allow for a more dynamic view of our organization. Finally, the MHS Strategic Plan acknowledges that providing globally accessible health and business information will enhance mission effectiveness and advocates for establishing an advanced electronic health system.

Through this goal, MHS can build upon the DMHRSi, DIMHRS, and NSPS initiatives that are currently being deployed to administer a successful unified IM capability with multiple components that can be driven by process or technology. The system will build off of a common human capital lexicon to enable joint understanding of terms and definitions. The IM system will also include tools to manage human capital with transparent and timely data. Finally, the system can enhance the function of human capital by automating human capital workflow processes.

Summary of Goal 1 Objectives

Implementation plans will be developed in the next phase of this project   Successful accomplishment of the five objectives developed and defined for Goal 1 will deliver the following:

- ▶ Common human capital lexicon across the MHS
- ▶ Common data standards to enable the sharing of data across the MHS and partner agencies (Veterans Affairs, Public Health Service, hospitals, etc.)
- ▶ Assessment to identify technology gaps in the MHS Information Technology (IT) portfolio to better enable human capital management
- ▶ Utilize transparent human capital reporting to better manage the Total Medical Force
- ▶ Identification, reengineering, and automation of human capital workflow processes

Initial performance measures can be found within the objective descriptions in this section.

Goal 1 Alignment

Plan	Alignment
MHS Strategic Plan	▸ Goal 3: Provide a globally accessible health and business information to enhance mission effectiveness. Deploy human resource, financial, logistics and other systems to create an integrated information network for the MHS.
DoD Human Capital Strategic Plan	▸ Strategic Initiative 1: Create a competency-based occupational planning system
DoD Civilian Human Capital Strategic Plan	▸ Goal 4: Develop a technology system that supports HR
QDR	▸ QDR 14: IM/IT Alignment

Objective 1.1: Define, manage, and communicate a common human capital lexicon that supports MHS and Service mission priorities

Communication between the Services becomes extremely limited when one term has multiple definitions. For example, preventive medicine technicians in the three Services perform different duties and have different requirements and standards. Similarly, communication is limited if multiple sources have different terms and requirements for the same concept or position. This situation presents a large barrier to interoperability with restricted communication.

To prevent confusion and expand interoperability, we must create and implement standard definitions for our human capital terms. Shared lexicons will create ease of communication, which will promote a more open and joint environment. This standard human capital lexicon has to be communicated and understood MHS-wide. We must ensure that we are all using the same terms with common meanings when communicating across Services.

Creating the common lexicon will be lengthy and require the commitment and dedication of all MHS components. This objective will be among the most challenging yet one of the most important to achieve a joint information management capability. A standard human capital language that is used across all medical components of the MHS will allow for better management of human capital across the organization.

Performance Measure	Equation	Description
Percentage of common human capital definitions required that have been published	Number of common human capital definitions required that have been published / Total number of required human capital definitions	Identification and definition of the terms requiring common definition will take place during future analysis. Having a common language that is used across systems and Services to use will increase interoperability.

Objective 1.2: Establish common data standards that allow for the sharing of data across the MHS and partner agencies

Currently, each of the Services and HA/TMA record, keep, use, and report data in different methods at different times in different formats. A limited quantity of the human capital data goes through a painstaking annual process to be assimilated and assembled into one coherent whole. By the time the data are gathered and combined, the data are no longer current. These situations impede interoperability and can be corrected by establishing requirements and data standards to allow for a more timely and interoperable sharing of data.

Data standards will enable economies of scale as each Service and HA/TMA use the same data collection method, timetable, and format. These common standards would also allow outside partner agencies, such as the Office of Personnel Management (OPM) and Veterans Affairs, to share and contribute to the MHS data where necessary. Achieving an enterprise-wide view of MHS human capital requires all stakeholders to utilize similar data standards in order for raw and analyzed data to assist strategic management.

While common data standards promote interoperability, they raise issues of data privacy and security. We will supplement our data standards with industry leading encryption and security of our human capital data.

Performance Measure	Equation	Description
Percentage of accredited human capital IM/IT systems utilizing common data standards	Number of required common data standards that have been successfully populated and are available MHS-wide / Total number of common data standards	To create interoperability, the MHS IM/IT systems must utilize and require the same data standards. This will aid transparency and assist the MHS produce usable and interoperable reports to improve human capital issues. Fields requiring common data standards will be identified during future analysis.

Objective 1.3: Develop a portfolio of collaborative, comprehensive, and globally accessible information technology tools to strategically manage human capital resources

Following the completion of a common lexicon and common data standards, we will build a tool or set of capabilities to collect, store, maintain, and deliver the interoperable data. The set of tools will enable the strategic development of human capital by providing for the comprehensive, strategic management of data systems from one location. Management of the portfolio also allows for identification and correction of errors as well as changes and updates to the system. Identifying and managing all information management tools and systems that address human capital creates efficiencies that will drive effective strategic human capital management. One example is the implementation of DMHRSi which is currently underway and full deployment is anticipated for 2008 in the Navy and early 2009 for the Army.

This objective does not specify the tool or tools to be used. Ideally, creating the portfolio of tools would allow for interoperability of current data tools as well as the development or purchase of new and interoperable tools that close IT gaps. Further analysis is needed to identify where sufficient IT currently exists and where additional tools or systems would make us more effective with consideration given to COTs and GOTs solutions.

Performance Measure	Equation	Description
Cost savings created through use of interoperable MHS human capital information technology tools	Cost of utilizing interoperable MHS human capital information technology tools for a similar timeframe / Average cost of utilizing MHS human capital information technology tools	Cost analysis will determine the savings to MHS as a result of using interoperable information technology.

Objective 1.4: Develop, collect, and integrate transparent and timely data on the Total Medical Force to enable human capital decisions

With the suite of data management tools available, the human capital IM/IT system can be populated with human capital data from all MHS components. MHS will establish a common data policy that standardizes the use of the IM capability. This policy will guide what types of data will be collected, what data will be reported, and how the data will be used to ensure completeness of information. Other data policy items include how often data will be collected to ensure timeliness. The increase in integrated, transparent, and timely data from the Total Medical Force will help enable MHS to make human capital decisions based on accurate, relevant, and consistent information.

In order to ensure data integrity and appropriate usage, we will establish a central point of data accountability that is responsible for the data and its use. Rather than pull reports from multiple locations that take many days to compile, MHS leaders will be able to establish regular standard reports and simple procedures for providing on-demand data as the need arises or requests are made. Those responsible for the data also will be responsible for analyzing the data and disseminating results to inform human capital decisions. Integrating the data will include addressing data inconsistencies, errors, and harmful gaps.

Performance Measure	Equation	Description
Percentage of enterprise-wide human capital reporting requirements that meet cycle time targets	Number of enterprise-wide human capital reporting requirements that meet cycle time targets / Total number of enterprise-wide human capital reporting requirements	There is the need to increase the timeliness of IM/IT information processing. Timely human capital reports assume that the information also meets the needs and expectations of the requestor.

Objective 1.5: Identify and automate critical human capital workflow processes to enable human capital management

As a world-wide healthcare organization often operating on the battlefield as well as in medical facilities, the MHS needs to streamline its workflow processes to deliver the best care to our beneficiaries in a timely, cost appropriate manner. Current technology developments enable the rapid sharing of information, such as healthcare records, to make timely healthcare decisions around the world. The same technology can be applied to human capital processes to enable MHS personnel to be highly trained, quickly recruited, and fairly assessed. For example, automating certain Federal Civil Service hiring procedures will reduce the current three month hiring process. Automation will also lend itself to better and faster data capture throughout the human capital lifecycle. Training completion forms and credential documents can automatically populate databases that track human capital information across the enterprise.

Analyzing standard human capital processes and adding technology solutions including DMHRSi and DIMHRS to these processes will enhance efficiency as an organization and work to make effective strategic management decisions. Personnel in human capital functions will have greater and timelier access to information. Applying data and technology solutions will also enhance readiness and enable a more accurate view of the workforce. Automated workflow processes will lend themselves to military preparedness for battle by helping to recruit the right individuals more quickly and more quickly identify and enroll them in training for a joint battlefield environment.

Automated human capital workflow processes will require an initial learning curve to change the way MHS delivers human capital services to its personnel. However, the organization will benefit tremendously from the streamlined processes and higher levels of efficiency. As a result, we will measure the automation of the appropriate workflow processes towards improving efficiency.

Performance Measure	Equation	Description
Percentage of critical human capital workflow processes that are automated	Number of critical human capital workflow processes that are automated / Total number of critical human capital workflow processes that should be automated	Workflow processes that should be included will be identified during future analysis. In addition, workflow processes that should be automated will be identified during future analysis.

Goal 2: Human Capital Lifecycle Management

> **Goal 2:**
> **Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels**

Total Medical Force human capital lifecycle management includes aspects from determining manpower requirements and the required skills mix to succession planning and career transitioning. In order to ensure that the Services have the right people in the right place at the right time with the right skills at the right cost, we need to focus on enhancing the planning and execution of all human capital processes across the Total Medical Force. The stages of the human capital lifecycle that we must address are: planning, recruiting, educating, developing, motivating, retaining, and transitioning.

We will examine each segment of the MHS human capital lifecycle while analyzing the impact that a change in one component, or category of lifecycle elements, may have on another. For example, if we increase manning requirements we may affect the number and types of staff that need to be recruited or trained to fill those positions. Successful implementation and alignment of the predetermined optimal mix will also have a major impact on all aspects of Total Medical Force management.

Environmental analysis of internal and external trends indicates that civilians are anticipated to play an increasingly important role in supporting future MHS and DoD missions. From FY 2005 to FY 2007 Federal Civil Service medical personnel increased by over 3,500 and are expected to continue to increase as military to civilian conversions continue. Challenges facing the civilian workforce specifically include the hiring process for civilians, civilian leadership development, and delays in filling civilian jobs. Fulfilling this goal will help increase civilian leadership opportunities that are currently limited or reserved for Active Duty members. This will be accomplished through increased coordination and cooperation on all initiatives across the Human Capital Lifecycle and will help improve these processes across the entire organization for every member of the MHS workforce.

Analyzing and implementing the appropriate human capital management system for the Total Medical Force supports the MHS Strategic Human Capital Plan and the many initiatives outlined in the QDR. For example, the planning stage will help determine the most effective and efficient way to contract for professional and healthcare services. Furthermore, all lifecycle stages work together to best shape the future joint medical force and deliver beneficiary healthcare.

The DoD strategic plans also highlight the need for interoperability through increased coordination on initiatives such as planning, recruiting, and retention within the Total Medical Force. We need to develop joint solutions for managing the human capital across the Total Medical Force, while ensuring that the Services maintain their own identities. Such solutions will directly support the MHS human capital priorities and gaps identified during the planning stage of the Human Capital Lifecycle.

Currently we have very few comprehensive human capital processes within the MHS that proactively look across the Total Medical Force. We need to increase coordination and planning on the optimal workforce mix (Active Duty, Reserves, Federal Civilians, contractors, and volunteers). In order to meet our mission, we will assess our needs proactively and then plan recruiting, retention, force shaping, and other lifecycle initiatives of that mix based on the needs identified.

Summary of Goal 2 Objectives

Implementation plans will be developed in the next phase of this project. Successful accomplishment of the seven objectives developed and defined for Goal 2 will deliver the following:

- Evaluation of existing Total Medical Force human capital lifecycle management processes and systems to determine opportunities for joint solutions
- MHS-wide system that defines and leverages the optimal mix
- Identification, development, and communication of career paths across the Total Medical Force
- Joint and Service-specific recruiting and retention strategies
- Joint workforce planning systems
- Performance-based leadership programs

Initial performance measures can be found within the objective descriptions in this section.

Goal 2 Alignment

Plan	Alignment
MHS Strategic Plan	▶ Goal 1: Enhance deployable medical capability, force medical readiness and homeland defense ▶ Goal 2: Create cost effective, patient centered care and effective long-term patient partnerships ▶ Goal 5: Development of our people ▶ Goal 6: Implementation of BRAC
DoD Human Capital Strategic Plan	▶ Strategic Initiative 3: Provide opportunities for personal and professional growth
DoD Civilian Human Capital Strategic Plan	▶ Goal 1: Manage the pipeline of future leaders by aligning recruitment, selection, education, training, and development strategies ▶ Goal 2: Review and evaluate the make-up of the workforce to ensure success in meeting mission requirements and conduct forecasting to ensure Human Capital readiness

Plan	Alignment
QDR	‣ QDR 1: Medical Readiness Review (MRR) ‣ QDR 6: Shaping the Future Joint Medical Force ‣ QDR 9: Process Improvement ‣ QDR 12: Eliminate Utilization Barriers ‣ QDR 13: Management of Jointly-Operated Military Treatment Facilities ‣ QDR 15: Contracting for Health Care Services ‣ QDR 16: Contracting for Professional Services

Objective 2.1: Evaluate, develop, implement, and utilize joint solutions for Total Medical Force human capital lifecycle management

True interoperability is dependent upon identification and employment of joint human capital lifecycle solutions. Establishing, documenting, and communicating these standard human capital solutions will create transparency of processes across the Services. This, in turn, will provide the Services with a framework to address human capital challenges and leverage the identified best practices in human capital management to enhance their current operations.

In addition to utilizing best practices, the Services need to look across the human capital lifecycle of the Total Medical Force to examine what processes would benefit from joint solutions or joint collaboration. This assessment and the establishment of joint solutions will allow the Services to work together in those areas that would benefit from joint operations.

Performance Measure	Equation	Description
Percentage of designated joint components employing joint solutions	Number of designated joint components employing joint solutions / Total number of joint solutions	This measure focuses on understanding how the Services collaborate and use Joint human capital solutions.

Objective 2.2: Establish a system that continuously identifies the optimal mix and shapes the Total Medical Force to achieve the evolving MHS and Service mission

Defining optimal mix as "the ideal MHS workforce mix of skills and abilities needed to meet strategic direction," we will identify and utilize processes, tools, and policies to make strategic decisions. Utilizing MRR recommendations to meet future medical readiness requirements, this system will identify existing definitions of optimal mixes and develop new definitions when necessary. MHS will work jointly on Total Medical Force solutions to achieve the best possible combination of personnel required to meet our mission. Since the missions are continuously evolving, the processes, tools, policies, and programs will need to be continuously reexamined for relevance.

Currently, determinations for Active Duty, Federal civilian, and contractor positions are made each year by a base or region. There is little proactive planning to determine the correct future Total Medical Force mix and little to no coordination among Services to determine the impact of the workforce mix on the ability to deliver the health benefit. Establishing a system, utilizing DMHRSi, that aggressively identifies the mix of Total Medical Force needed across Services and HA/TMA will increase efficiencies and enable collaborative and joint achievement of the MHS mission.

Performance Measure	Equation	Description
Percentage alignment to optimal mix	Number fit and fill for MHS / Number total billet allocation across MHS	This measure gauges whether or not the Services and MHS have successfully aligned the workforce to the identified optimal mix.

Objective 2.3: Define and communicate career paths across the Total Medical Force

Defining, documenting, and communicating career paths for each job family within the Total Medical Force will assist with human capital lifecycle management across our organization. Developing career paths for the strategic job families will be the initial priority, followed by competency-based career paths for all other job families.

Documenting career paths will detail the progression of jobs in a specific occupational field and provide a path for setting development expectation at each level. It will also create transparency across the Total Medical Force job categories. These career paths will serve as guidelines for career progression for all employees both military and civilian. We will work with the Services to ensure that defined career paths are clearly communicated and readily available to all employees.

From an organizational perspective, career paths will help to define other MHS human capital programs, such as succession planning, training, and leadership development, that tie into advancing personnel throughout their career. MHS will measure the success of defining, developing, and publishing the career paths for all job families by measuring the percentage of career paths that are in use.

Performance Measure	Equation	Description
Percentage of workforce for which job families are defined	Number of defined workforce job families / Total number of job families identified	The total number of job families will be identified through future analysis. Ensuring that the Total Medical Force knows and understands what job family they are in and the corresponding relevant information for that job family is essential for lifecycle management.
Percentage of job families for which career paths have been published	Number of job families for which career paths have been published / Number of job families with identified career paths	

Objective 2.4: Increase effectiveness of joint- and Service-specific recruiting strategies

Each Service will continue to conduct its own recruiting to attract, select, and hire applicants who possess needed Service-specific mission critical competencies. However, developing collaborative recruiting strategies and recruiting-related initiatives across the Services where beneficial will create interoperability and increase efficiency. For example, collaborative recruiting will significantly decrease cases where one Service has too many applicants for a particular specialty while another Service lacks qualified applicants for the same specialty. We must work across our components to foster collaboration on recruiting initiatives to mitigate potential competition for resources and increase efficiency.

Developing recruiting goals, using joint referrals, working together on recruiting fairs, and/or creating more interactive recruiting programs will enhance joint recruiting. National Guard and the Federal Civil Service recruiting from those separating from Active Duty are examples of a potential recruiting initiatives enhanced by joint planning. The Services can provide lists of upcoming separations to the National Guard and DoD medical civilian components. The Services can also create efficiencies by communicating and understanding the recruiting goals of the other Services. This will allow for shared information exchange when there is potential for a candidate placement referral.

Service-specific recruiting efficiencies will be increased by drawing from common recruiting databases and working to decrease time during the hiring process. Best practices from each Service will also be shared and adopted to enhance the experience for recruiters, applicants, and newly hired personnel. We will know when we are successful in these initiatives by measuring our percentage fill rate in critical shortage areas.

Performance Measure	Equation	Description
Percentage fill of Service-specific recruiting goals	Number of Service-specific recruiting goals met / Number of Service specific recruiting goals	The measure examines not only total recruiting goals but also those career fields identified by the Services that have critical shortages.
Percentage fill of Service specific critically short career fields	Number of Service specific critically short career fields met / Number of Service specific critically short career fields	

Objective 2.5: Increase effectiveness within and collaboration across the Services in the development and implementation of retention strategies

We will establish the mechanisms and processes to share retention strategies and programs across Services to help MHS increase its overall retention of the Total Medical Force. The individual organizations have made significant strides in retention of our workforce, particularly in retaining members through continuum of service type programs. However, current and future mission requirements will continue to place significant demands upon our workforce, thereby increasing the risk associated with decreasing retention rates. We can identify and adopt best practices to maximize our

workforce retention by collaborating across the MHS organization. These retention strategies, including flexible work schedules, telecommuting, and job sharing will be discussed and developed by all MHS components, and where applicable, joint strategies will be developed and employed.

Retention measures are monitored at the Service level but few solutions exist to increase retention rates outside of offering special pays to entice medical professionals or other Service-spanning programs. By identifying additional retention strategies that may be enhanced through collaboration, as well as using retention best practices from each of the Services, we can work together to improve strategies for the entire MHS workforce. Collaborative retention solutions would allow for the sharing of best practices and for greater geographic mobility across Services to retain personnel who would otherwise leave the Total Medical Force. Measuring retention changes in critically short areas will help MHS understand if retention strategies are effective.

Performance Measure	Equation	Description
Percentage of critical short career fields that are seeing an increase in retention	Number of critically short career fields that are seeing an increase in retention / Total number of critically short career fields	The measure examines retention rates in those career fields identified by the Services that have critical shortages.

Objective 2.6: Develop joint workforce planning systems to enhance interoperability

Each of the Services conducts its own workforce planning activities, assessing alterations in the current Service workforce and composition to determine future requirements. To promote interoperability, MHS can leverage DMHRSi, DIMHRS, and other systems to develop processes and programs that reflect the whole MHS when determining the current workforce against future needs and identifying actions in response to the needs. Such a system would be continuously updated to incorporate changes in missions and trends that affect human capital.

There are multiple ways in which the MHS can develop joint workforce planning systems. First, MHS can define job families across Services and HA/TMA to understand what types of training, skills, knowledge, and expertise are needed for groupings of similar jobs. Second, MHS can define and deploy a common credentialing and privileging system, building upon the Centralized Credentials Quality Assurance System (CCQAS) that will increase the interoperability of obtaining and reviewing the documentation of all DoD health professionals. Third, MHS can help make Total Medical Force decisions to ensure that pay, capabilities, and skill sets are comparable across the Total Medical Force for similar populations thereby enabling a more interoperable environment. These systems combined will allow for a more effective, efficient, and equitable use of the workforce across each of the MHS components.

Performance Measure	Equation	Description
Number of workforce planning systems that have been developed as joint systems which enable the identification of strategic job families, force leveling, or joint credentialing	Number of workforce planning systems that enable the identification of strategic job families, force leveling, or joint credentialing / Number of systems that have been identified as required joint systems for the identification of strategic job families, force leveling, and joint credentialing	This measure will help MHS identify workforce planning systems (both technologies and processes) that enhance interoperability.

Objective 2.7: Develop performance-based leadership programs to enhance career development and succession planning for the Federal civilian workforce

For the majority of the Federal Civil Service workforce, professional development has largely been the responsibility of the individual or his or her local commander. There are a few career programs in place to enable leadership development for the civilian workforce. Recently, both DoD and Congress have recognized the need for greater coordination across the Services with respect to the civilian workforce. The identification of development programs for MHS civilians will place a greater emphasize and clarity on and help provide lifetime civilian personnel with similar types of career programs that are currently available to Active Duty personnel.

Clearly outlined career development options will assist in succession planning initiatives for the MHS civilian workforce and will lead to enhanced performance, increased job satisfaction, and a pipeline of future leaders. The DoD civilian workforce continues to grow as a percentage of the Total Medical Force. The average age of the DoD civilian workforce is 47 and, as the workforce continues to age, it is critical that civilian personnel are developed and promoted to leadership positions to ensure continuity of knowledge and service. While military to civilian conversions can provide civilian leaders due to training received while active duty, there is a need for lifetime civilian workforce leadership development programs. Clearly outlined career development options will assist in succession planning initiatives for the MHS civilian workforce and will lead to enhanced performance, increased job satisfaction, and a pipeline of leaders. We should develop and maintain a dedicated cadre of civilian leaders who are effective in meeting our missions and achieving results. This civilian leadership can be achieved through numerous opportunities for personal growth and development in both formal as well as informal training and professional development programs.

Performance Measure	Equation	Description
Percentage of civilian job families with defined career paths	Number of civilian job families with defined career paths / Total number of civilian career paths	MHS will need to identify civilian job families and ensure that career paths and succession plans exist for all civilian job families. These measures will aid MHS in understanding how well the civilian workforce is aligning and using succession planning.
Percentage of civilians placements aligned with succession plans	Number of civilian placements aligned with succession plans / Number of civilian placements	

Goal 3: Performance-Based Management System

> **Goal 3:**
> *Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission*

We will utilize a performance-based management approach that encourages and rewards excellence and achievement of results. This performance-based management approach or system for MHS human capital focuses on recognizing, compensating, and rewarding employees based on their performance and contribution toward mission accomplishment. It also requires coordination efforts across all components of the MHS – HA/TMA and the Services. We have already begun working together through the development of this Human Capital Strategic Plan and will continue to collaborate, define, and refine requirements, establish targets for desired results, and agree on management methods for measuring and evaluating success. This system is designed to create a results-oriented culture focused on meeting mission through the Total Medical Force.

Implementation and adoption of the components of the performance-based management system instills the behaviors in our personnel and promotes the actions that are necessary in the execution of MHS programs and policies. Employing a performance-based management system allows for visibility across Services and Offices and identifies performance needs at multiple levels from individual to agency. Moreover, it creates equity between similar populations and job families, thus reducing competition between Services and enabling cross-leveling. Performance-based management requires the Services and Offices to be accountable to deliver programs and policies that align with the MHS vision and goals.

The current performance management systems exist within their respective organizations without commonality across the MHS. In order to further a performance-based culture across the organization, a common approach to two existing and critical performance-based management system components is necessary – assessment standards within the competency frameworks and incentive programs. Performance-based management has been encouraged at both the DoD and MHS levels. The DoD Human Capital Strategic Plan identifies performance-based management as a priority by aligning rewards with performance achieved. Similarly, the QDR emphasizes performance-based planning as a method to develop performance objectives, outcomes, and measures to achieve results. The QDR also links performance-based management to specific human capital functions, such as training and education. The MHS Strategic Plan identifies performance-based management as a method to build a culture that promotes collaboration, creates transparent performance measures, and develops successful incentives.

Summary of Goal 3 Objectives

Implementation plans will be developed in the next phase of this project. Successful accomplishment of the four objectives developed and defined for Goal 3 will deliver the following:

- ► Assessment standards analysis across all Services
- ► Baseline assessment standards for all Active Duty, Reserve, Federal civilians, and contracts (personal and non-personal service contract support for clinical and non-clinical missions)
- ► Incentives (special pays, incentives, special programs, etc) analysis among and across the Services to determine gaps
- ► Coordinated incentive programs development
- ► Human capital shared services assessment, design, and implementation

Initial performance measures can be found within the objective descriptions in this section.

Goal 3 Alignment

Plan	Alignment
MHS Strategic Plan	▶ Goal 4: Transform to performance based management for both force health protection and delivery of the healthcare benefit
DoD Human Capital Strategic Plan	▶ Strategic Initiative 2: Design a flexible system that will have the option of customizing incentive structures (monetary and non-monetary benefits) to reflect individual preferences and the institution's desire to retain that individual
DoD Civilian Human Capital Strategic Plan	▶ Goal 3: Build a mission-focused, results-oriented, and high-performing workforce requires a shift in the performance culture of DoD
QDR	▶ QDR 2: Interoperability and Agility of Operational Medicine Capabilities ▶ QDR 4: Healthy, Enhanced, and Protected Force ▶ QDR 5: Joint Medical Education and Training Focused on Performance-Based Management ▶ QDR 10: Performance-Based Planning ▶ QDR 11: Performance-Based Financing

Objective 3.1: Promote performance-based culture that links individual and organizational performance to ensure day-to-day operations support Service and MHS strategies and priorities

We want to ensure that the MHS and Service missions are applicable and relevant to the individual MHS member. Service members and Federal civilians can begin to understand and align activities to support the mission when there is a common understanding of strategies and priorities. A performance-based culture focuses on achieving results that align and support our overall strategic direction. Instilling a performance-based culture across the MHS involves the implementation and execution of the strategy as

laid out in this plan, with particular attention to the objectives that align specifically to this goal. Operating a performance-based culture will impact all lifecycle management stages (retention, development, etc.).

The understanding and alignment of our mission and our workforce's responsibilities in achieving that mission will be reflected in the competency frameworks that are developed and the associated assessment standards that are recommended. Another key tenet of our performance-based management system is acknowledging and rewarding performance that achieves the results desired – whether through mission execution or through operational efficiencies. In order to promote a performance-based culture, our workforce must understand that desired performance will be recognized and rewarded. We will work across the MHS to promote a common understanding of performance-based management and build a foundation for performance-based culture.

We will also support efforts to promote a performance-based culture through continuous process improvement, both in our management of the human capital lifecycle and the delivery of healthcare. Our workforce's participation in continuous process improvement initiatives such as Lean Six Sigma and Theory of Constraints will be monitored and evaluated as a measure for understanding our organization's transition to a performance-based culture. Understanding the extent of our success also includes evaluating the extent to which individuals perceive the culture to be performance-based.

Performance Measure	Equation	Description
Percentage of employees who feel the culture is performance-based	Number of employees who feel the culture is performance-based / Number of employees in workforce	This measure will determine if Total Medical Force members believe that they work in a performance-based culture.

Objective 3.2: Refine and recommend assessment criteria for all Active Duty, Reserve, Federal civilian, and contractor personnel that are consistent with Service doctrine and that enable interoperability

Currently, assessment standards vary widely between Services and between Active Duty and Federal civilian personnel within a Service. However, the competencies and skills needed to do the job may be very similar. This difference in assessment standards creates an inequity between Services' career paths and inhibits a common understanding of performance. We will develop guidelines for standardized medical military assessments by identifying a common baseline of performance across similar job families in the MHS. Guidelines for assessment standards will promote consistency in performance-based management throughout the Total Medical Force.

The Services and Offices will analyze their current assessment standards to create a baseline of common assessment standards between all Services across the Total Medical Force. Assessments are the responsibility of the individual Service and Office, this objective is not intended to infringe upon current Service personnel assessments and related tools. It is aimed to supplement the Service-unique assessments with an MHS-wide baseline for expected performance. For example, similar positions across Services and across the Total Medical Force requiring the same skill would have similar standards

for assessment since similar performance is expected. These assessment standards will help to create a common understanding of the responsibilities placed upon medical personnel.

Performance Measure	Equation	Description
Percentage of baseline assessment standards developed for similar job families across the Total Medical Force	Number of baseline assessment standards developed for similar job families / Total number of baseline assessment standards required for similar job families across the Total Medical Force	The baseline assessments standards requirement will be identified during future analysis. Baseline criteria should include all common performance measures. Similar job families are personnel with parallel skill sets, training, knowledge, and expertise across the Total Medical Force.

Objective 3.3: Employ equitable and coordinated incentives to increase coordination among the Services on human capital management and minimize inter-Service competition

We realize that current incentives have varying levels of success or may reward for alternative actions not intended by the incentive. Some of the incentives produce competition between Services to recruit for highly-qualified candidates or retain key personnel. Therefore, creating and using equitable incentives across the Total Medical Force will allow the Services to promote jointness and interoperability rather than competition to hire and keep the best medical professionals. Some progress has already been made on this initiative through the work of the HPIWG, a group that creates a forum through which the Services coordinate on Special Pays.

Equitable and coordinated incentives create a level playing field across the Services and facilitate a joint performance–based management system. When aligned with the goals of the MHS Strategic Plan and the MHS Human Capital Strategic Plan, these incentives will promote cooperation across Services and meet the greater needs of the organization as a whole by furthering the development of a performance and reward based culture.

Performance Measure	Equation	Description
Percentage of Service-level incentive programs that are equitable and/or coordinated that are employed by the Services	Number of Service-level incentive programs employed by the Services that are coordinated and/or equitable / Total number of Service–level incentive programs offered	MHS will also have to determine what is considered "equitable". Once the programs that should be coordinated are identified, MHS will monitor the programs to ensure they remain equitable and coordinated.

Objective 3.4: Establish human capital shared services where appropriate to achieve effectiveness and efficiency

We will work collaboratively across the MHS to identify management opportunities throughout the human capital lifecycle to design and implement shared services where efficiencies exist and the Service and MHS believe interoperability will be effective. This requires an increased level of collaboration, coordination, communication, and execution across the Services and HA/TMA with the consolidation of functions, operations, and practices. Human capital practices that may be managed as shared services include civilian human resources offices or training centers of excellence. MHS components that may be eligible for shared services include medical command, recruiting and accession services, retention services, transition services, medical training, professional certification and credentialing, professional and leadership development, and human capital IM/IT.

These shared services opportunities would provide value by combining duplicative functions that currently occur across multiple Services and HA/TMA. DMHRSi and DIMHRS will help streamline processes and increase operational efficiency by providing a holistic picture of key personnel and organizational activities. The shared services would achieve increased effectiveness and efficiency in executing common human capital management functions. At the same time, the shared services would ensure that each of the unique needs of the Services are met and bring forth the best offerings of each Service into one common offering.

Understanding the cost of utilizing a shared service is one element in determining how to effectively implement joint performance-based management programs. Knowing where shared services have reduced cycle times for human capital lifecycle components will help identify where efficiencies have been achieved. Once the shared services are implemented, we will want to measure the quality of service to ensure that the assistance to MHS personnel has not deteriorated.

Performance Measure	Equation	Description
Cost per transaction of shared human capital services Cycle time for human capital processes (ex. hiring, firing)	Total cost / Total number of transactions Total time for human capital processes / Total number of human capital processes executed	Where applicable, shared services will increase efficiencies and create economies of scale. MHS will analyze the cost per transaction for each potential shared service to identify where joint efforts make sense. Cycle time of individual human capital lifecycle processes has a major impact on efficiency and can be a major factor in reduction or increase in cost. Cost is not only financial but may include time, man-hours, benefits, etc.

Goal 4: Development of the Total Medical Force

> **Goal 4:**
> *Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability*

Education, training, and development of the Total Medical Force improves employee performance, morale, and retention. Education and training provide mechanisms to grow necessary skills within the Total Medical Force and have direct impacts on recruiting and retention. We will attract more personnel when we champion personal and professional growth. Our workforce is more likely to remain with the MHS if we provide challenging opportunities to learn new skills and broaden their abilities. At this critical time in our history, training, and education provide fertile ground to develop interoperable skills across the MHS. Common education and training that is attended by personnel from across the Services will enhance interoperability. This is further reinforced when our personnel from across the Services collaborate in these learning environments and develop knowledge of Service-specific differences. Increasing the knowledge of Service commonalities and differences may be leveraged as MHS personnel continue to participate in joint missions and activities. Additionally, education and training programs will help close strategic gaps in workforce skills. Upcoming medical specialty shortages will be addressed by education and training programs in that specialty by delivering more staff with the appropriate training, degrees, and certifications specific to the need.

Total Medical Force education and training remains consistent with the QDR Roadmap, QDR 5 and QDR 7 specifically. QDR 5 states, "Medical education and training must prepare medical personnel for future requirements, improving overall capabilities and increasing joint medical interoperability and deployability among the Services. Military and civilian training programs should integrate information from all of these sources in order to ensure leaders have the information required for successful mission performance." QDR 7 states, "Integrate Graduate Medical Education (GME) will optimize GME training capabilities without compromising the Services' ability to meet those training requirements." Additionally, as noted in the DoD Human Capital Strategic Plan, there is a premium placed on education and training approaches as they must be capable of adapting and responding to needs as they emerge.

We currently conduct education and training programs within each of the Services with no central training plan linked to the core competencies required for Total Medical Force effectiveness. Similar functions often have widely different training standards and, as a result, our personnel across the Services have not been interoperable in some engagements. While we have continued to make progress at USUHS in Bethesda, the nation's federal school of medicine and graduate school of nursing, and have made significant progress at combining enlisted training at the METC in San Antonio we still have opportunities to limit duplication between the Services at enlisted and officer levels. Additionally, civilian training and development programs are limited in nature and are not coordinated with these programs offered to Active Duty and Reserves.

To achieve this goal, we will focus on building a competency-based occupational system. We will assess and align the current medical capabilities across the Services to establish a common understanding of competencies. The use and understanding of these common competencies will enable us to identify and align education and training programs. We will leverage existing programs and build partnerships between Services to develop the educational and training programs necessary to grow future generations of MHS medical leaders. We will seek opportunities to offer joint education and training to build a firm foundation for understanding the joint environment and to develop a common set of basic capabilities. By leveraging existing programs, we will seek opportunities to reduce duplication in programs and maximize cost savings. We will evaluate and measure our progress in meeting the learning needs of our workforce and our ability to adapt future educational policies and programs to those needs.

Summary of Goal 4 Objectives

Implementation plans will be developed in the next phase of this project. Successful accomplishment of the four objectives developed and defined for Goal 4 will deliver the following:

- Common capabilities and competency frameworks for strategic and all job families
- Joint education and training requirements and program assessment
- Joint education and training programs development
- Degree and certification granting program assessment against critical shortages
- Process design to evaluate education and training policies and programs

Initial performance measures can be found within the objective descriptions in this section.

Goal 4 Alignment

Plan	Alignment
MHS Strategic Plan	▸ Goal 1: Develop our people using cross-training opportunities across Services ▸ Goal 5: Development of our people
DoD Human Capital Strategic Plan	▸ Strategic Initiative 3: Enables organizations to enhance opportunities for personal and professional growth
DoD Civilian Human Capital Strategic Plan	▸ Goal 1: Establish common definitions of competencies and work across DoD to develop a competency-based occupational system ▸ Goal 4: Develop human resources skills and competencies needed to achieve goals outlined by the DoD Civilian plan
QDR	▸ QDR 5: Joint Medical Education and Training Focused on Performance-Based Management ▸ QDR 7: Integrate Graduate Medical Education (GME)

Objective 4.1: Design and implement common capabilities and competency frameworks to drive Total Medical Force interoperability in alignment with Service-specific doctrine

In order to align education and training programs across Services, we will need first to understand the necessary skills of the medical workforce throughout MHS. Currently, positions across Services may carry the same title but require different competencies and/or capabilities. Similarly, individuals with the same competencies may have different titles, and some individuals with similar titles may have different competencies. Identifying and adopting basic commonalities in capabilities and competencies across the Total Medical Force will allow for greater interoperability and is in alignment with the DoD Human Capital Strategic Plan, which defines operational success as the ability to harness competency frameworks and quickly adapt to changing opportunities.

Our workforce capabilities include knowledge, skills, abilities, and behaviors categorized into competencies. Implementing common capabilities and competency frameworks is not intended to force personnel to adopt common competencies when unnecessary. Competency frameworks identify basic, common knowledge and skill sets that are universal across job families. In addition to the common competencies, each Service will have its own set of competencies unique to that Service beyond the medical foundation established through common competencies. Ultimately, common capabilities and competency frameworks should define the medical skills, expertise, and capabilities for all personnel at certain positions and levels.

Strategic job families will be groups of occupations that share similar vocational characteristics and accomplish the MHS strategic mission. Establishing strategic job families, with standard competencies will promote understanding not only of the expectations of a Service member's own job family across Services but also of the expectations of other job families across Services. Service and MHS coordination to standardize competency frameworks will increase interoperability across the Services by building relationships, knowledge, and experience in addition to creating a culture that is critical to achieving MHS' operational and readiness missions.

Performance Measure	Equation	Description
Percentage of strategic job families that have competency frameworks (primary) Percentage of job families that have competency frameworks (secondary)	Number of strategic job families that have competency frameworks / Number of total strategic job families Number of job families that have competency frameworks / Number of total job families	Strategic job families and all other job families will be identified as a result of this Strategic Plan. MHS is making the commitment that each strategic job family should have a competency framework associated with it. The competency framework should be developed and agreed upon by all Services to establish commonality.

Objective 4.2: Identify, design, and implement joint education and training programs to leverage common capabilities and efficiencies across the Services in alignment with Service-specific doctrine

We will first look across our components and organizations to coordinate and build joint education and training programs where applicable. Currently, Services offer similar training programs in the same regional location but often do not take advantage of common faculty, infrastructure, materials, and other learning resources. While Base Realignment and Closure (BRAC) and other efforts will provide some guidance for combining training programs, the need remains to identify, design, and implement joint education and training programs across MHS.

We will identify existing opportunities to use overlapping programs and infrastructure to the advantage of all Services. We will create partnerships between Services or programs where best practices are identified and would contribute to the success of our Total Medical Force. The subsequent increase in joint education and training will help foster a joint culture from Service member's earliest career stages as they learn more about one another and build the same basic, universal skills. At the same time, service-specific training resources that are unique and critical to the distinct Service mission will not be decentralized nor disbanded. To achieve this outcome, MHS will need to identify what training should be conducted jointly.

Performance Measure	Equation	Description
Percentage of people who are trained to perform the common capability in a joint environment/platform as a result of training	Number of people who are trained to perform the common capability in a joint environment / Total number of people in that job family	Increasing the number of people who can perform a common capability across Services and missions will increase interoperability.

Objective 4.3: Identify or develop degree and certification granting programs required to ensure mission requirements are met

Historically, the Services have used a variety of ways to recruit and retain members for critical positions, especially those facing workforce shortages. Future trends indicate that we will have shortages in key medical fields and will increasingly have to compete with the private sector for that limited pool of skilled resources. As a result, we will focus on providing opportunities within our organization to educate and advance those within the Total Medical Force. These opportunities will provide additional mechanisms for developing the workforce we need with the appropriate level of skills and capabilities.

We will build upon existing Service and DoD degree granting and certification programs or partnerships with external institutions in various medical fields by first identifying the critical skills that are not being met through other recruiting sources. Then, we will better meet the needs of our workforce by conducting an analysis of those critical skills and identifying educational program opportunities that provide accredited healthcare-related degrees at various levels (BS, MD, PhD, etc) or certification programs to address

those shortages. These programs can be made available through joint partnerships with private institutions or DoD-run institutions. Where hiring incentives meet with limited success in critical shortages areas, education and training programs will help fill the gap by growing the necessary resources internally for selected job fields. Using educational programs to fill critical needs and grow necessary skills will help decrease DoD's reliance on the availability of certain skills in the market, as well as provide a retention incentive. These opportunities will be communicated and available across all Services to grow critical skills in our future medical workforce.

Performance Measure	Equation	Description
Percentage of critical authorizations (Active Duty and Federal civilians) in professions (current and future) requiring a degree and/or certification that have available degree-granting or certification programs with the capacity to meet requirements	Number of authorizations in critically short career fields requiring a degree and/or certification that are identified as having critical shortages, which have available degree-granting programs / Total number of authorizations of critically short career fields	Degree-granting and certification programs can either be offered by DoD or through an established partnership. Degrees and certification also includes certificates that may be required for a medical specialty or to show proficiency in a medical skill. Available programs takes into account total available capacity.

Objective 4.4: Measure and evaluate the effectiveness of education and training policies, programs, and impact on Total Medical Force current and future capabilities

The results of our efforts and strategies to promote education and training across the MHS Total Medical Force will be minimized if we do not assess the effectiveness and impact of our initiatives. We need to understand the extent to which education and training policies and programs are developing the needs of the Total Medical Force as determined by the outcome of our workforce planning efforts. We will assess the degree that training programs build the Total Medical Force current and future capabilities.

This assessment provides feedback on our progress in attaining, education, training, and developing the MHS Total Medical Force to provide quality care while assuring interoperability. We will focus on understanding how well education and training programs meet the needs of the competency frameworks and commonalities identified by the Services. Furthermore, the performance measure will help identify the impact of joint education and training programs and expanded degree granting and certification programs to meet the needs of the workforce.

Performance Measure	Equation	Description
Percentage of people who demonstrated improved performance and increased capability as a result of training	Number of people sent to training who were later reviewed as being more effective / Number of people sent to training	Training measures are required to ensure that efforts to educate personnel are effective. It is critical to understand what individuals are retaining and using and if performance has improved as a result of training.

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Goal 5: Adaptable Human Capital Solutions

> ### Goal 5:
> ### Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs

Our nation continues to face new threats that result in new national security requirements. The missions that we are given are changing; these changes directly impact the types of skills, knowledge, abilities, and the number of people that our workforce needs. Our medical and health operating environments are also rapidly changing. New technologies impact the delivery of healthcare, requiring medical professionals to have the requisite competencies and skills to deliver innovative care. Changes are occurring in the number and types of students that are participating in medical training and education programs. We must understand both the short and long-term impact of those changes. In order to be better prepared for the future, we also need to understand the changes occurring in the private sector that might prove successful in attracting and retaining our future workforce. Changes in our beneficiary population will demand changes in the types of healthcare needed and the way in which we deliver the benefits. These are all examples of requirements, trends, and issues that we need to be aware of and leverage to develop and implement human capital solutions that enable us to meet our mission.

We must continuously research and analyze future mission requirements, healthcare, and human capital trends to understand how these changes will affect our business and workforce. Staying ahead of these future changes and trends will allow our organization to be more responsive and agile in meeting mission requirements. We are currently responsive to trends in the workforce and healthcare needs of the beneficiaries, but only after those needs have become readily apparent across the organization. Not enough concerted effort is spent in identifying, analyzing, and developing a robust understanding of future healthcare needs and identifying the capabilities that will be required to meet them. One of the challenges in a healthcare environment is the amount of time required to grow a trained and experienced healthcare professional. With some medical specialties requiring over ten years of training and experience, we have to be forward looking in planning for and adapting to these changes proactively in the workforce, healthcare, and mission requirements. Planning for future requirements would allow us to focus on critical shortages, such as nursing. Knowing ahead of time that nursing shortages are looming, MHS can train nurses into certain specialties or recruit and hire nurses to avoid stretching our current nursing staff too thin that it reduces patient care and safety.

The DoD Human Capital Strategic Plan enables flexible management systems designed to increase agility. Using adaptable human capital solutions to meet changing needs of the workforce and the healthcare environment will assist in the creation of flexible systems better able to deliver benefits. DoD-level plans, such as the DoD Civilian Human Capital Plan, also emphasize the ability to plan for contingencies and to hire personnel for high-performance potential rather than for just those able to

perform to current expectations. This strategic planning effort also meets the QDR requirements of responsiveness and adaptability to forecasted trends and unexpected disasters.

This goal is purposely broad enough to address the spectrum of future trends, challenges, and needs that the MHS may face. We will develop a comprehensive lifecycle capability that begins with the integration with Service and joint deliberate planning processes to understand and incorporate future workforce needs. We will also improve MHS' ability to be flexible and plan for this broad set of changes by developing and implementing mechanisms that continuously research, analyze, and leverage our insight into future needs, trends, and mission requirements.

Summary of Goal 5 Objectives

Implementation plans will be developed in the next phase of this project. Successful accomplishment of the three objectives developed and defined for Goal 5 will deliver the following:

Initial performance measures can be found within the objective descriptions in this section.

- ▸ Joint manning solutions that are defined by the requirements resulting from the joint deliberate planning process
- ▸ Capability to scan the environment to identify key internal and external trends that impact MHS human capital and human capital management decisions
- ▸ Processes and initiatives that implement the results of the environmental scan

Goal 5 Alignment

Plan	Alignment
MHS Strategic Plan	▸ *Not included in the MHS Strategic Plan*
DoD Human Capital Strategic Plan	▸ Strategic Initiative 2: Design a flexible system that will have the option of customizing incentive structures (monetary and non-monetary benefits) to reflect individual preferences and the institution's desire to retain that individual
DoD Civilian Human Capital Strategic Plan	▸ Goal 4: Build a civilian HR community that is strategically aligned and customer-focused, and provides measurable, leading-edge results
QDR	▸ QDR 1: Medical Readiness Review ▸ QDR 3: Homeland Defense and Medical Civil-Military Operations ▸ QDR 17: Effective Patient Partnerships

Objective 5.1: Continuously develop and improve workforce capabilities and workflow processes in alignment with joint and Service deliberate planning processes

The Services and the Joint Staff have deliberate planning processes that identify and determine workforce needs for planned and anticipated future missions. It is critical that we directly align and support those planning processes to ensure that we understand mission requirements and their impact on our workforce, as well as have an opportunity to influence medical planning activities based on our Total Medical Force expertise. Making changes to workforce capabilities and sharing our insights into our workforce will ensure that DoD and MHS missions are successfully met.

This applies to both joint and Service-specific mission requirements as the impact on the human capital of one Service will often impact the human capital of another as we become increasingly interoperable. Understanding the human capital implications is critical to our ability to make human capital decisions. Additionally, discussing the human capital implications and impacts by communicating current and future demands for workforce requirements across Services will improve MHS-wide readiness and agility of the Total Medical Force. The performance measure for this objective focuses on identifying the percentage of human capital capabilities that align with joint or Service planning processes.

Performance Measure	Equation	Description
Percentage of capabilities that are met as a result of joint or Service deliberate planning processes	Number of capabilities that are met as a result of joint or Service deliberate planning processes / Total number of capabilities identified during joint or Service deliberate planning processes	MHS should use joint processes to meet the current and future needs of the Total Medical Force. This measure will capture those human capital actions that are implemented out of the total human capital actions that are brainstormed through joint or Service planning.

Objective 5.2: Design and implement a capability to scan the environment to identify trends in DoD mission requirements, the workforce, healthcare delivery, and healthcare demand

We will develop a capability to conduct research and analysis of internal and external factors that may affect our human capital and ability to fulfill future mission requirements. These factors or trends may be related to the changing nature of the workforce skills and demographics, the latest methods and mechanisms of providing healthcare, or emerging demands placed upon healthcare systems. Additionally, we will analyze how trends, including possible military strategies and new DoD and MHS directives, within our own Total Medical Force will affect human capital.

We will regularly report to MHS leadership regarding the impact of these trends on our workforce's requirements and capabilities To enable MHS to be future focused, it is important that we consistently monitor the environment to stay ahead of these trends. The information needs to be up to date and, as such, the trends will be researched and analyzed on a regular basis. Each trend category will have its

own timeframe for renewal since the timeframe for refreshing the information may differ depending on the type of trend being examined. For example, workforce demographics are slower to change over years while emerging infectious diseases can change in a relatively short timeframe. Environmental scan progress will be measured by tracking those trend categories that are updated with new trends.

Performance Measure	Equation	Description
Percentage of trend categories with updated trends identified	Number of trend categories with updated trends identified / Total number of trend categories identified	Specific trend categories will be defined as a result of a trend analysis (i.e., critical areas for which trend analysis needs to be conducted). Once the trend categories have been identified, MHS will monitor trends against those categories. Continuous updates ensure that trends are developed on a recurring basis.

Objective 5.3: Leverage requirements from the environmental scan to develop and improve workforce capabilities and workflow processes

Based upon the findings of internal and external trends analysis research, we will leverage lessons learned to identify MHS human capital implications on our workforce's capabilities and our workflow processes. Trends in upcoming workforce shortages may affect human capital areas such as recruiting policies, procedures, and goals as well as workflow processes that adapt to the shortage of a particular skill, for example by substituting similar personnel with similar medical training for the critically short career field.

Some results from the environmental scan will require immediate action by our leadership if there is an immediate or imminent negative impact on our ability to deliver care. Other less pressing results will serve as information and input to shape the requirements for our future workforce. Both immediate and long-term trends should be included in consideration of all MHS human capital decisions that address the human capital lifecycle. Determining the number of human capital capabilities and processes that are developed and or enhanced due to lessons learned in the environmental scan will help the MHS identify the impact of the scanning capability and allow for focused and continual development of human capital solutions.

Performance Measure	Equation	Description
Percentage of requirements resulting from the environmental scan that have been leveraged in developing or modifying workforce capabilities/ processes	Number of requirements leveraged in developing or enhancing workforce systems and processes / Total number of lessons learned resulting from the environmental scan	MHS will conduct internal and external environmental scans to analyze and identify trends that impact human capital. Understanding how the information gathered in the scan has been leveraged will create additional solutions to address changing human capital: mission requirements, healthcare delivery trends, and emerging healthcare needs.

Conclusion

The MHS Human Capital Strategic Plan establishes a strategic, enterprise-wide approach to human capital management that is aligned with DoD and MHS strategic goals. The plan provides direction for the Total Medical Force that will strengthen MHS' service to its warfighters and beneficiaries and set a path for continued mission success both in war as well as in peace. As a plan that reaches across all components of MHS, it is in line with Title X by providing for unity while respecting Service-specific doctrine. Its goals serve to overcome current challenges and enhance the existing network of personnel across the MHS components to deliver a superior product to our beneficiaries.

The challenges we must overcome include the increased costs associated with providing the benefits, an increasingly competitive job market resulting from a strong economy, challenges in retention as we continue to fight a demanding war, a growing and changing beneficiary population that brings new health challenges and requires new innovative solutions, an increased need to work in a collaborative environment while maintaining and respecting our Service specific doctrines, and increasing pressures from Congressional and oversight bodies to provide accountability. The MHS Human Capital Strategic Plan will be regularly reviewed and updated to ensure it provides the appropriate strategic direction and is responsive to any future challenges stemming from changes in the environment.

The plan also serves as the guide for implementing strategic human capital management across the MHS. Although several activities that support the plan are currently underway across the MHS, the execution of this plan throughout the Services and HA/TMA will further instill and support a performance-based management culture to track progress towards meeting the goals and objectives. Implementation will be carried out and measured in different phases beginning with the development of action plans communicated from leadership across MHS. We will know success when our organizational collaboration results in an increasingly interoperable and agile Total Medical Force.

APPENDICES

APPENDIX A: MHS STRATEGY MAP

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APPENDIX B: CROSSWALK OF DOD AND SERVICE STRATEGIC PLANS

GOALS	DOD HUMAN CAPITAL PLAN ALIGNMENT		
	COMPETENCY-BASED OCCUPATIONAL PLANNING SYSTEM Create a common framework or set of descriptions to define the precision of work, the worker and the workplace across components	**PERFORMANCE-BASED MANAGEMENT** Design a flexible system that will have the option of customizing incentive structures (monetary and non-monetary benefits) to reflect individual preferences and the institution's desire to retain that individual	**ENHANCED OPPORTUNITIES FOR PERSONAL & PROFESSIONAL GROWTH** Enable organizations to develop capabilities needed to carry out the national security strategy
1. Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management	✓	✓	
2. Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels			✓
3. Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission		✓	
4. Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability			✓
5. Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs		✓	

MHS STRATEGIC PLAN ALIGNMENT						
GOALS	1. Enhance deployable medical capability, force medical readiness and homeland defense	2. Cost effective, patient centered care and effective long-term patient partnerships	3. Globally accessible health and business information	4. Performance based management for both force health protection and healthcare delivery	5. Development of our people	6. Implementation of BRAC
1. Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management			✓			
2. Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels	✓	✓			✓	✓
3. Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission				✓		
4. Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability	✓				✓	
5. Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs						

DOD CIVILIAN HUMAN CAPITAL PLAN ALIGNMENT				
GOALS	1. WORLD-CLASS ENTERPRISE LEADERS Diverse civilian leaders who effectively manage people in a joint environment, ensure continuity of leadership, and sustain a learning environment that drives continuous improvement across the enterprise	2. MISSION READY WORKFORCE A highly capable workforce characterized by agility, flexibility, diversity, and seamless integration with the Total Force	3. RESULTS-ORIENTED PERFORMANCE CULTURE A mission-focused, results-oriented, high-performing culture	4. ENTERPRISE HR SUPPORT A civilian HR community that is strategically aligned and customer-focused, and provides measurable, leading-edge results
1. Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management				✓
2. Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment	✓	✓		
3. Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission			✓	
4. Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability	✓	✓		✓
5. Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs				✓

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APPENDIX C: ENVIRONMENTAL ANALYSIS DETAILS

Internal Factors		
Category	**Key Trends**	**Impact on MHS Human Capital**
DoD Strategic Initiatives	*Fiscal Realities:* ▸ Rise in military health expenditures ▸ Increase healthcare costs without an increase in beneficiary premiums and cost shares for retirees in TRICARE ▸ Rise in the number of Military retirees and their family members	▸ MHS will need to examine ways of restructuring the healthcare workforce and the healthcare benefit to control this rising cost ▸ The decrease in contribution will place an increased budget constraint on the MHS forcing it to do more with less ▸ An increase in the number of beneficiaries will place an increased budget constraint on the MHS forcing it to do more with less
	Business Transformation: ▸ Base Realignment and Closure ▸ Quadrennial Defense Review (QDR) ▸ Increased support for humanitarian crises	▸ MHS will need to understand the implications, changes needed to the organization, culture, processes, workforce makeup and capabilities needed to meet the BRAC requirements and the QDR initiatives ▸ MHS should understand the impact of the emerging missions on the MHS – what are the workforce requirements, skills, and composition needed
	Jointness: ▸ Defense Health Agency	▸ As the joint war fight evolves, the Military medical capability must transform with it and doing so requires building a Medical Force of the right size and with the right mix of skills
MHS Manning Trends	*Gender* ▸ Unequal gender distribution	▸ With a significantly higher number of men than women in all three Services and with an increasing number of women attending medical schools, the MHS organization will need to examine its recruiting strategies to attract new demographic populations ▸ MHS must work to find new ways to attracts highly skilled populations that have not traditionally chosen to serve
	Authorizations v. Inventory ▸ Staffing imbalances across the three Services	▸ Some specialties are understaffed in one Service and overstaffed in another. As such, the Services will need to work together to address these imbalances ▸ The Services will need to work together to proactively plan for shortages and share resources across the Total Medical Force

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External Factors		
Category	**Trend**	**Impact on MHS Human Capital**
Human Capital	*Human Capital Planning:* ▸ Competency assessment ▸ Knowledge management and knowledge retention	▸ Competency-based career roadmaps will enable the MHS to plan for and execute a strategic approach to professional development both at the individual and organizational levels ▸ MHS will need to examine ways in which it can capture, retain, and share knowledge within the organization in order to ensure consistent long-term success
	Workforce Planning: ▸ A link between human capital plans and long-term strategy	▸ MHS will need to examine ways in which its medical workforce can help support DoD's long term strategies
	Employee Development: ▸ Increased focus on training and development	▸ MHS will need to assess training and development needs within its workforce – especially those elements of the workforce that are not currently developed (e.g. civilian, reserves)
	Performance Management: ▸ Increased focus on measuring performance	▸ MHS will need to focus on identifying and implementing performance measures for its workforce

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External Factors		
Category	**Trend**	**Impact on MHS Human Capital**
	Workforce Demographics: ▸ Shortage of healthcare workers nationally ▸ Aging workforce ▸ Diverse workforce ▸ Expanded role of nurses ▸ Rising debt burden of medical school students	▸ There is increased competition within the MHS for highly skilled and limited resources ▸ An increasing number of non-US medical school graduates further reduces the available pool for military service ▸ MHS will need to assess the current diversity of its workforce and develop recruiting initiatives to address any gaps in diversity ▸ While more women are choosing a medical career, they are less likely to choose a military career or the specialties most needed in the MHS ▸ The number of military to civilian conversions will increase across the Services ▸ A one-size-fits all approach on incentives for joining no longer suits today's multigenerational and diverse workforce ▸ MHS is competing with the private sector for a very limited supply of nurses, resulting in a need for creative incentive programs to attract nurses ▸ The shortages in certain areas (e.g. nurses, specialty physician, etc,) will not be addressed through traditional recruiting strategies alone. New care delivery models may need to be developed to bridge the gap ▸ MHS should consider demand side solutions as well as supply side solutions
Healthcare Planning and Management	*Costs:* ▸ Increased focus on containing costs ▸ Increase in prescription drug costs and usage	▸ Increase in costs is forcing all healthcare providers to examine their processes in order to contain these costs while maintaining the benefit ▸ Medical care is accounting for an increasing share of the Defense budget – up from 6.1 % in FY 2000 to 8.8% in FY 2005 ▸ Increases in costs are forcing all healthcare providers to examine their processes in order to contain costs and do more with less ▸ Fiscal constraints limit MHS' ability to pay the salaries desired by top healthcare providers ▸ The MHS pharmacy program has become the largest drug distribution/pharmacy operation in the world with DoD Drug Expenditures rising from $1B (1997) to $5B (2005)

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External Factors		
Category	**Trend**	**Impact on MHS Human Capital**
	Workforce Demographics: ▸ Shortage of healthcare workers nationally ▸ Aging workforce ▸ Diverse workforce ▸ Expanded role of nurses ▸ Rising debt burden of medical school students	▸ There is increased competition within the MHS for highly skilled and limited resources ▸ An increasing number of non-US medical school graduates further reduces the available pool for military service ▸ MHS will need to assess the current diversity of its workforce and develop recruiting initiatives to address any gaps in diversity ▸ While more women are choosing a medical career, they are less likely to choose a military career or the specialties most needed in the MHS ▸ The number of military to civilian conversions will increase across the Services ▸ A one-size-fits all approach on incentives for joining no longer suits today's multigenerational and diverse workforce ▸ MHS is competing with the private sector for a very limited supply of nurses, resulting in a need for creative incentive programs to attract nurses ▸ The shortages in certain areas (e.g. nurses, specialty physician, etc,) will not be addressed through traditional recruiting strategies alone. New care delivery models may need to be developed to bridge the gap ▸ MHS should consider demand side solutions as well as supply side solutions
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External Factors		
Category	**Trend**	**Impact on MHS Human Capital**
	Logistics: ▸ Increased streamlining of operations	▸ In following industry trends, MHS will need to examine ways in which it could streamline operations to decrease costs and increase efficiency by leveraging best practices ▸ The MHS is already looking to integrate medical personnel which will have medical personnel implications
	Health IT: ▸ Increased use of electronic case management and electronic medical records ▸ Increased use of telemedicine ▸ Increased use of the internet for research on health information by consumers	▸ Introduction of state-of-the-art case management system could increase quality and productivity and decrease costs for patients and complexity for clinical staff ▸ MHS needs to understand the impact on skill requirements and capabilities of clinical staff to work in a more technology focused environment (in-patient EHR, telemedicine, etc.)
	Total Customer Solutions: ▸ Patient centric medicine ▸ High Military output utilization ▸ Increase number of support staff per physician	▸ MHS will need to adjust its processes and systems to be more patient centric to compete with private sector to maintain the "training environment" needed ▸ Current benefit structure may encourage "unnecessary" visits and drive up costs for the MHS. In an effort to stem the rise in costs, MHS may need to examine the relationship between benefit structure, demand, and staffing ▸ MHS may need to examine the impact of the number of support staff per FTE physician on physician efficiency and change the care delivery model ▸ As more beneficiaries seek medical treatment more frequently and as the baby boomers move into the 65+ bracket, physicians will struggle to keep up with demand

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External Factors		
Category	**Trend**	**Impact on MHS Human Capital**
Consumer	***Diseases & Conditions that impact the general population:*** ▸ Increased health threats (Avian Flu) ▸ Increase in preventable illnesses (obesity, smoking, poor diet) ▸ Increase in Post Traumatic Stress Disorder Among Iraq War Veterans	▸ MHS will need to invest more resources in preventive medicine ▸ A flu outbreak could have significant effects on the international economy, military operations, and critical infrastructure ▸ Lifestyle challenges, including obesity, smoking, and drug abuse, will contribute to increased utilization of MHS services which will put a strain on resources ▸ MHS will need to hire more psychiatrists, psychologists, and mental health support staff in order to provide adequate resources to help deployed forces address PTSD
	Socio-Economic/ Demographic Trends: ▸ Aging US population ▸ Retirement of the baby boomer generation	▸ An aging population and increased average life span will place capacity burdens on healthcare organizations such as the MHS ▸ Retirement of the baby boomers will decrease the supply of labor and create workforce shortages in the healthcare sector ▸ As they grow older, baby boomers will require more frequent, specialized medical care and will place demand pressure on MHS services

Environmental Analysis Sources:
▸ *MHS Overview HC Strategy and CBO's Growth in Medical Spending by DoD, September 2003*
▸ *Health Manpower Personnel Data System (HMPDS) 2005*
▸ *Quadrennial Defense Review 2006*
▸ *The National Military Strategy of the USA: A Strategy for Today; A Vision for Tomorrow – 2004*
▸ *World Health Organization (WHO)*
▸ *Social Security Administration (SSA)*
▸ *National Veterans Foundation*
▸ *Bureau of Labor and Statistics (BLS)*
▸ *Department of Labor (DoL)*
▸ *Office of Personnel Management (OPM)*
▸ *Health Resources and Services Administration (HRSA)*
▸ *GAO Reports – GAO-05-952 & GAO-07-358T*
▸ *Association of American Medical Colleges (AAMC)*
▸ *American Association of Colleges of Nursing*
▸ *The Organization on Obesity in America – www.obesityinamerica.org*
▸ *RAND Corporation studies*
▸ *PwC Health Industries top issues for 2006*
▸ *PwC HealthCast 2020 and Standard & Poor's Healthcare: Manage Care Industry Survey*

- *Standard & Poor's Healthcare: Manage Care Industry Survey and CBO's Growth in Medical Spending by DoD, September 2003*
- *Overview of Plunkett's healthcare Industry coverage and Standard & Poor's Healthcare: Manage Care Industry Survey*
- *Congressional Budget Office (CBO) Study (2003) – Growth in Medical Spending by DoD*
- *Addressing the Human Capital Crisis in the Federal Government by Liebowitz*

APPENDIX D: COMPREHENSIVE CHART OF GOALS, OBJECTIVES, AND PERFORMANCE MEASURES

Goal 1: Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
1.1 Define, manage, and communicate a common human capital lexicon across the MHS	Percentage of common human capital definitions required that have been published	Output	Number of common human capital definitions required that have been published / Total number of required human capital definitions	Identification and definition of the terms requiring common definition will take place during future analysis. Having a common language that is used across systems and Services to use will increase interoperability.
1.2 Establish common data standards that allow for the sharing of data across the MHS and partner agencies	Percentage of accredited human capital IM/IT systems utilizing common data standards	Outcome	Number of required common data standards that have been successfully populated and are available MHS-wide / Total number of common data standards	To create interoperability, the MHS IM/IT systems must utilize and require the same data standards. This will aid transparency and assist the MHS produce usable and interoperable reports to improve human capital issues. Fields requiring common data standards will be identified during future analysis.
1.3 Develop a portfolio of collaborative, comprehensive, and globally accessible information technology tools to strategically manage human capital resources	Cost savings created through use of interoperable MHS human capital information technology tools	Outcome	Cost of utilizing interoperable MHS information technology tools for a similar timeframe / Average cost of utilizing MHS information technology tools	Cost analysis will determine the savings to MHS as a result of using interoperable information technology.
1.4 Develop, collect, and integrate transparent and timely data on the Total Force to enable human capital decisions	Percentage of enterprise-wide human capital reporting requirements that meet cycle time targets	Outcome	Number of enterprise-wide human capital reporting requirements that meet cycle time targets / Total number of enterprise-wide human capital reporting requirements	There is the need to increase the timeliness of IM/IT information processing. Timely human capital reports assume that the information also meets the needs and expectations of the requestor.

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Goal 1: Build and maintain a unified information management capability to enable an enterprise-wide view of MHS human capital and energize strategic human capital management				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
1.5 Identify and automate critical human capital workflow processes to enable human capital management	Percentage of critical human capital workflow processes that are automated	Output	Number of critical human capital workflow processes that are automated / Total number of workflow processes that should be automated	Workflow processes that should be included will be identified during future analysis. In addition, workflow processes that should be automated will be identified during future analysis.

Goal 2: Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
2.1 Evaluate, develop, implement, and utilize joint solutions for Total Force human capital lifecycle management	Percentage of designated joint components employing joint solutions	Outcome	Number of designated joint components employing joint solutions / Total number of joint solutions	This measure focuses on understanding how the Services collaborate and use Joint human capital solutions.
2.2 Establish a system that continuously identifies the optimal mix and shapes the Total Force to achieve the evolving MHS mission	Percentage alignment to optimal mix	Outcome	Number fit and fill for MHS / Number total billet allocation across MHS	This measure gauges whether or not the Services and MHS have successfully aligned the workforce to the identified optimal mix.
2.3 Define and communicate career paths across the Total Force	Percentage of workforce for which job families are defined

Percentage of job families for which career paths have been published | Output | Number of defined workforce job families / Total number of job families identified

Number of job families for which career paths have been published / Number of job families with career paths | The total number of job families will be identified through future analysis. Ensuring that the Total Force knows and understands what job family they are in and the corresponding relevant information for that job family is essential for lifecycle management. |
| 2.4 Increase effectiveness of joint- and Service-specific recruiting strategies | Percentage fill of Service specific recruiting goals

Percentage fill of Service specific critically short career fields | Outcome | Number of Service specific recruiting goals met / Number of Service specific recruiting goals

Number of Service specific critically short career fields met / Number of Service specific critically short career fields | The measure examines not only total recruiting goals but also those career fields identified by the Services that have critical shortages. |

Goal 2: Plan and execute an empowering human capital lifecycle for the Total Medical Force to optimize MHS mission accomplishment and allow people to perform at their highest levels				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
2.5 Increase effectiveness within and collaboration across the Services in the development and implementation of retention strategies	Percentage of critically short career fields that are seeing an increase in retention	Outcome	Number of critically short career fields that are seeing an increase in retention / Total number of critically short career fields	The measure examines retention rates in those career fields identified by the Services that have critical shortages.
2.6 Develop joint workforce planning systems to enhance interoperability	Number of workforce planning systems that have been developed as joint systems which enable the identification of strategic job families, force leveling, or joint credentialing	Output	Number of workforce planning systems that enable the identification of strategic job families, force leveling, or joint credentialing	This measure will help MHS identify workforce planning systems (both technologies and processes) that enhance interoperability.
2.7 Develop performance-based leadership programs to enhance career development and succession planning for the civilian workforce	Percentage of civilian job families with defined career paths

Percentage of civilians placements aligned with succession plans | Output | Number of civilian job families with defined career paths / Total number of civilian career paths

Number of civilian placements aligned with succession plans / Number of civilian placements | MHS will need to identify civilian job families and ensure that career paths and succession plans exist for all civilian job families. These measures will aid MHS in understanding how well the civilian workforce is aligning and using succession planning. |

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Goal 3: Leverage existing performance-based management systems to create and lead an agile and responsive Total Medical Force to accomplish the MHS mission				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
3.1 Promote performance-based culture that links individual and organizational performance to ensure day-to-day operations support Service and MHS strategies and priorities	Percentage of employees who feel the culture is performance-based	Outcome	Number of employees who feel the culture is performance-based / Number of employees in workforce	This measure will determine if Total Medical Force members believe that they work in a performance-based culture.
3.2 Develop and recommend assessment standards for all Active Duty, Reserve, civilian, and contractor personnel that are consistent with Service doctrine and that enable interoperability	Percentage of baseline assessment standards developed for similar job families across the Total Force	Output	Number of baseline assessment standards developed for similar job families / Total number of baseline assessment standards required for similar job families across the Total Force	The baseline assessments standards requirement will be identified during future analysis. Baseline criteria should include all common performance measures. Similar job families are personnel with parallel skill sets, training, knowledge, and expertise across the Total Medical Force.
3.3 Employ equitable and coordinated incentives to increase coordination among the Services on human capital management and minimize inter-Service competition	Percentage of Service-level incentive programs that are equitable and/or coordinated that are employed by the Services	Output	Number of Service-level incentive programs employed by the Services that are coordinated and/or equitable / Total number of Service–level incentive programs offered	MHS will also have to determine what is considered equitable and/or coordinated. Once the programs that should be coordinated are identified, MHS will monitor the programs to ensure they remain equitable and coordinated.
3.4 Establish human capital shared services where appropriate to achieve effectiveness and efficiency	Cost per transaction of shared human capital services Average cycle time for human capital processes (ex. hiring, firing)	Output	Total cost / Total number of transactions Total time for human capital processes / Total number of human capital processes executed	Where applicable, shared services will increase efficiencies and create economies of scale. MHS will analyze the cost per transaction for each potential shared service to identify where joint efforts would benefit the organization. Cycle time of individual human capital lifecycle processes has a major impact on efficiency and can be a major factor in reduction or increase in cost. Cost is not only financial but may include time, man-hours, benefits, etc.

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Goal 4: Educate, train, and develop the Total Medical Force to provide quality care while assuring interoperability				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
4.1 Design and implement common capabilities and competency frameworks to drive Total Force interoperability in alignment with Service-specific doctrine	Percentage of strategic job families that have competency frameworks (Primary) Percentage of job families that have competency frameworks (Secondary)	Output	Number of strategic job families that have competency frameworks / Number of total strategic job families Number of job families that have competency frameworks / Number of total job families	Strategic job families and all other job families will be identified as a result of this Strategic Plan. MHS is making the commitment that each strategic job family should have a competency framework associated with it. The competency framework should be developed and agreed upon by all Services to establish commonality.
4.2 Identify, design, and implement joint education and training programs to leverage common capabilities and efficiencies across the Services in alignment with Service-specific doctrine	Percentage of people who are trained to perform the common capability in a joint environment/platform as a result of training	Outcome	Number of people who are trained to perform the common capability in a joint environment / Total number of people in that job family	Increasing the number of people who can perform a common capability across Services and missions will increase interoperability.
4.3 Identify or develop degree and certification granting programs required to ensure mission requirements are met	Percentage of critical authorizations (Active Duty and civilians) in professions (current and future) requiring a degree and/or certification that have available degree-granting or certification programs with the capacity to meet requirements	Output	Number of authorizations in critically short career fields requiring a degree and certification that are identified as having critical shortages, which have available degree-granting programs / Total number of authorizations of critically short career fields	Degree-granting and certification programs can either be offered by DoD or through an established partnership. Degrees and certification also includes certificates that may be required for a medical specialty or to show proficiency in a medical skill. Available programs takes into account total available capacity.
4.4 Measure and evaluate the effectiveness of education and training policies, programs and impact on Total Force current and future capabilities	Percentage of people who demonstrated improved performance and increased capability as a result of training	Outcome	Number of people sent to training who were later reviewed as being more effective / Number of people sent to training	Training measures are required to ensure that efforts to educate personnel are effective. It is critical to understand what individuals are retaining and using and if performance has improved as a result of the training.

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Goal 5: Create and implement adaptable and inspirational human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs				
Objective	**Performance Measure**	**Measure Type**	**Equation**	**Description**
5.1 Continuously develop and improve workforce capabilities and workflow processes in alignment with joint and Service deliberate planning processes	Percentage of capabilities that are met as a result of joint or Service deliberate planning processes	Output	Number of capabilities that are met as a result of joint or Service deliberate planning processes / Total number of capabilities identified during joint or Service deliberate planning processes	MHS should use joint processes to meet the current and future needs of the Total Medical Force. This measure will capture those human capital actions that are implemented out of the total human capital actions that are brainstormed through joint or Service planning.
5.2 Design and implement a capability to scan the environment to identify trends in DoD mission requirements, the workforce, healthcare delivery, and healthcare demand	Percentage of trend categories with updated trends identified	Output	Number of trend categories with updated trends identified / Total number of trend categories identified	Specific trend categories will be defined as a result of a trend analysis (i.e., critical areas for which trend analysis needs to be conducted). Once the trend categories have been identified, MHS will monitor trends against those categories. Continuous updates ensures that trends are developed on a recurring basis.
5.3 Leverage requirements from the environmental scan to develop and improve workforce capabilities and workflow processes	Percentage of requirements resulting from the environmental scan that have been leveraged in developing or modifying workforce capabilities/ processes	Outcome	Number of requirements leveraged in developing/ enhancing workforce systems and processes / Total number of lessons learned resulting from the environmental scan	MHS will conduct internal and external environmental scans to analyze and identify trends that impact human capital. Understanding how the information gathered in the scan has been implemented and leveraged will create additional solutions to address changing human capital: mission requirements, healthcare delivery trends, and emerging healthcare needs.

APPENDIX E: LIST OF ACRONYMS

AFMS   Air Force Medical Service

AMEDD   Army Medical Department

BRAC   Base Realignment and Closure

BUMED   Navy Bureau of Medicine and Surgery

CHCO   Chief Human Capital Officer

CSRB   Critical Skills Retention Bonus

DHP   Defense Health Program

DIMHRS   Defense Integrated Military Human Resources System

DMHRSi   Defense Medical Human Resource System – internet

DOD   Department of Defense

EA   Enterprise Architecture

FAP   Financial Assistance Program

GME   Graduate Medical Education

HA   Health Affairs

HPSP   Health Professions Scholarship Program

IM   Information Management

IT   Information Technology

MEDCOM   Army Medical Command

METC   Medical Education and Training Campus

MHS   Military Health System

MHSER   Military Health System Executive Review

MRMC   Medical Research and Materiel Command

MRR   Medical Requirements Review

MTF   Military Treatment Facility

OASD   Office of the Assistant Secretary of Defense

OPM   Office of Personnel Management

QDR   Quadrennial Defense Review

ROTC   Reserve Officers' Training Corps

SMMAC   Senior Medical Military Advisory Committee

TMA   TRICARE Management Activity

TRO   TRICARE Regional Office

USUHS   Uniformed Services University of the Health Sciences

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APPENDIX F: GLOSSARY

Term	Definition
Balanced Scorecard	*The balanced scorecard is a strategic management approach used by organizations to describe, implement and manage strategy at all levels of the organization. A balanced scorecard has been used for strategic management within the MHS since 2002.*
Best practices	*The practices that enable an organization to achieve superior organizational performance results.*
Capabilities	*The ability to execute a specified course of action.*
Career Development	*The process by which individuals establish their current and future career objectives and assess their existing skills, knowledge or experience levels and implement an appropriate course of action to attain their desired career objectives.*
Career Paths	*The progression of jobs in an organization's specific occupational fields ranked from lowest to highest in the hierarchal structure.*
Chief Human Capital Officer (CHCO)	*Title 13 of the Homeland Security Act establishes CHCOs in agencies. The act establishes a relation between strategic human capital management, agency performance plans and reports, and human resources flexibilities. It clarifies management accountability for managing human resources.*
Competency	*The knowledge, skills, and abilities that serve as the foundation for workforce behaviors and for successful performance. Competencies can generally be improved via training and development. Examples of competencies include problem solving, analytical thinking, and leadership.*
Credentialing	*The process of obtaining and reviewing the documentation of health professionals. Includes a review of training, educational degrees, licensure, experience, and expertise of a practitioner.*
Culture	*That which reflects the fundamental assumptions and values about what behaviors are appropriate through the organization.*
Data Standards	*Established consensus on data definitions and requirements.*
Deliberate Planning Process	*Planning process that actively examines the impact of strategy on decisions.*
Doctrine	*Fundamental principles by which the military forces or elements thereof guide their actions in support of national objectives.*
Education	*The gradual process of acquiring knowledge through formal instruction.*
Enterprise-wide	*Across the entire MHS organization.*

Term	Definition
Environmental Scan	*A process that systematically surveys and interprets relevant data to identify internal as well as external opportunities and threats.*
Force Leveling	*Joint credentialing to ensure you can deploy effectively – ability to look across the MHS. Uniform titles.*
Governance	*The process through which organizations make strategic decisions, determine whom they involve and demonstrate accountability for the results of their actions. The process of governance relies on a system or framework to define how the process is supposed to function in a particular setting.*
Human Capital	*The collection of "people" assets, including capabilities, competencies and capacities that help an organization achieve its mission and realize its vision.*
Human Capital Lifecycle Management	*That which supports employees through every phase of their service with the organization, from recruitment through training, development, and retention. It enables the organization to find the best people, leverage their talent, align employee goals with corporate goals, maximize the impact of training, and retain top performers.*
Information Management	*The defining, using, planning, manipulating, and controlling of information as an organizational resource.*
Information Technology	*The study, design, development, implementation, support, or management of computer-based information systems, particularly software applications and computer hardware.*
Interoperable	*The ability to operate in synergy in the execution of assigned tasks.* *(DoD) 1. The ability to operate in synergy in the execution of assigned tasks. 2. The condition achieved among communications-electronics systems or items of communications-electronics equipment when information or services can be exchanged directly and satisfactorily between them and/or their users. The degree of interoperability should be defined when referring to specific cases.* *The ability of systems, units, or forces to provide data, information, material, and services to and accept the same from other systems, units, or forces and to use the data, information, material, and services so exchanged to enable them to operate effectively together. Information technology and National Security Systems interoperability includes both the technical exchange of information and the end-to-end operational effectiveness of that exchange information as required for mission accomplishment.*
Interservice Training	*Two or more Services training together, including consolidated, collocated, quota or DoD Executive Agent courses. It does not address joint doctrine, tactics, techniques, and procedures. (DODD 1322.18)*
Job Families	*Groups of occupations that share similar vocational characteristics such as work performed, skills, education, training, and credentials. Strategic job families are those that are job categories within an organization that have the greatest impact on the strategy.*
Joint	*Used to connote activities, operations, etc., in which two or more military departments participate.*

Term	Definition
Joint Education and Training	*Training, including mission rehearsals, or individuals, units, and staffs using joint doctrine or joint tactics, techniques, and procedures to prepare joint forces or joint staffs to respond to strategic, operational, or tactical requirements considered necessary by the Combatant Commanders to execute their assigned or anticipated missions. (DODD 1322.18)*
Knowledge Management	*A systematic approach to identifying, documenting, organizing, distributing, reusing, and modernizing an organization's mission critical knowledge.*
Leadership Development	*Formal and informal training and professional development programs designed for all management and executive-level employees to assist them in developing the leadership skills and styles required to deal with a variety of situations.*
Optimal Mix	*The ideal MHS workforce mix of skills and abilities needed to meet strategic direction – DoD as well as MHS.*
Performance Measures	*Performance information used to monitor the progress of a program or policy as well as to make decisions about strategic objectives and resource allocations.*
Performance-Based Culture and Management	*Efforts to achieve a diverse, results-oriented, high-performing workforce that links individual and team performance to organizational goals and desired results.*
Privilege system	*The listing of the specific clinical privileges an organization's staff member is permitted to perform in the organization.*
Service Training	*Military training based on Service policy and doctrine to prepare individuals and interoperable units. Service training includes basic, technical, operational, and interoperability training in response to operational requirements deemed necessary by the Combatant Commands to execute assigned missions. (DODD 1322.18)*
Single Point of Accountability	*One entity within the organization that contributes to enhanced performance by monitoring and evaluating the results of human capital management policies, programs, and activities.*
Skill	*An observable and measurable expertise needed to perform a task.*
Strategic Business Partner	*The active alignment of human capital with DoD and MHS Strategic Plans. The process ensures that the strategic planning process includes human capital planning decisions.*
Strategic Human Capital Management	*The active alignment of the talent, energy, knowledge and enthusiasm that people invest in their work, with the strategic objectives of the organization. Leaders and managers can maximize their human capital assets by leading from the perspective that human capital produces sustained advantage; and by actively advancing the relationships among strategy, organizational design, deployment of talent, and results.*

Term	Definition
Succession Planning	*A deliberate and systematic effort by an agency to ensure continuity of leadership and critical staff skills in mission-critical positions as well as to encourage individual development. Succession planning is a subset of workforce planning, and is designed to ensure the continued effective performance of an agency by identifying, developing, and replacing key people over time. Succession planning provides an opportunity to align diversity management programs with the larger agency objectives.*
Total Medical Force	*All types of human capital (Active Duty, Reserve, civilian, contractor ((personal and non-personal service contract support for clinical and non-clinical missions)) within all Services (Army, Navy, Air Force) that provide and support medical services.*
Training	*The teaching of vocational or practical and relates to specific useful skills.*
Unified	*A command with a broad continuing mission under a single commander and composed of significant assigned components of two or more military departments that is established and so designated by the president, through the Secretary of Defense with the advice of the Chairman of the Joint Chiefs of Staff. Also called unified combatant command.*
Workforce Planning	*A process that ensures people with the appropriate skills are in the right place at the right time to meet the organizations' changing needs. It examines what an organization needs to accomplish in a given period of time; what knowledge, skills, and experience are required to get the job done; and how large and what type of workforce is required to provide that mix of skills, knowledge, and experience.*

APPENDIX G: PERSONNEL NUMBERS

Number	Representation	Reference
9.1M	Tricare eligible beneficiaries as of September 2006	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
65	Number of Military Hospitals	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
412	Number of Medical Clinics	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
414	Number of Dental Clinics	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
132,700	Approximate number of DHP Military and DHP Civilians	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
86,400	Approximate number of DHP Military	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
46,300	Approximate number of DHP Civilians	9/11/07 - http://www.tricare.mil/pressroom_facts.aspx
163,000	Approximate total number of Military and Civilian for EYF 07	FY08 Defense Manpower Requirements Report
116,700	Approximate number of total Military	FY08 Defense Manpower Requirements Report
46,300	Approximate number of Civilians	FY08 Defense Manpower Requirements Report

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

AUG 29 2007

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
     CHAIRMAN OF THE JOINT CHIEFS OF STAFF
     UNDER SECRETARIES OF DEFENSE
     COMMANDERS OF THE COMBATANT COMMANDS
     ASSISTANT SECRETARIES OF DEFENSE
     GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
     DIRECTOR, OPERATIONAL TEST AND EVALUATION
     INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
     ASSISTANTS TO THE SECRETARY OF DEFENSE
     DIRECTOR, ADMINISTRATION AND MANAGEMENT
     DIRECTOR, PROGRAM ANALYSIS AND EVALUATION
     DIRECTOR, NET ASSESSMENT
     DIRECTORS OF THE DEFENSE AGENCIES
     DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Implementation of the President's Commission on Care for America's Returning Wounded Warriors (The Dole/Shalala Report)

   The Wounded, Ill, and Injured Senior Oversight Committee (WII-SOC), a joint Department of Defense (DoD) and Department of Veterans Affairs (DVA) committee, met on August 7, 2007, and approved the following policy changes in response to the subject Commission. The Military Departments and DoD Principal Staff Assistants are directed to take the following actions:

     (1) The Secretaries of the Military Departments will use all existing authorities (e.g., special pays, critical wartime accession bonuses, and recruitment, retention, and relocation incentives) to recruit and retain military and civilian personnel to the limits authorized in current manning documents, required for care of our Seriously Injured Warriors, as that term is defined on page 1 in the Commission report. These authorities will be fully funded to achieve this goal, in concert with Secretary Gates' commitment that this effort is the highest priority of the DoD, second only to winning the Global War on Terror.

     (2) No later than September 30, 2007, the Secretary of the Army will assess the current organizational structure at Walter Reed Army Medical Center (WRAMC) and ensure that it reflects the skill/grade mix needed to deliver world class care expected for our Service members. A robust recruitment plan will be developed and implemented to

address identified gaps. Further, the Secretary of the Army will ensure that the WRAMC budget is sufficient to fully fund the required recruitment and retention incentives.

        (3) The Under Secretary of Defense for Personnel and Readiness, in concert with the Departments of the Army and Navy, will develop a plan to maximize placement of WRAMC employees affected by the transfer of health care services under the Base Realignment and Closure process to the National Naval Medical Center and Dewitt Army Community Hospital. This plan will provide a "Guaranteed Placement Program" for all WRAMC employees to transfer to the new Walter Reed National Military Medical Center at Bethesda or DeWitt Army Community Hospital, Fort Belvoir, and will serve as an incentive for continued employment at WRAMC up to, and including, its closure.

        (4) The Under Secretary for Personnel and Readiness, in coordination with the Secretaries of the Military Departments and the Under Secretary of Defense (Comptroller), will assess the Department's progress implementing these actions and, not later than October 30, 2007, provide that assessment together with recommended adjustments to programs and policies necessary to more fully comply with the intent of these instructions and the recommendations of the President's Commission. At this same time, the Under Secretary of Defense (Comptroller) will provide an assessment of the incremental costs (in excess of the President's Budget Request for FY08) associated with implementation of the actions directed in this memorandum.

SEP 0 8 2008

MEMORANDUM FOR THE COMMANDERS OF
WALTER REED ARMY MEDICAL CENTER
NATIONAL NAVAL MEDICAL CENTER
DEWITT ARMY COMMUNITY HOSPITAL
MALCOLM GROW MEDICAL CENTER

Subject: Joint Task Force National Capital Region Medical Civilian Personnel
Policy

1. BACKGROUND. On 12 September 2007, the Deputy Secretary of Defense
established the Joint Task Force National Capital Region Medical (JTF CapMed)
to ensure effective and efficient delivery of world-class military health care
within the NCR Tricare Sub-region and to oversee the consolidation and
realignment of military healthcare within the region.

2. PURPOSE. A key objective of the JTF CapMed is to ensure the continuity
and readiness of the dedicated civilians who will support military healthcare
through the transition to the new regional model. In order to achieve that
objective, the JTF will take necessary action to support stable employment for
civilian employees in the region, particularly those employees who will be
affected by the closure of the Walter Reed Army Medical Center. In order to
provide greater stability and begin developing the regional workforce of the
future, the Joint Task Force will coordinate/oversee the development and
implementation of specific regional civilian HR strategies and processes to be
utilized by Walter Reed Army Medical Center, the National Naval Medical
Center, DeWitt Army Community Hospital, and Malcolm Grow. Those policies
and procedures will:

    a. Ensure the placement of employees who remain at Walter Reed Army
Medical Center through closure or until their work is transferred.

    b. Fully utilize available incentives and pay flexibilities to achieve Walter
Reed sustainment and the availability of needed skills across the region.

c. Provide for a phased approach designed to maximize the movement of current employees to preferred locations and the recruitment of new employees with designated 2011 duty stations in order to avoid involuntary displacements and to ensure that the Walter Reed National Military Medical Center and the Community Hospital at Fort Belvoir have trained and ready staffs when new facilities are available.

d. Comply with applicable laws and regulations.

3. ACTION. Enclosure (1) charters the Joint Task Force National Capital Region Medical Civilian Human Resources Council (JTF CapMed CHR Council) responsible for overseeing the development and implementation of the policies and procedures needed to ensure that the civilian workforce objectives are achieved. Quarterly updates on the development and implementation of these policies and procedures will be published in the JTF CapMed Newsletter.

4. PROPONENT. The JTF CapMed is the proponent of this policy letter. The point of contact is Debra Edmond, Special Assistant for Civilian Human Resources, debra.edmond@med.navy.mil.

J.M. MATECZUN
Rear Admiral, United States Navy
Commander
Joint Task Force National Capital Region Medical

Enclosure

2

CHARTER

NATIONAL CAPITAL REGION MEDICAL (CapMed)
CIVILIAN HUMAN RESOURCES COUNCIL

JOINT TASK FORCE NATIONAL CAPITAL REGION MEDICAL
(JTF (CapMed))

1. PURPOSE, SCOPE AND AUTHORITY:

The Commander, JTF (CapMed) was appointed by the Deputy Secretary of Defense in the September 12, 2007 memorandum "Establishing Authority for Joint Task Force National Capital Region Medical (JTF CapMed) Transition Team". One of the two broad responsibilities outlined in this memorandum was to oversee the consolidation and realignment of military healthcare within the JOA in accordance with the Base Realignment and Closure Act (BRAC). Pursuant to this authority, the National Capital Region Medical Civilian Human Resources Council (CapMed CHR Council) is established under the direction and control of the Commander, JTF (CapMed). The CHR Council is charged with considering, approving and directing the implementation of the full range of CHR plans, procedures and processes necessary to implement the vision of a Joint CHR system that fully supports the delivery of world-class medical care in the NCR while at the same time mitigating the adverse effects of BRAC-associated staff consolidation and realignment.

2. OBJECTIVES:

Responsibilities of the Council include evaluating a range of CHR issues and recommendations developed for the Council's consideration and, based on a collective assessment, taking appropriate action within their respective commands to:

    a. Support recruitment and retention of a civilian workforce necessary to maintain world-class medical care.

    b. Effectively and fully use all existing authorities and incentives designed to recruit and retain hard-to-fill and otherwise vitally needed civilian positions, with emphasis on retaining the Walter Reed workforce until its work can be transitioned to the gaining activities.

    c. Implement a comprehensive plan that will allay employee and candidate concerns regarding their future employment within the JOA, to include development of the parameters of the DoD-mandated Guaranteed Placement Program.

d. Develop a comprehensive and multi-phased CHR transition plan that coincides with mission-based work transfer and transition plans.

e. Develop, implement and update a robust and dynamic communications plan of action to ensure the workforces are aware of proposed plans, transition issues, and existing and proposed incentives and authorities.

3. MEMBERSHIP:

a. Members: The CapMed CHR Council will consist of the Commanders of Walter Reed Army Medical Center, the Bethesda National Naval Medical Center, the DeWitt Army Community Hospital at Ft. Belvoir and Malcolm Grow Medical Center and will be chaired by the JTF Special Assistant for Civilian Human Resources. If a Commander wishes to send a designee, the designee must have signatory authority for the Commander and must be able to make CHR decisions for the Command. To the maximum extent possible, there should be continuity of membership among the members so that only the Commander or his/her designee attends all Council meetings. The Council will make decisions based on consensus of the members. Where consensus is not possible on a significant issue requiring a unified regional approach, the Chairperson will prepare a recommended decision brief for the Joint Transition Planning Board (JTPB) and, if necessary, a decision by the JTF Commander.

b. Advisory members: The CapMed CHR Advisory Group will consist of senior HR experts and/or managers and JTF Counsel. The designated HR experts and/or managers will identify issues and oversee necessary fact finding, research, and analysis, and will prepare/present issue papers and recommendation briefs for the HR Council's consideration. JTF Counsel will provide legal review when concerns are raised regarding the application of existing regulations or where an action is deemed without precedent under current regulations. Designated members of the CHR Advisory Group will attend meetings of the Council, keep minutes and coordinate and oversee the execution of actions agreed to by the Council.

c. Technical Specialists/Advisors: The HR Advisory Group will appoint, oversee and coordinate the work of various technical HR specialists. This group of specialists will delve into the details of CHR processes and procedures and will prepare papers that outline options, issues, recommendations, and ramifications of the full range of CHR matters.

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
1	**Major Milestones**					Major Milestones	1	1
3	Confirm Joint Activity Civilians will be DoD Employees	20-Oct-08	20-Oct-08	NA	DSD	Major Milestones	2	1.1
4	Receive Draft Clinical Transition Schedule	NA	NA	NA		Major Milestones	2	1.2
5	Receive Draft Manpower Doc by Type	NA	24-Apr-09	NA		Major Milestones	2	1.3
6	Receive Clinical Transition Schedule Rev 0	NA	NA	NA		Major Milestones	2	1.4
7	Receive Fully Vetted Manpower Doc	NA	NA	N A		Major Milestones	2	1.5
8	Personnel Relocation Assignments Determined (95% Solution)	NA	NA	NA		Major Milestones	2	1.6
10	**HR Transition Staff**					HR Transition Staff	1	2
12	**Staff CHR Advisory Group Support (Add 4 FTEs)**					HR Transition Staff	2	2.1
13	Fund CHR Advisory Group FTEs	6-Oct-08	6-Oct-08	Edmond	Edmond	HR Transition Staff	3	2.1.1
14	Staff the CHR Advisory Group with Full-Time Technical Specialists & Experts	11-Nov-08	30-Mar-09	Edmond	Barrow, Tavares, Emery	HR Transition Staff	3	2.1.2
15	CHR Advisory Group Strategic Communication	5-Jan-09	23-Mar-09	Edmond	Emery, Morales, Wrighten, Relerford	HR Transition Staff	3	2.1.3
16	Define Roles & Resp of the CHR Advisory Group	17-Oct-08	12-Feb-09	Edmond	Edmond, Morales, Nicholl, Tavares, Relerford	HR Transition Staff	3	2.1.4
17	Brief Stakeholders on CHR Council Roles & Plans	15-Jan-09	15-Feb-09		Advisory Group	HR Transition Staff	3	2.1.5
18	Prepare Orientation Handbook for CHR Advisory Group Support Staff	6-Feb-09	NA	Edmond	Edmond	HR Transition Staff	3	2.1.6
21	**Communications**					Communications	1	3
23	**HR Strategic Communications**					Communications	2	3.1
24	**Develop HR Strategic Communication Plan w/ PAO JPG**					Communications	3	3.1.1
25	Develop Initial Talking Points Series for Managers & Supervisors	10-Nov-08	21-Nov-08	Ratcliff		Communications	4	3.1.1.1
26	Develop Process for Collecting & Responding to Employee FAQs	10-Nov-08	11-Jun-09			Communications	4	3.1.1.2
	Identify current installation processes for responding to employee inqu	10-Oct-08	28-May-09					
	Develop strawman for regional process including installation POC's	16-Feb-09	11-Jun-09					
	Request comments from stakeholders and incorporate feedback							
	Hold teleconference to discuss unresolved items							
	Publish final process to Advisory Group							
	Hold meetings and teleconferences to brief process to stakeholders			Marvin, Ryan				
	Publicize process to workforce							
27	Brief & Achieve Agreement with JTPB on HR Strategic Communication Plan	11-Feb-09	11-Feb-09			Communications	3	3.1.2
28	Execute Strategic Communication Plan	12-Feb-09	NA	Ryan	JTF PAO, Emery, McGlothlin	Communications	3	3.1.3
	April - June 2009	26-Mar-09	NA					
	July - September 2009	NA	NA					
	October - December 2009	NA	NA					
	January - March 2010	NA	NA					
	April - June 2010	NA	NA					
	July - September 2010	NA	NA					
	October - December 2010	NA	NA					
	January - March 2011	NA	NA					
	April - June 2011	NA	NA					
	July - September 2011	NA	NA					
29	Designate CHR Advisory Group Rep to Opening/Closing Ceremony Planning G	NA	NA		JTF PAO	Communications	3	3.1.4
31	**Surveys & Focus Groups**					Communications	2	3.2
32	Develop Plan for Employee Survey & Focus Groups w/ JTPB Excom	12-Feb-09	NA	Barrow	RYAN, Marvin, McGlothlin, Rashid, Morales, Wrighten, Re	Communications	3	3.2.1
	Prepare draft list of information and data needed from workforce through transition		NA					
	Identify stakeholders who may need workforce information		NA					
	Provide draft list to stakeholders for comments and additions	NA	NA					
	Incorporate additions to list	NA	NA					
	Match information or data need to optimum methodology (survey/focus group	NA	NA					
	Develop plan to administer surveys and focus groups and provide analysis to	NA	NA					
	Incorporate schedule in Project Plan	NA	NA					
33	Implement Employee Survey & Focus Group Program (Ongoing)	NA	NA		RYAN, Barrow, Emery, Morales, Wrighten, Relerford	Communications	3	3.2.2
34	Survey Staff on Relocation Preferences (see above)	12-May-09	NA		RYAN, Barrow, Emery, Morales, Wrighten, Relerford	Communications	3	3.2.3
35	Issue Relocation Survey Data to J1/HR (see above)	NA	NA		RYAN, Barrow, Emery, Morales, Wrighten, Relerford	Communications	3	3.2.4
37	**Labor**					Labor	1	4
38	Labor Strategic Communication	NA	NA	Emery	Emery, Morales, Tavares, Relerford	Labor	2	4.1
39	**Guidance Paper on Labor Obligations during Transition Period**					Labor	2	4.2
40	Develop Guidance Paper on Labor Obligations during Transition Period for Sup	NA	NA	Emery	Emery	Labor	3	4.2.1
41	Issue Guidance Paper on Labor Obligations during Transition Period for Superv	NA	NA	Emery	Emery, Barrow, Tavares	Labor	3	4.2.2
42	Update/Reissue Guidance Paper on Labor Obligations during Transition Period	NA	NA	Emery	Emery, Barrow, Tavares	Labor	3	4.2.3
44	**Bargaining Units & Contracts**					Labor	2	4.3
	Obtain facility collective bargaining agreements	1-Feb-09	31-Mar-09	Emery				

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
45	Scrub DCPDS BUS Codes (Update Semi-Annually)	2-Mar-09	NA	Emery	Emery, Barrow, Tavares	Labor	3	4.3.1
46	Develop Matrix Comparing Bargaining Unit Composition for JOA	30-Mar-09	NA	Emery	Emery, Barrow, Tavares	Labor	3	4.3.2
47	Obtain Certificates of Representation for Each Bargaining Units	15-Mar-09	15-Mar-09	Emery	Emery, Barrow, Tavares	Labor	3	4.3.3
51	Conduct necessary I&I bargaining	NA	NA	Emery	Emery, Barrow, Tavares	Labor	3	4.3.7
53	**Establish Labor Relations Working Group**					Labor	2	4.4
54	ID Appropriate Reps for Labor Relations Working Group	2-Mar-09	4-Mar-09	Emery	Emery, Barrow, Tavares	Labor	3	4.4.1
55	Develop Charter for Labor Relations Mgmt Working Group	16-Mar-09	14-May-09	Emery	Emery	Labor	3	4.4.2
	Brief CHR Council	14-May-09	14-May-09	Emery				
57	Extend Invitations for Labor Relations Mgmt Working Group	NA	NA	Emery	JTF or CHR Council	Labor	3	4.4.4
58	Establish Labor Relations Mgmt Working Group (Quarterly Meetings)	NA	NA	Emery	JTF or CHR Council	Labor	3	4.4.5
	Obtain final decision on manning document	NA	NA	Emery				
	Obtain final decision on personnel servicing	NA	NA	Emery				
	Obtain date for formal UIC change	NA	NA	Emery				
59	First Labor Relations Mgmt Working Group Mtg	NA	NA	Emery	Emery, Morales, Tavares	Labor	3	4.4.6
48	Review Bargaining Unit Contracts	3-Mar-09	3-Mar-09	Emery	Service or DoD Labor Rep	Labor	3	4.3.4
	Identify bargaining obligations	3-Mar-09	3-Mar-09	Emery				
	Prepare labor strategy courses of action	3-Mar-09	3-Mar-09	Emery				
	Brief Labor COAs to CHR Council	NA	NA	Emery				
	Brief Labor COAs to DoD	NA	NA	Emery				
	Obtain DoD authorization to meet with National and Local AFGE representative	NA	NA	Emery				
	Arrange for meeting with FLRA for pre-petition discussions	NA	NA	Emery				
	Develop petition based on outcome of meeting	NA	NA	Emery				
	Obtain CJTF signature on petition, file petition	NA	NA	Emery				
	Implement FLRA decision	NA	NA	Emery				
65	**Classification & Position Management**					Classification & Position Manag	1	5
73	**Classification Transition Plan**					Classification & Position Manag	2	5.2
	Develop resource requirements for PD librarian and contractors to implement/maintain FASCLASS, consistency review, creating new JDs, and processing realignments	18-Mar-09	14-May-09	Hagerty				
74	Working Group Reviews Position Classification Approaches and Recommends	20-Nov-08	9-Apr-09	Hagerty	Vaccaro, McGlothlin, Relerford	Classification & Position Manag	3	5.2.1
	Council approves Regional approach for Position Classification	9-Apr-09	14-May-09	Hagerty				
	Implement Council decision	NA	NA	Hagerty				
	Determine how to implement FASCLASS for NCR CapMed	15-Mar-09	14-May-09	Hagerty				
	Develop, socialize and finalize JTF classification policies and procedures	NA	NA	Hagerty				
	Create JTF PD library	NA	NA	Hagerty				
	Develop SOW to hire contractor to create PD library	NA	NA	Hagerty				
	Develop funding requirements (current and out years) for implementati	NA	NA	Hagerty				
	Obtain approval and MIPR funds	NA	NA	Hagerty				
	Begin with Navy standardized positions	NA	NA	Hagerty				
	Incorporate Air Force standardized positions	NA	NA	Hagerty				
	Add other positions incrementally	NA	NA	Hagerty				
75	ID & Eval Classification Anomalies of Positions/ Job Descriptions at Walter Ree	30-Mar-09	14-May-09	Hagerty	McGlothlin, Nicholl, Wrighten, Hagerty, Rashid	Classification & Position Manag	3	5.2.2
	Conduct preliminary analysis of scope of review and publish identified scope	14-May-09	14-May-09	Hagerty				
	Project 25% complete - publish progress and identify issues	14-May-09	14-May-09	Hagerty				
	Project 50% complete - publish progress and identify/clarify issues to date	14-May-09	14-May-09	Hagerty				
	IPR to Council	14-May-09	14-May-09	Hagerty				
	Project 75% complete - publish progress and identify/clarify issues to date	14-May-09	14-May-09	Hagerty				
	Project 100% complete - publish final results and conclusions with recommer	14-May-09	14-May-09	Hagerty				
	Prepare, schedule and deliver Council briefing	14-May-09	14-May-09	Hagerty				
76	Conduct Consistency Review of Position Classifications across JOA	11-May-09	NA	Hagerty	McGlothlin, Nicholl, Wrighten, Hagerty, Rashid	Classification & Position Manag	3	5.2.3
	Develop plan of action outlining approach, method and timelines	11-May-09	NA	Hagerty				
	Develop SOW to hire 2-3 contractors to complete consistency review	NA	NA	Hagerty				
	Obtain approval and arrange for necessary addition to existing contract	NA	NA	Hagerty				
	Conduct preliminary analysis of scope of review and publish identified scope	NA	NA	Hagerty				
	Project 25% complete - publish progress and identify issues	NA	NA	Hagerty				
	Project 50% complete - publish progress and identify/clarify issues to date	NA	NA	Hagerty				
	IPR to Council	NA	NA	Hagerty				
	Project 75% complete - publish progress and identify/clarify issues to date	NA	NA	Hagerty				
	Project 100% complete - publish final results and conclusions with recommer	NA	NA	Hagerty				
	Schedule teleconference with stakeholders to discuss issues	NA	NA	Hagerty				
	Prepare, schedule and deliver Council briefing	NA	NA	Hagerty				

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
77	Develop Job Descriptions Consistent with Manning Doc	NA	NA	Hagerty	McGlothlin, Nicholl, Wrighten, Hagerty, Rashid	Classification & Position Manag	3	5.2.4
	Obtain decision on how work will be assigned in the new integrated departme	NA	NA	Hagerty				
	Develop plan of action outlining approach, method and timelines	NA	NA	Hagerty				
	Project 25% complete - publish progress and identify issues	NA	NA	Hagerty				
	Project 50% complete - publish progress and identify/clarify issues to date	NA	NA	Hagerty				
	IPR to Council	NA	NA	Hagerty				
	Project 75% complete - publish progress and identify/clarify issues to date	NA	NA	Hagerty				
	Project 100% complete - publish final results and conclusions with recommer	NA	NA	Hagerty				
	Prepare, schedule and deliver Council briefing	NA	NA	Hagerty				
79	**Realign Workforce**					Classification & Position Manag	2	5.3
	Obtain final decision on effective date and servicing personnel office							
	Notify unions and accomplish necessary I&I							
80	Create Org Structure & UICS in DCPDS	NA	NA	Wrighten	DoD, Wrighten, Hagerty, Rashid, Relerford	Classification & Position Manag	3	5.3.1
	Notify DFAS of planned realignments - obtain servicing POC	NA	NA	Wrighten				
	Ensure necessary DFAS tables are created in payroll	NA	NA	Wrighten				
81	Interface/Transfer Data from DCPDS to DFAS	NA	NA	Wrighten	DoD, Wrighten, Hagerty, Rashid, Relerford	Classification & Position Manag	3	5.3.2
82	Create & Review Mass Realignment Spreadsheets (Table 30s)	NA	NA	Wrighten	DoD, Wrighten, Hagerty, Rashid, Relerford	Classification & Position Manag	3	5.3.3
83	Process/Implement Realignments for FB Stand-Up	NA	NA	Wrighten	DoD, Wrighten, Hagerty, Rashid, Relerford	Classification & Position Manag	3	5.3.4
84	Process/Implement Realignments for Bethesda Stand-Up	NA	NA	Wrighten	DoD, Wrighten, Hagerty, Rashid, Relerford	Classification & Position Manag	3	5.3.5
	Ensure NSPS Hierarchies conforms to new org structure							
87	**Performance Management**					Performance Management	1	6
89	**NSPS Compensation Policies**					Performance Management	2	6.1
90	Collect NSPS Compensation Policies across JOA	3-Mar-09	24-Apr-09	Morales	Nicholl, Morales, Wrighten	Performance Management	3	6.1.1
91	Analyze Existing NSPS Policies. ID Consistencies/Discrepancies & Recommen	24-Apr-09	NA	Morales	**Morales,** Mcglothlin	Performance Management	3	6.1.2
	Prepare charter, identify and request representatives	22-Apr-09	NA	Morales				
	Charter Working Cell of NSPS PMs with Advisory Group Facilitator, schedule	NA	NA	Morales				
	PM Working cell develops proposed NCR CapMed NSPS and Compensation	NA	NA	Morales				
	PM Working cell IPR to Council	NA	NA	Morales				
	PM Working cell IPR to Council	NA	NA	Morales				
	PM Final Report	NA	NA	Morales				
92	CHR Council to Decide on Consistent Business Rules for NSPS Compensation	NA	NA	Morales		Performance Management	3	6.1.3
93	NSPS Compensation Policies Strategic Communications	NA	NA	Morales	RYAN,Emery, Morales, Wrighten, Relerford, Holloway	Performance Management	3	6.1.4
94	Develop & Deliver Training on New NSPS Policies	NA	NA	Morales	Emery, Morales, Wrighten, Relerford	Performance Management	3	6.1.5
95	Implement New NSPS Compensation Policies	NA	NA	Morales		Performance Management	3	6.1.6
97	**Perfomance Management Objectives**					Performance Management	2	6.2
98	ID GS & NSPS Employees	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.1
99	ID End of Cycle Rating Periods	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.2
100	Map Impacts of Changing Performance Mgmt Systems	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.3
101	Performance Mgmt Strategic Communications	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.4
102	Develop Plan for Standardizing Perf Mgmt Objectives	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.5
103	Develop Standards for Performance Mgmt Objectives	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.6
104	Develop & Deliver Training on New Perf Mgm't Policies	NA	NA	Morales	Emery, Hagerty, Wrighten, Relerford	Performance Management	3	6.2.7
105	Implement Standard Perf Mgmt Objectives	NA	NA	Morales		Performance Management	3	6.2.8
107	**Personnel Servicing**					Personnel Servicing	1	7
109	**Establish Regional DCPDS Capability with Shared Views**					Personnel Servicing	2	7.1
110	Eval use of Army Portal as Common Access to Navy & Air Force Data	15-Jan-09	1-Feb-09	McGlothlin	McGlothlin, Nicholl, Morales, Tavares , JTF J6	Personnel Servicing	3	7.1.1
111	Prepare Brief to CPMS Excom on Requirements	NA	NA	McGlothlin	McGlothlin, Edmond	Personnel Servicing	3	7.1.2
112	Incorp CPMS Excom comments into Requirements Docs	NA	NA	McGlothlin	McGlothlin, Edmond	Personnel Servicing	3	7.1.3
113	Obtain CPMS Concurrence & Funding	NA	NA	McGlothlin	Edmond	Personnel Servicing	3	7.1.4
114	Build Regional CMIS	1-Oct-08	30-Mar-09	McGlothlin	CPMS or DCPDS	Personnel Servicing	3	7.1.5
115	Prepare Business Rules for use of Regional CMIS Database (DELETE)	NA	NA	McGlothlin	McGlothlin	Personnel Servicing	3	7.1.6
116	Develop Training for use of Regional CMIS Database	24-Feb-09	13-Apr-09	McGlothlin	McGlothlin	Personnel Servicing	3	7.1.7
117	Implement Regional CMIS with Shared Views	30-Mar-09	9-Apr-09	McGlothlin	McGlothlin	Personnel Servicing	3	7.1.8
119	**Personnel Servicing Agency Selection**			Edmond		Personnel Servicing	2	7.2
120	Eval Servicing Options & Select Best Value	1-May-09	NA		McGlothlin, Barrow, Gilmour, Tavares, Relerford	Personnel Servicing	3	7.2.1
	Obtain PBD/PDM decision to determine new "owning" organization	13-Apr-09	NA					
	Determine requirements and flexibilities	1-Jun-09	NA					
	Obtain sample MOA/MOU from DLA/DFAS/Army/Navy	NA	NA					
	Prepare matrix/summary evaluation of options(COAs)	24-Jun-09	NA					
	ID HR workyears needed based on servicing ratio?	NA	NA					

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
	Develop Draft MOU	NA	NA					
	Reconcile MOU with HR CONOPS	NA	NA					
	Forward Draft MOU to potential providers for cost estimate	NA	NA					
	Coordinate cost and planned transfer of reimbursable funding with J8/RM	NA	NA					
121	Servicing Options Strategic Communications	NA	NA		RYAN, Emery, Morales, Tavares, Relerford	Personnel Servicing	3	7.2.2
122	Brief JTF & Receive Agreement on Servicing Option	NA	NA		Edmond, McGlothlin	Personnel Servicing	3	7.2.3
	Notify unions	NA	NA					
	Conduct I&I as needed	NA	NA					
123	Develop Implement Plan for Personnel Servicing	NA	NA		McGlothlin, Barrow, Gilmour, Tavares, Relerford	Personnel Servicing	3	7.2.4
124	Develop Work Transfer Plan (obtain existing WTP from DA Regionalization)	NA	NA		McGlothlin, Barrow, Gilmour, Tavares, Relerford	Personnel Servicing	3	7.2.5
	Schedule OPF transfer	NA	NA					
	FECA Record transfer	NA	NA					
	EEO Record transfer	NA	NA					
125	Personnel Servicing Agency Strategic Communications	NA	NA		Emery, Morales, Tavares, Relerford	Personnel Servicing	3	7.2.6
	(Inform employees of all associated changes)	NA	NA					
126	Implement New Personnel Servicing Agency	NA	NA		McGlothlin, Barrow, Gilmour, Tavares, Relerford	Personnel Servicing	3	7.2.7
129	**Change Management**					Change Management	1	8
131	Develop & Present Issue Paper to JTF on Change Mgmt Reqm'ts	6-Mar-09	NA	Emery	Emery, Edmond	Change Management	2	8.1
132	Change Management Strategic Communications	NA	NA		RYAN, Emery, Morales, Wrighten, Relerford	Change Management	2	8.2
133	Eval need for Ombudsman Role at MTFs for Regional Transition	NA	NA		Emery, Morales, Wrighten, Relerford	Change Management	2	8.3
136	**Recruitment & Staffing**					Recruitment & Staffing	1	9
138	**Walter Reed Sustainment Plan**			Barrow		Recruitment & Staffing	2	9.1
139	Monitor and report to CHR Council Employee Gains/Losses at WR (Ongoing Mo	2-Jun-08	NA		Barrow. McGlothlin	Recruitment & Staffing	3	9.1.1
140	WASS CivFors Projections to Anticipate Retirement & other Losses (Ongoing)	8-Sep-08	NA		McGlothlin	Recruitment & Staffing	3	9.1.2
141	Revise Recruitment Strategies (Ongoing)	28-Jan-09	NA		Holloway, Barrow, Rashid, Wrighten, Morales	Recruitment & Staffing	3	9.1.3
143	Secure Funding to Market WR Jobs	8-Sep-08	8-Sep-08		Barrow. McGlothlin	Recruitment & Staffing	3	9.1.4
144	Implement Marketing Pilot to Advertise WR Jobs	9-Sep-08	NA		Holloway, Barrow	Recruitment & Staffing	3	9.1.5
145	Build Relationship with Local Colleges & Institutes & Develop SCEP/STEP Prog	13-Feb-09	NA		Holloway, Barrow	Recruitment & Staffing	3	9.1.6
146	Sustainment Plan For JOA			McGlothlin				
147	**Develop Standard Candidate Selection/Position Fill Process across JOA**			Rashid/Wrighten		Recruitment & Staffing	2	9.2
67	**Position Management**					Classification & Position Manag	2	5.1
68	Establish Business Rules to Manage new Jobs Created in Integrated Depts	6-Oct-08	NA	McGlothlin	McGlothlin	Classification & Position Manag	3	5.1.1
	Develop Summary of current position management practices at NNMC, DeW	6-Oct-08	28-Feb-09	McGlothlin				
	Draft business rules for pilot program to standardize filling supervisory jobs i	1-Mar-09	10-Mar-09	McGlothlin				
	Develop forwarding memo to request feedback from Advisory Group member	1-Mar-09	10-Mar-09	McGlothlin				
	Forward draft business rules for comment and feedback	11-Mar-09	11-Mar-09	McGlothlin				
	Consolidate feedback	11-Mar-09	15-Mar-09	McGlothlin				
	Schedule teleconference with stakeholders to discuss issues	15-Mar-09	20-Mar-09	McGlothlin				
	Finalize proposed business rules, including necessary implementation memo	7-Apr-09	NA	McGlothlin				
	Prepare and schedule Council briefing	14-May-09	14-May-09	McGlothlin				
69	CHR Council to Decide on Business Rules for New Jobs in Integrated Depts	14-May-09	NA	McGlothlin	Council	Classification & Position Manag	3	5.1.2
70	Position Management Strategic Communications	NA	NA	McGlothlin	RYAN, McGlothlin, Hagerty, Morales, Wrighten, Relerford	Classification & Position Manag	3	5.1.3
71	Implement New Position Mgm't Policies	NA	NA	McGlothlin	Emery, Barrow, Tavares	Classification & Position Manag	3	5.1.4
181	**Standard Merit Promotion Plan (End-State)**			Rashid		Recruitment & Staffing	2	9.6
182	Collect Merit Promotion Plans across JOA	1-Feb-09	28-Feb-09		McGlothlin, Rashid, Morales, Tavares, Relerford	Recruitment & Staffing	3	9.6.1
183	Analyze Existing Plans. ID Consistencies/Discrepancies & Recommend Best Pr	1-Feb-09	NA		McGlothlin	Recruitment & Staffing	3	9.6.2
184	Standard Merit Promotion Strategic Communications	NA	NA		Rashid, Morales, Wrighten, Relerford	Recruitment & Staffing	3	9.6.3
185	CHR Council to Decide on Standard Merit Promotion Plan	NA	NA			Recruitment & Staffing	3	9.6.4
186	Develop & Deliver Training on New Policies - Standard Merit Promotion	NA	NA		Rashid, Wrighten, Hagerty, Relerford	Recruitment & Staffing	3	9.6.5
187	Implement New Merit Promotion Policies	NA	NA			Recruitment & Staffing	3	9.6.6
155	**Gap Analysis/ Civilian Hiring Actions**			McGlothlin/Morale	Rashid, Barrow, Wrighten, Relerford, Nichol	Recruitment & Staffing	2	9.3
156	Support Reassignment Strawman Development w/ J1 (Faces to Spaces)	NA	NA			Recruitment & Staffing	3	9.3.1
157	Identify Civilian Vacancies (Faces Gap Analysis)	NA	NA			Recruitment & Staffing	3	9.3.2
158	Prioritize Civilian Vacancies	NA	NA			Recruitment & Staffing	3	9.3.3
159	Submit RPA (Request for Personnel Action)	NA	NA			Recruitment & Staffing	3	9.3.4
160	Advertise Civilian Vacancies	NA	NA			Recruitment & Staffing	3	9.3.5
161	Receive Referral List	NA	NA			Recruitment & Staffing	3	9.3.6
162	Select New Civilian Employees	NA	NA			Recruitment & Staffing	3	9.3.7
163	Coordinate Start Dates	NA	NA			Recruitment & Staffing	3	9.3.8
164	Inprocess New Employees	NA	NA			Recruitment & Staffing	3	9.3.9
165	**Surplus**			Wrighten		Recruitment & Staffing	2	9.4

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
166	ID Surplus Positions	NA	NA	Wrighten	McGlothlin, Nicholl, Morales, Wrighten, Hagerty, Relerford	Recruitment & Staffing	3	9.4.1
167	ID Surplus Employees	NA	NA	Wrighten	McGlothlin, Nicholl, Morales, Wrighten, Hagerty, Relerford	Recruitment & Staffing	3	9.4.2
	Augment Staff with contract POC	NA	NA	Wrighten	McGlothlin, Nicholl, Morales, Wrighten, Hagerty, Relerford	Recruitment & Staffing		
168	Review Existing Contracts & ID Civilian Conversion Opportunities	NA	NA	Wrighten	Nicholl, Morales, Wrighten, Hagerty, Relerford	Recruitment & Staffing	3	9.4.3
169	ID Potential Placements for Surplus Employees outside JOA	NA	NA	Wrighten	Barrow. McGlothlin, Robertson	Recruitment & Staffing	3	9.4.4
170	Establish Target List of Surplus Employees	NA	NA	Wrighten	Nicholl, Morales, Wrighten, Hagerty, Relerford	Recruitment & Staffing	3	9.4.5
172	**Personnel Relocation**			Edmond//Moores		Recruitment & Staffing	2	9.5
173	Analyze Clinical Relocation Plan	NA	NA		Nicholl, Morales, Tavares, Relerford	Recruitment & Staffing	3	9.5.1
174	**Bridging Strategy for JOA**					Recruitment & Staffing	3	9.5.2
175	Develop Phasing Bridging Strategy	NA	NA		McGlothlin, Barrow, Emery, Tavares, Relerford	Recruitment & Staffing	4	9.5.2.1
176	ID Cost & Funding Avail for Bridging Strategy	NA	NA		McGlothlin, Barrow, Emery, Tavares, Relerford	Recruitment & Staffing	4	9.5.2.2
177	Implement Bridging Strategy	NA	NA		McGlothlin, Barrow, Emery, Tavares, Relerford	Recruitment & Staffing	4	9.5.2.3
179	Determine Final Personnel Reassignments for End-State Positions	NA	NA		McGlothlin, Barrow, Emery, Tavares, Relerford	Recruitment & Staffing	3	9.5.3
	Paysetting Plan for JOA	NA	NA	Rashid /Wrighten		Recruitment & Staffing		
	Collect Plans across JOA				Barrow, Releford, Morales, McGlothlin			
	Analyze Existing Plans. ID Consistencies/Discrepancies & Recommend Best Practices				Barrow, Releford, Morales, McGlothlin			
	Strategic Communications				Barrow, Releford, Morales, McGlothlin			
	CHR Council to Decide on Plan				Barrow, Releford, Morales, McGlothlin			
	Develop & Deliver Training on New Policies				Barrow, Releford, Morales, McGlothlin			
	Implement Policies				Barrow, Releford, Morales, McGlothlin			
190	**Training & Development**			Hagerty	id training people	Training & Development	1	10
	Transition training for all NCR MHS employees	NA	NA		Emery, Penny, Crandall			
	Develop cost estimates	NA	NA					
	HR Tools - benefits, timekeeping, new HR policies and procedures, job applic	NA	NA					
	Conduct training	NA	NA					
192	**Retraining for Surplus Employees**	NA	NA			Training & Development	2	10.1
193	Develop Retraining Plans for Surplus Employees	NA	NA		Barrow, Holloway, Morales, Nicholl	Training & Development	3	10.1.1
194	Estimate Cost of Retraining Surplus Employees	NA	NA		Barrow, Holloway, Morales, Nicholl	Training & Development	3	10.1.2
195	Fund Retraining Programs for Surplus Employees	NA	NA		Comptroller/BRAC Office	Training & Development	3	10.1.3
196	Implement Retraining Programs for Surplus Employees (Ongoing)	NA	NA		Barrow, Holloway, Morales, Nicholl	Training & Development	3	10.1.4
198	Eval Opportunities for Surplus Employees with DOL BRAC Transition Offices	NA	NA		Barrow, Holloway, Morales, Nicholl	Training & Development	3	10.1.5
201	**Federal Employment Compensation Act (FECA)**			Emery	Schupay, Cummings, Newman	Federal Employment Compensa	1	11
203	**FECA Policies**					Federal Employment Compensa	2	11.1
204	Collect FECA Policies across JOA	NA	NA		Nicholl, Morales, Tavares, Relerford	Federal Employment Compensa	3	11.1.1
205	Analyze Existing FECA Policies. ID Consistencies/Discrepancies & Recommen	NA	NA		Emery	Federal Employment Compensa	3	11.1.2
206	CHR Council to Decide on Best Practices for FECA across JOA	NA	NA			Federal Employment Compensa	3	11.1.3
207	FECA Policies Strategic Communications	NA	NA		Emery, Morales, Tavares, Relerford	Federal Employment Compensa	3	11.1.4
208	Develop & Deliver Training on New FECA Policies	NA	NA		Emery, Barrow, Tavares, Relerford	Federal Employment Compensa	3	11.1.5
209	Implement New FECA Policies	NA	NA			Federal Employment Compensa	3	11.1.6
211	**FECA Case Accountability & Disposition**					Federal Employment Compensa	2	11.2
212	Develop Plan for FECA Case File Disposition & Assign Accountability	NA	NA		Emery, Barrow, Tavares, Relerford	Federal Employment Compensa	3	11.2.1
215	**Equal Employment Opportunities (EEO)**					Equal Employment Opportunitie	1	12
217	**EEO Reps**			Barrow		Equal Employment Opportunitie	2	12.1
218	Make Initial Contact with EEO Reps Re: Transition Communications	5-Jan-09	2-Feb-09		Emery, Morales, Wrighten, Relerford	Equal Employment Opportunitie	3	12.1.1
219	EEO Strategic Communications	NA	NA		Emery, Morales, Wrighten, Relerford	Equal Employment Opportunitie	3	12.1.2
220	Clarify Role of EEO Reps in Transition	NA	NA		Edmond, Emery, Barrow, Tavares, Relerford	Equal Employment Opportunitie	3	12.1.3
222	**Special Needs Equipment**					Equal Employment Opportunitie	2	12.2
223	Identify Owner of existing Special Needs Equipt (State or Federal)	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.2.1
224	Confirm Special Needs Equipt Placement at new Locations	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.2.2
226	**EEO Policies**					Equal Employment Opportunitie	2	12.3
227	Collect EEO Policies across JOA	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.3.1
228	Analyze Existing EEO Policies. ID Consistencies/Discrepancies & Recommend	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.3.2
229	CHR Council to Decide on Best Practices for EEO across JOA	NA	NA			Equal Employment Opportunitie	3	12.3.3
230	EEO Policies Strategic Communications	NA	NA		Emery, Morales, Wrighten, Relerford	Equal Employment Opportunitie	3	12.3.4
231	Develop & Deliver Training on New EEO Policies	NA	NA		Emery, Barrow, Wrighten Relerford	Equal Employment Opportunitie	3	12.3.5
232	Implement New EEO Policies	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.3.6
234	**EEO Case Accountability & Disposition**					Equal Employment Opportunitie	2	12.4
235	Develop Process for Accountability of EEO Case Files & Records	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.4.1
236	Final Decision on Disposition of Pending EEO Cases	NA	NA		Emery, Barrow, Wrighten, Relerford	Equal Employment Opportunitie	3	12.4.2

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
239	**Transition Assistance: VERA, SIP, GPP, PPP**			Morales/Relerford		Transition Assistance: VERA, S	1	13
240	Transition Assistance Strategic Communications	NA	NA		RYAN, Emery, Morales, Wrighten, Relerford	Transition Assistance: VERA, S	2	13.1
242	**BRAC Incentives for WRAMC**			Barrow		Transition Assistance: VERA, S	2	13.2
243	WRAMC Commander receives Authority to Distribute BRAC Incentives	31-Oct-08	31-Oct-08		Higher Powers/**Morales**	Transition Assistance: VERA, S	3	13.2.1
244	Develop BRAC incentive plan of action	31-Jan-09	15-Feb-09		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.2
245	Tailor Incentives to Essential Personnel to Remain at WRAMC until Closure	1-Apr-09	1-Apr-09		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.3
247	Analyze workforce for applicability of BRAC Incentives: Key Leadership & Gro	6-Oct-08	15-Feb-09		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.4
248	Develop Cost Estimates of BRAC Incentives	31-Jan-09	15-Feb-09		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.5
249	Submit Unfunded Finance Requirements	1-Apr-09	1-Apr-09		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.6
250	NARMC Submits POM for Funding thru 2011	NA	NA		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.7
251	Brief BRAC Incentives to WRAMC Command	NA	NA		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.8
252	Market BRAC Incentives	NA	NA		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.9
253	Implement BRAC Incentives & Adjust as Necessary (Ongoing)	NA	NA		McGlothlin, Barrow, Holloway, Morales	Transition Assistance: VERA, S	3	13.2.10
255	**Priority Placement Program (PPP)**			Rashid		Transition Assistance: VERA, S	2	13.3
256	Receive Manpower Doc (TDA)	NA	NA		Manpower	Transition Assistance: VERA, S	3	13.3.1
257	Define Key Position	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.2
258	Identify Key Positions	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.3
259	Identify Key Positions for PPP Waivers	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.4
260	ID & Request Initial PPP Waivers for Key Positions	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.5
261	Process PPP Waivers for Positions (Ongoing)	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.6
263	ID Eligible Employees for PPP	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.7
264	Brief Eligible Employees on PPP	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.8
265	Request Early PPP Registration as Appropriate	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.9
266	Register Eligible Employees in PPP	NA	NA		Morales, Nicholl,Wrighten, Relerford	Transition Assistance: VERA, S	3	13.3.10
268	**GPP**					Transition Assistance: VERA, S	2	13.4
269	Define GPP Coverage (Who's Covered under GPP?)	30-Dec-08	NA	Edmond	Edmond	Transition Assistance: VERA, S	3	13.4.1
270	Define transition sequence to include specific timing of GPP implementation	NA	NA	Edmond	Edmond	Transition Assistance: VERA, S	3	13.4.2
272	**3R Incentives**			McGlothlin		Transition Assistance: VERA, S	2	13.5
273	Collect Baseline Data for Incentive Usage across JOA	28-Feb-09	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid	Transition Assistance: VERA, S	3	13.5.1
	Collect Implementing instructions from DoD and Components	5-Jun-09	30-Jun-09		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid			
274	Apply Army Risk Matrix Methodology to incentives for JOA & Report to CHR Co	12-Mar-09	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid	Transition Assistance: VERA, S	3	13.5.2
	Develop JOA wide 3R Incentive Policy	5-Jun-09	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid			
	Present to HRC for Approval	NA	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid			
276	ID sources of Funding for Incentives	NA	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid	Transition Assistance: VERA, S	3	13.5.4
277	Implement new 3R Methodology	NA	NA		Morales, Nicholl,Wrighten, Relerford, Barrow, Rashid	Transition Assistance: VERA, S	3	13.5.5
280	**VERA/VSIP Workforce Shaping**			Morales/Relerford		Transition Assistance: VERA, S	2	13.6
281	Request Clarification of Army BRAC Policy for Expanded SIP	NA	NA		Edmond, McGlothlin	Transition Assistance: VERA, S	3	13.6.1
282	Eval Usage of VSIP Phase 2	NA	NA		Ehrbar, Robertson, Vaccaro	Transition Assistance: VERA, S	3	13.6.2
284	ID Positions/Grades that are Eligible for VSIP/VERA	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.3
285	ID Employees who are Eligible for VSIP/VERA	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.4
286	Conduct 2009 VSIP/VERA Survey amongst Eligible Employees	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.5
	Request VERA/VSIP Authority From DA				Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, SIP, GPP, PPP		
287	Offer 2009 VSIP/VERA to Personnel in Surplus Positions	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.6
288	Asses Results of 2009 VSIP/VERA Offering	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.7
289	Conduct 2010 VSIP/VERA Survey amongst Eligible Employees	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.8
290	Offer 2010 VSIP/VERA to Personnel in Surplus Positions	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.9
291	Asses Results of 2010 VSIP/VERA Offering	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.10
292	Conduct 2011 VSIP/VERA Survey amongst Eligible Employees	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.11
293	Offer 2011 VSIP/VERA to Personnel in Surplus Positions	NA	NA		Barrow, Emery, Wrighten, Relerford	Transition Assistance: VERA, S	3	13.6.12
295	**WRAMC Out-Placement Transition Center**			Barrow		Transition Assistance: VERA, S	2	13.7
296	Operate Out-Placement Transition Center at WRAMC	1-May-09			WRAMC	Transition Assistance: VERA, S	3	13.7.1
299	**Recognition**					Recognition	1	14
301	**Transition Recognition Plan**					Recognition	2	14.1
302	Create Program for Employee Recognition for Contributions to Transition	NA	NA		Nicholl, Morales, Tavares, Relerford	Recognition	3	14.1.1
303	Transition Recognition Plan Strategic Communications	NA	NA		Emery, Morales, Tavares, Relerford	Recognition	3	14.1.2
305	**Recognition Policies**					Recognition	2	14.2
306	Collect Recognition Policies across JOA	NA	NA		Nicholl, Morales, Wrighten, Relerford	Recognition	3	14.2.1
307	Analyze Existing Recognition Policies. ID Consistencies/Discrepancies & Reco	NA	NA		Nicholl, Morales, Tavares, Relerford	Recognition	3	14.2.2
308	CHR Council to Decide on Best Practices for Recognition across JOA	NA	NA			Recognition	3	14.2.3
309	Recognition Policies Strategic Communications	NA	NA		Emery, Morales, Wrighten, Relerford	Recognition	3	14.2.4
310	Develop & Deliver Training on New Recognition Policies	NA	NA		Emery, Barrow, Wrighten, Relerford	Recognition	3	14.2.5

ID	Name	Actual_Start	Actual_Finish	Lead	Resp	Group	Outline_Level	WBS
311	Implement New Recognition Policies	NA	NA			Recognition	3	14.2.6
314	**Other**					Other	1	15
316	**HR Execution Gap Analysis**					Other	2	15.1
317	Develop Reqm't Doc for HR Execution Resources Required for Transition	NA	NA	Edmond/McGlothli	Edmond, McGlothlin, Vaccaro, Robertson	Other	3	15.1.1
318	Perform Gap-Analysis (Existing versus Req'd Resources) for HR Execution Staf	NA	NA		Edmond, McGlothlin, Vaccaro, Robertson	Other	3	15.1.2
319	Submit Request for Funding to JTF	NA	NA		JTF	Other	3	15.1.3
321	**JTF CHR Plan of Action (This Schedule)**					Other	2	15.2
322	Develop JTF HR Plan of Action (Schedule)	1-Oct-08	17-Oct-08			Other	3	15.2.1
323	Update the JTF HR Plan of Action (Ongoing)	2-Dec-08	NA			Other	3	15.2.2
325	**Misc**					Other	2	15.3
327	Eval Joint PRA for Jan 2011 NSPS Payout	NA	NA		Edmond, Vaccaro, McGlothlin, Relerford	Other	3	15.3.1
329	Communicate Avail of PCS $ for Relocation within JOA (None)	NA	NA		Edmond, McGlothlin	Other	3	15.3.2
331	Issue Reqm'ts for IT support from DoD for HR Server/Database Transition	NA	NA			Other	3	15.3.3

Roles and Responsibilities of Civilian Human Resources Advisory Group Members

Members of the CHR Advisory Group are designated by their Commanders to support transition planning and execution for MHS civilian employees in the National Capital Region in order to fulfill the Guaranteed Placement commitment to Walter Reed employees.   The authority to determine policy and direct action in connection with civilian employees resides with the CHR Council. Members of the Advisory Group will serve as trusted advisors to the Council.

 Each Advisory Group member shall:
1) Based on his or her position expertise and organizational knowledge, bring relevant information to the attention of the Advisory Group and Council for consideration during the discovery and decision making processes.
2) Work with his or her command leadership and fellow Advisory Group members to clarify issues and concerns and to develop solutions or alternatives to resolve installation specific problems and challenges.
3) *Attend and participate in CHR Council meetings*.
4) Provide timely responses and deliverables as indicated in the CHR Project Plan.
5) Develop and maintain a network of installation contacts and deliver regular briefings based on strategic communication materials developed by the Advisory Group and approved by the Council.
6) Fully support the implementation of Council decisions.
7) Safeguard confidential personnel information and official Council information that is not yet ready to be released.
8) Participate in activities at other NCR MTF's to help build greater understanding of common regional goals.
9) Serve as a role model for regional thinking.
10) Provide written notice to the CHR Council Chairperson if he or she is no longer able to participate in the Advisory Group.

Roles and Responsibilities for full-time CHR Council support positions (Draft)

Duties Statement from YA-0201-02 for BRAC Implementation Advisor/HRM Consultant

Serves as the HRM Consultant for implementing Base Realignment and Closure (BRAC) decisions affecting healthcare organizations within the National Capital Area. Independently provides advice, guidance, reports, analyses and oversight on a wide range of HRM issues relating to BRAC implementation. Duties include:

a. Interpreting OPM, DOD and service-specific HRM policies and provides practical guidance on implementation
b. Identifying, gathering, analyzing and presenting quantitative data and qualitative information relating to HRM programs
c. Researching, analyzing and advising senior leaders, managers and program specialists on laws, rules, regulations and methods that may contribute to the successful completion of BRAC initiatives
d. Drafting and presenting a variety of correspondence, papers, and projects needed to successfully implement BRAC decisions
e. Participating on work groups and other teams seeking solutions to a variety of HRM related issues
f. Assessing effectiveness of initiatives and recommending changes to address shortfalls or evolving issues

The incumbents of these positions will be known collectively as the CHR Council Consulting Team. They will become a bridge between the current autonomous HR organizations and a future regional HR architecture by supporting the development and implementation of effective interim processes that allow employees and managers to being "practicing" regional HR.

JTF CapMed CHR Consulting Team will:
1. As a team, develop and maintain regional references for common use including
    a. A comprehensive list of regional contacts including designated POC's from regional MTF's and clinics. (2/5/09)
    b. A Consultant Handbook that contains consolidated reference materials from NNMC, WRAMC, DeWitt and 79th MedWing. (2/5/09)
    c. An agreed upon process and criteria for updating and maintaining the document repository in the JTF Portal. (2/5/09)
2. As a team, designate leads for specific task or program areas to streamline, align and focus work on Project Plan tasks and other regional initiatives. (1/26/09)
3. As a team, use Business Objects as the data mining and reporting tool in order to access and download data, develop reports and conduct necessary analysis as required. Collaborate on regional reporting.(ongoing)
4. Develop and maintain effective working relationships with designated installation POC's. Establish and carry out planned communication with designated stakeholders to ensure that they are receiving updated information and issues and

concerns are brought to the attention of the Advisory Group and Council as needed. (ongoing)

5. Submit assigned reports on time – ensure that work products are coordinated with HRM Consulting team members in advance to ensure complete staff work for presentation to the Council.
6. Provide monthly reports to the Council Chairperson on actions taken in connection with the CHR Project Plan. (ongoing)
7. Attend all Council, Advisory and Working Group meetings. (ongoing)
7. When assigned, attend meetings on behalf of the Special Assistant for Civilian Human Resources, JTF Cap Med. (ongoing)

JTF CapMed Civilian Personnel Strategic Communication Plan
DRAFT – January 15, 2009

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Background:

BRAC 2005 mandated the realignment of Walter Reed Army Medical Center, Washington, DC, as follows: relocate all tertiary (sub-specialty and complex care) medical services to National Naval Medical Center, Bethesda, MD, establishing it as the Walter Reed National Military Medical Center, Bethesda, MD; Relocate all non-tertiary (primary and specialty) patient care functions to a new community hospital at Fort Belvoir, VA.

To accomplish this transition, military members will be reassigned by their component commands to JTF CapMed's Joint Table of Distribution (JTD) manpower model, and the civilian workforce will follow their current workload. The civilian workforce transition is, by far, the more complex of these two actions and has required DoD-level decisions regarding civilian personnel systems, reporting requirements, and incentive programs.

In concert with the Departments of Army and Navy, the Undersecretary of Defense for Personnel and Readiness was tasked by the Deputy Secretary of Defense (DEPSECDEF) to oversee the development of a plan to maximize placement of Walter Reed Army Medical Center (WRAMC) civilian employees affected by the transfer of healthcare services under the BRAC process to the new Walter Reed National Military Medical Center (WRNMMC) and the new community hospital at Fort Belvoir.

Purpose

This communication plan represents the product of a collaborative effort from among all affected commands and their public affairs representatives to provide consistent and timely information for all stakeholders regarding the civilian personnel transition plan that has been approved by the services and JTF CapMed.

Communication Goal

To ensure that the information, guidance, and direction provided to the employees during the transition are coordinated and consistent, that there are established processes to ensure employee feedback is captured and considered, and to support the development and deployment of a regional civilian personnel culture in advance of the 2011 clinical migration.

Communication Strategy and Tactics

- All information related to the continued and future employment of civilian employees within the NCR will be linked with and aligned to the established Civilian Personnel Strategic Communication Plan. The JTF CapMed CHR Advisory Council will serve as primary coordinators of strategic communication messages and timing. JTF CapMed will make every reasonable effort to keep its Component Commands informed of any issues that may affect the current and future civilian workforce populations.

- Maintaining a synchronized administration schedule throughout the JOA is the key to the success of this plan. The synchronized schedule contained in this plan has been agreed to by the component commanders and will be executed simultaneously by them. JTF CapMed Public Affairs, under the guidance of JTF CapMed Leadership and subject matter experts (SMEs) will provide periodic information to Service Component leaders and MTF Commanders to assist with the implementation of this plan.

- JTF CapMed, Service, and MTF subject matter experts and leaders should make themselves available for news media interviews when requested or needed. All interviews will be coordinated by the appropriate Public Affairs Office, with Command approval.

- All JTF CapMed Component Commands will be involved in the production of this strategic communication plan.

- For each milestone or issue requiring communication, a variety of strategies/media will be selected to convey important key points. Communication channels may include:

    - JTF CAPMED Commander's Letter of Intent and subsequent communications

    - Press releases

    - JTF CAPMED Newsletter articles

    - JTF CAPMED and facility Web sites (2-way communication initiative)

    - Fact Sheets

    - Focus Groups (2-way communication initiative)

    - Surveys (2-way communication initiative)

    - Individual counseling availability (2-way communication initiative)

    - PowerPoint presentations

    - Suggested Installation Newspaper Articles

    - Suggested briefings for Commander's Calls/All-Hands gatherings

    - News Media interviews

    - Town Halls (2-way communication initiative)

    - Other material as needed

- **Key Milestones (notional) – Pilot for regional approach to filling supervisory positions**

Projected Date/s	Event	Target Audience/s	Recommend Public Affairs Approach
3/1/09 – 3/15/09	Strategy Mtg/JTF and Components	Component Commanders	Active (Informational)
3/15/09 – 3/31/09	Strategy Mtg/Component Commanders and MTF Commanders	MTF/Clinic Commanders	Active (Informational)
4/1/09 – 4/15/09	Town Hall	Civilian Workforce	Active
4/1/09	Staff Email	Civilian Workforce	Active
N/A	Survey	Civilian Workforce	Active
N/A	Focus Group	Civilian Workforce	Active
N/A	"Commander's Call," etc.	Civilian Workforce	Active
N/A	Job Fair	Potential Workforce (Recruiting)	Active
3/15/09 – 9/30/09	News Media Interviews	Civilian and Potential Workforce	Passive
3/15/09 – indef	Fact Sheets on Websites and Newsletters	Civilian and Potential Workforce	Passive

Assumptions

- This topic is of vital importance to the civilian workforce.

- Keeping rumors under control by ensuring a constant flow of information will be critical.

- Recruiters must be kept informed so that the future workforce receives messages consistent with the present workforce.

- MTF and Clinic staff stand to lose critical civilian employees if the employees don't agree with the decisions or the messages presented.

Responsibilities:

JTF CapMed:

a. Is the POC for the component commands on the Civilian Personnel Communication plan.

b. Will provide periodic communications to the Component Commands and MTFs regarding pertinent DoD information and updates as they occur.

c. Coordinates with Component Commands and MTFs for communication support related to the Civilian Personnel Communication plan.

Implementation:

The component commands agree to simultaneously execute this plan immediately upon the plan's unanimous approval by JTF CapMed and the component commands.

Talking Points

To be developed and archived as needed on a case-by-case basis**.**

JTF CapMed Transition Wargame Final Report

Joint Task Force National Capital Region Medical

March 5, 2009

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Contents

Executive Summary

Background

The primary mission of the Joint Task Force National Capital Region Medical (JTF CapMed) is to oversee the consolidation and realignment of military healthcare in the National Capital Region (NCR). The transition plan for such massive change in the NCR is complicated given that over 160 services will be relocated to multiple locations, no later than by the Base Realignment and Closure (BRAC) deadline of September 2011. Given the complexity of the challenge, a structured, holistic and multi-disciplinary approach to identify the relationships and interdependencies among the various functions and capabilities must be developed.

The transition involves more than the bricks and mortar. Rather, the vision for the region is the transformation of separate, service-specific MTFs into one integrated healthcare system that leverages the assets of all DoD healthcare treatment facilities in the NCR. The tri-service WRNMMC will be a world-class academic medical center at the hub of the nation's premier regional healthcare system.

Thus the transition requires a transformation of people, process, and technology to ensure success.

During the opening remarks of the JTF CapMed Transition Wargame, VADM Mateczun discussed the the historic significance of the wargame planning event, calling attention both to the magnitude of the task and the collective depth of experience of those involved. While he mentioned that the road ahead would be trying, at times, and require an immense effort, a focus on the four C's – Collaborate, Communicate, Coordinate and Compromise – would ensure the wargame's success.

Wargame Purpose

To begin this process of transformation, in February 2009, the JTF CapMed sponsored a strategic event, the JTF CapMed Transition Wargame, at the Bethesda Marriott in Bethesda, Maryland. The goal of the wargame was to mobilize WRAMC stakeholders to evaluate various strategies to transition existing services at WRAMC to their final location. The wargame was designed to meet the following objectives:

- Explore strengths, weaknesses and gaps of alternative courses of action (COA) for moving patients, staff and equipment
- Identify and analyze levers that may impact various timelines
- Identify stakeholders' concerns—obstacles and derailers—with potential COAs, suggestions, and next steps
- Identify a preferred COA to best ensure access to medical services in the NCR.

More than 130 stakeholders participated, representing a mix of component clinicians (e.g., WRAMC, DeWitt Army Community Hospital [DACH], and NNMC), command staff, JTF CapMed, administrators, logisticians, equipment planners, facility/construction experts, and patients. Throughout the four days,

stakeholders were assigned to one of five teams (inpatient, outpatient, diagnostic and ancillary services, administration, and patients) and were tasked with examining each COA and responding to specific questions.

Transition Courses of Action

Stakeholders evaluated three COAs that varied primarily in the duration of the planned move—ranging from an extended move of various services from as early as November 2010 and extending to August 2011 to moving all at once over the course of a long weekend in August 2011.

Each COA is described below:

COA One Multi-Phased Moves	Spreads the movement of WRAMC clinical and clinical support personnel over time, occurring as new buildings and renovated space are completed both at the new FBCH and at Bethesda. Movement occurs in four or five planned and executed moves for several services/departments at a time. NNMC internal moves as new construction and renovated spaces become available. Begins in December 2010
COA Two Workload Driven Move	Seeks to concentrate the transition in June 2011 to take advantage of a traditionally low inpatient census period and accommodate the PCS cycle One large move June 2011 for FBCH; second large move in August/September 2011 for WRNMMC
COA Three End-load Move	Primary move of WRAMC personnel occurs when all new and renovated facilities are completed. Considered as primary and contingency option in case of extended construction or other delays. WRAMC personnel ideally move over a four-day weekend at the end of August 2011
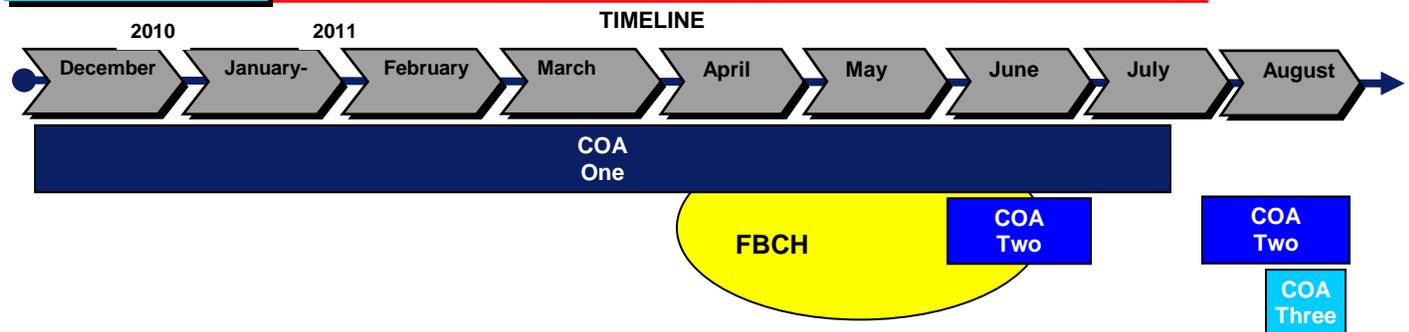
TIMELINE

2010: December | January- | February | March | April | May | June | July | August :2011

COA One (December – July)
FBCH
COA Two (June)
COA Two (August)
COA Three (August)

All courses of action operate within a set of planning assumptions:

- Continuity of care will be 100 percent assured throughout the transition with minimum interruption in health service delivery. While consideration may be given to sending patients out to the network on an as-needed basis, this practice will be the exception, not the rule. The goal is to maintain the care of all WRAMC primary beneficiaries within the NCR to the greatest extent possible.

- WRNMMC and FBCH will be governed and operated as joint integrated facilities. While the precise governing authority and lines of reporting have yet to be determined, the two new MTFs will operate seamlessly in governance and operations.

- All certification, equipment testing, equipment training, and support system setup will be completed before the first patient day. All activities relating to the installation, setup, and operation of both fixed and moveable equipment will occur in advance of any major patient moves from WRAMC.

- **Accreditation will be maintained or achieved.** The JTF will work with accrediting bodies, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Accreditation Council for Graduate Medical Education (ACGME), ensuring that the WRAMC transition does not impede or negatively impact accreditation.

- **All staff training, including conducting "day-in-the-life" exercises (as necessary), will have been completed before the first patient day.** Day-in-the-life and other staff training will be conducted months prior to the first patient day, ensuring that staff have full knowledge and understanding of the "new" facility's layout, equipment, processes, etc.

- **A strategic communication plan will be executed.** A comprehensive strategic communication plan will be developed and executed, with appropriate messaging for all stakeholders impacted by the WRAMC move, including WRAMC patients, their families, personnel, and the community.

- **Transition moves occur during times that minimize patient and staffing disruptions.** The physical movement of patients will occur ideally over a long weekend and/or at times to leverage a low patient census.

- **Resources ensuring the viability of the preferred course of action will be provided.** Funding supporting an extended weekend move, beefed up staffing during the transition, extra shuttle services for patients, etc will be provided to support the smooth efficient transition of patients.

- **All WRAMC primary beneficiaries will be accommodated in their final healthcare "home" by the BRAC deadline**

Data Analysis

To inform the transition process, each stakeholder team reviewed and analyzed data, including the following:

- The Fort Belvoir and Bethesda construction completion schedules for each service
- Construction staging diagrams
- A list of major equipment requiring a long lead time
- A list of services showing independencies
- Warrior care diagnoses data.

This data review clearly validated the following constraints significantly impeding the ability to move patients out of WRAMC any earlier than April 2011:

- Due to the construction completion schedule, the new FBCH outpatient care can begin no earlier than April 4, 2011
- FBCH inpatient services cannot operate until June 2011
- WRNMMC expanded capacity for inpatient services will not be operational until August 2011
- The Warrior Transition Unit (WTU) barracks, staff parking, and new Walter Reed administrative offices will not come online (assuming RFP2 funding) until August 2011, at the earliest.

Armed with this information, the stakeholder groups discussed the strengths and challenges of each COA, in detail, considering the following criteria shown in Table ES-1.

Table ES-1. Transition Course of Action Criteria

Criterion	Definition
Maintain Patient Safety and Quality of Care	▪ Provide quality healthcare that is free from accidental injury due to medical care or medical errors ▪ Remain compliant with the Patient Safety and Quality Improvement Act of 2005 ▪ Maintain and utilize qualified staff ▪ Promote an environment that maintains patient confidentiality ▪ Develop and implement activities that will improve patient safety and the quality of healthcare delivery
Provide Full Access to Services Throughout	▪ Provide a full range of services to all patients (ability and capacity), which may include, but is not limited to, specialty services, diagnostic testing, and substance abuse treatment
Minimize Impact on Graduate Medical Education/Health Professions Education	▪ Maintain quality education and training programs for interns, residents, and fellows ▪ Remain compliant with all policies and procedures with the Accreditation Council for Graduate Medical Education's (ACGME) Institutional and Program Requirements
Promote Patient Satisfaction	▪ Provide a patient-centered environment that exudes trust, professionalism, responsiveness, and quality care
Promote Transition	▪ Minimize disruptions and adverse impact on staff ▪ Meet all targeted dates and construction deadlines

Results

After four days, the consensus among all stakeholder groups was the following:

▪ Belvoir and Bethesda internal moves should occur as new and renovated space comes online
  – For Bethesda, that movement occurs from spring 2009 through August of 2011
  – For Belvoir, patients move from DACH to FBCH in April 2011 for outpatient services and diagnostic care and in June 2011 for inpatient care

▪ WRAMC functions transition to Belvoir and Bethesda over a compressed timeframe, ideally over one long weekend in late August/Early September, following completion of several key trigger activities at Bethesda including:
  – Parking garages, Warrior Transition Center Complex, inpatient renovations, administrative complex
  – Equipment installation, certification, testing, training
  – Support system setups and commissioning
  – Building systems commissioning
  – Staff training, including "day-in-the-life" exercises
  – All critical Joint LOOs are resolved and in place
  – Mitigation Strategies (See Table 7)
  – Attrition of inpatient census.

The wargame participants noted the following benefits of a late August/early September move for WRAMC during a compressed timeframe (i.e. over a long weekend). Such a move:

▪ Eliminates multiple risks of critical interdependency breakage across a protracted array of moves

- Best promotes procedural volume, staff supervision, and interdependencies at WRAMC to ensure Residency Review Committee (RRC) accreditations
- Best ensures clinical accreditations (blood bank, radiology, The Joint Commission, etc.)
- Optimizes access to clinical services, patient satisfaction, continuity of care
- Minimizes risk of loss of patients to civilian sector.

Wargame Decision Brief

February 6th, the principle directors of the Clinical Transition War Game Exercise met with other senior leaders in the National Capital Area having joint oversight of the WRAMC transition. Attendees included: VADM Mateczun, Commander of CapMed JTF, BGen Volpe, JTF Vice Commander, Col Wardell, JTF Chief of Staff, MGen Hawley-Bowland, NARMC Commander, Col Jones, NARMC Chief of Staff, Col Coots, WRAMC Commander, Col Damiano, WRAMC Deputy Commander for Integration, Col Jolissaint, WRAMC Director of Transition, Capt Valentin, Navy NCA Chief Of Staff , Capt Zinder, NNMC Deputy Commander for Operations, Col Moores, NNMC Deputy Commander for Integration, Col Callahan, Commander of Dewitt Army Community Hospital, Col Bulick, JTF Director of Logistics, Capt Berry, JTF Director of Operations, Col Argyros, JTF Director of Medical Education, and Ms. Regina Little, lead JTF Transition Support Contractor.

Attendees discussed the results of the War Game Exercise and debated the way forward. Group consensus was that, other than by exception, services should not transition from WRAMC to WRNMMC and FBCH until all critical trigger activities are completed at the Bethesda campus and/or mitigation strategies are leveraged. A key trigger activity is ensuring that are essential clinical and supporting services are in place and fully functional. Several facilities including staff parking garages and the Warrior Transition Center Complex are not expected to be ready for occupancy until late summer 2011. The consensus of the group was that it would be an unnecessary risk to attempt to transition patients and staff with construction contractors spread across the Bethesda installation and inadequate staff parking.

Following completion of all critical trigger activities, delivery of a "quick" transition is desired. While advantageous to shift services in phases, over a longer period of time, the group discussed the presumed industry standard to transition whole services all at once, i.e. over one long weekend. It was even suggested that to do otherwise would, in medical parlance, be going "off standard." CJTF, VADM Mateczun essentially agreed with this position but directed the transition team to provide supporting case studies[1] and develop a detailed execution plan for all precedent activities and mitigation strategies required to facilitate a smooth transition.

The most critical precedent and preparatory actions that must be in place prior to support an "all at once" move are enumerated as follows in Table ES-3.

Table ES-3. High Priority Preparatory Transition Actions

Action	Targeted Completion
Finalize equipment reuse plan	March-09
Approve funding for IM/IT plan execution	Mar-09
Finalize resource REQ Plan (Staff) for North and South	Mar-09
Finalize WRAMC IM/IT migration plan for North and South	Mar-09
Put in place equipment acquisition strategy and contracts with the capacity to support transition	Apr-09
Develop, populate and finalize JTD	Apr-09
Ensure EBD Technology and Lifecycle Management (ACQ Plan for equipment APR 2009)	Apr-09
Develop MHS Network Infrastructure (Fiber Optic Ring) Plan	Apr-09
Develop strategy to mitigate patient health information (PHI) and personally identifiable information (PII) risk	May-09
Ensure DACH Data Center Design and Procurement	Jun-09
Finalize DACH migration plan	Jun-09
Implement joint business plan for healthcare operations	Jul-09
Test and refine software system for referral management and patient appointing	Jul-09
Establish single privileging body	Sep-09
Develop a JOA-wide enrollment plan	Oct-09
Renovate North Data Center Project	Apr-10
Identify essential military staff that would stabilize (freeze) and stop-move	Jun-10
Develop new position descriptions for the new campuses	Jun-10
Develop JOA IM/IT standard business rules and policies by June 2010	Jun-10
Draft COA 3 logistical execution plan	Jul-10
Fully execute all modules of DMHRSi	Jul-10
Deliver training and orientation plan for staff moving to a new facility	Jul-10
Renovate South Data Center Project	Sep-10
Implement joint (mirror) SOPs and business processes	Oct-10
Assign common governance to maintain accreditations	Oct-10
Ensure that all clinical areas document care in single electronic system	Oct-10
Implement DOD civilian manning model	Oct-10
Ensure JOA portfolio integration, including applications and systems	Jan-11
Create hospital ID badges in advance (security)	Jan-11
Attempt to purge and archive files/records/inventory proactively	Mar-11
Implement and/or expand joint recruiting and retention plan	ASAP

Background

In the 2005 amendment to Public Law 101-510, the Defense Base Closure and Realignment Act of 1990 (BRAC LAW), recommendations were made to realign certain Walter Reed Army Medical Center (WRAMC) activities from Washington, DC to the National Naval Medical Center (NNMC) in Bethesda, Maryland. When implemented the existing WRAMC will close and the NNMC will be renamed the Walter Reed National Military Medical Center (WRNMMC) at Bethesda, Maryland.

To oversee the consolidation and realignment of military healthcare in the National Capital Region (NCR), the Joint Task Force National Capital Region Medical (JTF CapMed) was established in September 2007. As part of the BRAC implementation, the current state of healthcare delivery in the NCR—with its two large medical centers and two hospitals with service-specific staffing—will be transformed. In short, by September 15, 2011, the Walter Reed Army Medical Center (WRAMC) will cease its operations, and all of its components will be relocated. This consolidation and realignment will result in one large medical center (the new Walter Reed National Military Medical Center [WRNMMC] in Bethesda, Maryland), one large hospital (the Fort Belvoir Community Hospital [FBCH] in Fort Belvoir, Virginia), and one outpatient clinic (the Malcolm Grow Clinic at Andrews Air Force Base, Maryland), all with joint staffing. Both the new WRNMMC and the new FBCH, currently under construction, are scheduled for completion prior to the BRAC deadline.

Achieving BRAC objectives depends on the successful management and integration of a portfolio of projects and schedules at the receiving MTFs: the new WRNMMC at Bethesda, the FBCH at Fort Belvoir, Virginia and the closing location at WRAMC in Washington, DC. Because the new facilities will not come online simultaneously, careful consideration of transition options and opportunities is required. All factors associated with the design, construction, outfitting, manpower planning, clinical practice, operations, and move must be flawlessly planned, budgeted, coordinated, scheduled, and executed.

Both the new FBCH and the new WRNMMC are currently under construction and are scheduled for completion prior to the BRAC deadline. However, the transition of WRAMC to these new facilities is no easy task:

- First, the clinical transition is extremely complex and must be flawlessly planned and skillfully executed. M160 unique services/departments must be relocated to one or both resulting military treatment facilities (MTFs).

- Secondly, the construction completion dates vary significantly between the new facilities, creating clinical and logistical challenges.

- Third, the transition involves more than the bricks and mortar. Rather, the vision for the region is the transformation of separate, service-specific MTFs into one integrated healthcare system that

leverages the assets of all DoD healthcare treatment facilities in the NCR. The tri-service WRNMMC will be a world-class academic medical center at the hub of the nation's premier regional healthcare system.

For these reasons, the transition requires a transformation of people, process, and technology to ensure success.

This report describes the wargaming event conducted on February 2–5, 2009, to evaluate various transition strategies and their implications. It examines in detail the wargaming participants' discussions of these strategies, and based on their discussions and analysis, presents the preferred, recommended course of action (COA) for transitioning existing services at the WRAMC to their final location. The remainder of this report is organized as follows:

- Statement of wargame purpose, objectives, and outcomes

- Description of wargame approach, including the procedure, schedule, stakeholder teams and their composition, the courses of action considered, assumptions, and the limitations/challenges of the wargaming approach

- Analysis and comparison of COAs, by stakeholder team, along with their recommended course of action

- Preliminary requirements for making the recommended COA successful

- Next steps to consider in the transition planning process.

Wargame Purpose

To begin the process of transformation, the JTF CapMed sponsored a strategic event, the JTF CapMed Transition Wargame, at the Bethesda Marriott in Bethesda, Maryland from February 2–5, 2009. The goal of the wargame was to mobilize WRAMC stakeholders to evaluate various strategies to transition existing services at WRAMC to their final location. The wargame was designed to meet the following objectives:

- Explore strengths, weaknesses and gaps of alternative courses of action for moving patients, staff, and equipment

- Analyze and identify levers that may impact various timelines

- Identify stakeholders' concerns—obstacles and derailers—with potential COAs, suggestions, and next steps

- Identify a preferred COA to best ensure access to medical services in the NCR.

The wargame brought together participants to collaboratively address core issues surrounding the transition planning involved with the closure of WRAMC. The emphasis was on providing a comprehensive analysis of alternatives for the transition planning and scheduling timelines for both clinical and non-clinical moves.

During the wargame, participants grappled with what would be the "best" COA for moving patient, staff, and equipment and the consequences of that action as it relates to the move, as well as identified next steps to improve coordination and capabilities to ensure quality healthcare throughout the transition. It was the hope that the wargame would not only result in being able to maintain patient safety and quality healthcare, but also in addressing the priorities and concerns of the stakeholders about the transition of services from the current WRAMC to multiple locations.

What Is Wargaming?
Wargaming is a powerful process for thinking about the future that challenges conventional wisdom and allows participants to break with "known truths" and past assumptions. The basic assumption is that the old rules don't apply any more—and most players don't know what the new rules will be. A wargame provides dynamic interaction among stakeholders in a realistic environment. It allows analysis of alternatives "under fire" while compressing months or years into days. It acts as a catalyst, invokes intuition, and encourages creativity to deliver an integrated perspective—a shared vision of the direction that should be pursued. In this case, it is designed to help create a shared vision of the transition timeline to be implemented for executing the BRAC business plans, while ensuring the effective and efficient delivery of world-class military healthcare to the NCR.

Wargame Approach

Wargames provide an opportunity to evaluate alternative COAs in a realistic environment, with actual stakeholders, under a compressed schedule. The JTF CapMed wargame, which took place over four days, explored three options for the transition from the WRAMC to the WRNMMC. This section describes the overall approach for the wargame, including the procedure, schedule, the stakeholder teams and their composition, the COAs considered, assumptions, and the limitations/challenges of the wargaming approach.

Wargame Procedure

Wargame play of each COA consists of a four-part process described as follows:

- Phase 1: Play begins with the Control Team briefing the plan and state of the transition to be considered to all participants during the plenary session. Teams are also provided essential data on each department and where it stands, along with summary totals for staffing, patients, etc. at each site. Additional data provided to participants included JTF background, a list of interdependent services, inpatient bed utilization and occupancy rates by facility and ward, manpower information, risks and issues, construction and site utilization, and a glossary of terms.

- Phase 2: Play continues in breakouts where teams modify COAs if needed. Each team meets in its breakout to consider the state of the transition from its assigned stakeholder point of view. During this time, teams may query other teams or negotiate changes to the COA (meetings are limited to representatives of the concerned teams and up to 10 minutes). Communication between teams can occur via e-mail or face to face. Breakouts typically last two hours.

- Phase 3: Stakeholder teams brief their decisions—and the rationale for any changes to the COA to all participants during a plenary session. This briefing includes each team's assessment of the (modified) COA to meet the criteria for success. Within the time allotted for the session, limited question and answer may follow. This part of the process lasts no more than about an hour.

- Phase 4: Following completion of each COA, the Control Team assesses the impact of the COA against each of the five criteria using established scoring guidelines (see Courses of Action Scoring Criteria). During the wargame, this activity provides a "scorecard" of the COAs under consideration. The Control Team also identifies the strengths and weaknesses of each COA.

Wargame Schedule

The wargame was conducted Monday through Wednesday February 2nd – 4th, 2009, followed with a debrief on Thursday, February 5th.   Below are brief descriptions of each day of the wargame:

- Day 1: The first day of the wargame consisted of VADM Mateczun making opening remarks to wargame participants followed by an afternoon breakout session where stakeholder teams critically evaluated the first phase of COA 1.

- Day 2: The second day consisted of three breakouts sessions evaluating the second phase of COA 1, the strategies to make COA 1 successful, in what ways COA 1 is harder or easier than COA 3, and the risks and mitigation strategies specific to COA 3. After the teams modified COA 1 during wargaming, the Control Team eliminated COA 2 from consideration, determining that it was redundant with COA 1.

- Day 3: The third day focused on the timeline for transition, and in particular, how the timeline could be adjusted to make COA 3 successful. The breakout session on this day also explored additional strategies for mitigating the risks associated with COA 3.

- Day 4: The fourth day included a debrief and a request from VADM Mateczun to modify COA 3 and brainstorm which services could potentially be moved earlier in the transition.

Figure 1 depicts the wargame agenda and identifies the stakeholder groups that participated in each session.
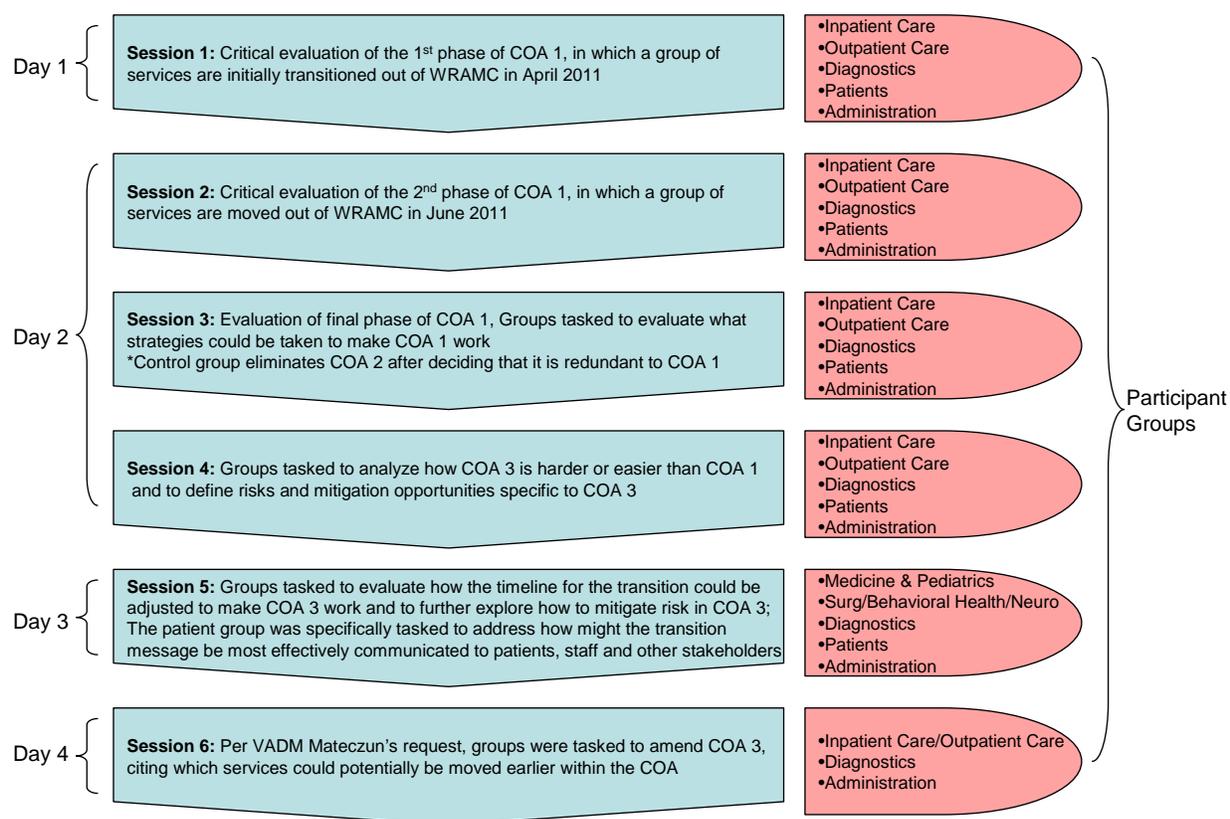
Figure 1. Wargame Breakout Session Agenda and Participant Groups

Stakeholder Teams and Composition

Wargame participants were assigned to teams that represent key perspectives for the transition. The JTF CapMed wargame involved six stakeholder teams, each of which represented one of the following stakeholder points of view:

- **Inpatient Care.** This stakeholder point of view represents a healthcare environment that cares for patients whose conditions require hospitalization for a minimum of one night and who are formally admitted. It represents all healthcare providers involved with caring for and treating these patients (e.g., doctors, nurses, practitioners, staff, etc.).

- **Outpatient Care.** This stakeholder point of view describes medical care or treatment that does not require an overnight stay in a hospital or medical facility (e.g., outpatient clinics, emergency room, etc.). It represents all healthcare providers involved in caring for and treating these patients (e.g., doctors, nurses, practitioners, staff, etc.).

- **Diagnostic and Ancillary Services.** The stakeholder point of view refers to services provided to patients to assist in the diagnosis or treatment of an illness or injury. It represents laboratory support services, imaging, and pharmacy in inpatient and outpatient settings.

- **Administration.** This stakeholder point of view consists of the managerial personnel who implement policies and direct activities at a hospital. It represents the Bethesda Hospital Command Group, the DeWitt Army Hospital Command Group, the Walter Reed Hospital Command Group, staff, case managers, etc.

- **Patients.** This stakeholder point of view can be described as any individual who receives medical attention or treatment. It represents all patients (e.g., inpatients, outpatients, service members) and their families.

- **Control Team.** This point of view oversees the wargame, assesses impact, and evaluates each COA against success criteria. It represents all other parties (e.g., the White House, the Joint Commission on Accreditation of Healthcare Organizations [JCAHO], the Bureau of Medicine and Surgery [BUMED], Public Affairs Officers [PAOs], JTF, etc.) in the wargame.

Figure 2 not only depicts these stakeholder points of view, but also the layout and proximity of these teams to each other during the wargame.
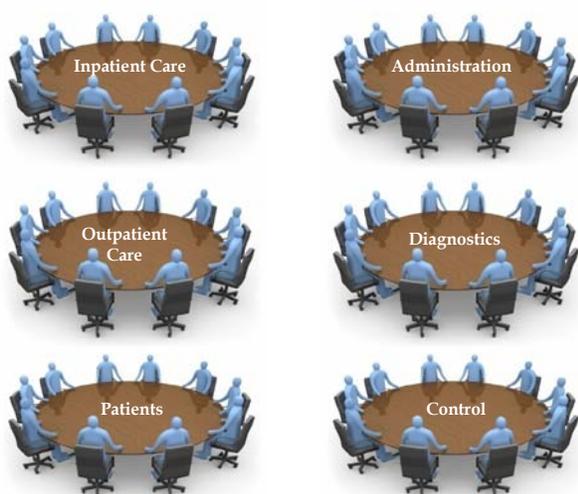
Figure 2. Stakeholder Team Layout

Stakeholder teams consisted of a cross-organizational, cross-functional mix of about 20 participants. Participants included healthcare providers and patients and staff from the WRAMC, DeWitt Army Community Hospital (DACH), National Naval Medical Center (NNMC), Fort Meade, and Malcolm Grow Medical Center.

These teams focused on assessing the transition from each of the key perspectives in a holistic manner across the facilities. Participants were instructed to "wear one hat" throughout the dialogue—and to devote their energies to thinking through the issues from that perspective.

Changes to a COA or to the underlying assumptions to better accommodate one stakeholder needed to be negotiated with the other stakeholders in an attempt to "find common ground." At critical points for each COA, each team, from *their one stakeholder perspective*, assessed the transition state on the ability of *all facilities* to deliver safe, quality care and ensure access. If a team identified better trade-offs

to make in the transition, the team informed and/or negotiated changes to the COA with the other stakeholder teams.

Teams were able to assess each COA against scoring criteria, identify the strengths and weaknesses of each COA, and provide recommendations to modify the COA accordingly.

Each team was led by a facilitator with clinical proficiency who helped guide the team through the discussion and questions from the Control Team to better assess the COA, interact with other stakeholder teams, share concerns, and document actions and insights.

Table 1 lists the wargame's participants by stakeholder team.

Table 1. Wargame Participant List

Outpatient Care	Inpatient Care	Administration
Jennifer Allen	Greg Argyros	Lea Beilman
David Bartoszek	John Brune	Patti Boone
Dale Christopher	Thomas Burklow	Terrance Branch
Art DeLorimier	Charles Callahan	Tracy Cusick
Brian Hayes	Brooks Cash	Kathleen Ford
Dennis Kellen	Rosemarie Edinger	Daniel Gall
Charles McQueen	Paul Florentino	Susan Galloway
Raymond Nudo	Martha Girz	Vinette Gordon
John O'Brien	Ernest Lockrow	Lela King
Paul Pasquina	Douglas Onkst	Frank Rowland
Kevin Quinn	Chris Reed	Catherin Simpson
Chris Rheney	John Scott	Kevin Smith
Jay Riddle	Cheryl Taylor-Whitehead	Philip Purdue
Timothy Strickland	Clyde Abbott	Marc Rattigan
Mr. Dunbar	Ann Andrews	Col Rice
Phil Federle	Dave Barber	Barbara Ryan
Julie Hall	Lori Carlson	Terri Sharp
Bill Hatcher	Christopher Castle	
Chris Jahrling	Catherine Cramer	
Sally Ann Jarvis	Michael Dake	
David Johnson		

Patient	Diagnostic & Ancillary Services	Control
John Bradley	Thomas Baker	Rick Bond
Norman Charboneau	Linda Blackman	John Bulick
Debra Edmonds	David Bobb	Lou Damiano
Suzie Farley	Bob Braunagel	Patricia Haley
Teri Hassell	Mcihael Brazaitis	Mary Jane Herden
Wanda Richards	Alison Castro	Barbara Jefts
Terri Shelton-Phillips	Cecilia Dowers	James Jolissaint
Robert Stewart	Cheryl Evans	Leon Moores
Sarah Wade	Carrol Grant	Richard Repeta
Thomas Winthrop	Kurt Hummeldorf	
Marc Harris	Janie Lott	
Terry Lewis	Janice McCreary-Watson	
Jim McGowan	John Ralph	
David Mudrik	Stephen Sears	
John Murray	John Spain	
Bernadette Niter	Lori Sydes	
Maureen Padden	Reinaldo Vaillant	
Thomas Winthrop	Jeffery Vaughn	
SME/Floater		
Susan Baker	Pamela Giza	David Oliveria
Gabriel Brown	Kristi Kelly	Felicia Pehrson
LaShanda Cobbs	Jamie Kersten	
Norvell Coots	Jeff Longacre	
Paolo Fleurant	Eugene Monroe	
Dave Fortune	Adrian Morales	

Courses of Action Considered

This wargame considered the following COAs for transitioning the existing services at WRAMC to their final location:

- COA 1 – Multiphased Moves. COA 1 represents a multiphased approach that spreads the transition from WRAMC over a 6-8 month period. Moves would occur as new buildings and renovated space are completed and as they become available at both the new FBCH and at WRNMMC. COA 1 would most likely occur as four or five planned and executed moves for several services/departments. This COA could begin as early as December 2010. Most likely, the first wave of moves would be spread across April through July 2011 and the second wave of transition moves would occur from July through September 2011.

- COA 2 – Workload-Driven Move. COA 2 represents a workload-driven approach that seeks to concentrate the transition in one large move during June 2011. This strategy minimizes the timeframe between the first transition wave and the end of transition, while it also aims to transition as many services as possible prior to the end of June. The driving feature of this scenario is the desire to best facilitate the Graduate Medical Education (GME) cycle by having all GME providers in place by July. Additionally, this option takes advantage of the typical trough in inpatient census during June and respects the traditional military personnel Permanent Change of Station (PCS) cycle.

- COA 3 – End-Load Move. COA 3 represents an end-load approach that primarily makes the move when all new and renovated facilities are completed and available. This option was considered as the

primary and contingency option in case of extended construction or other delays. Ideally, this move would take place over a four-day weekend at the end of August 2011.
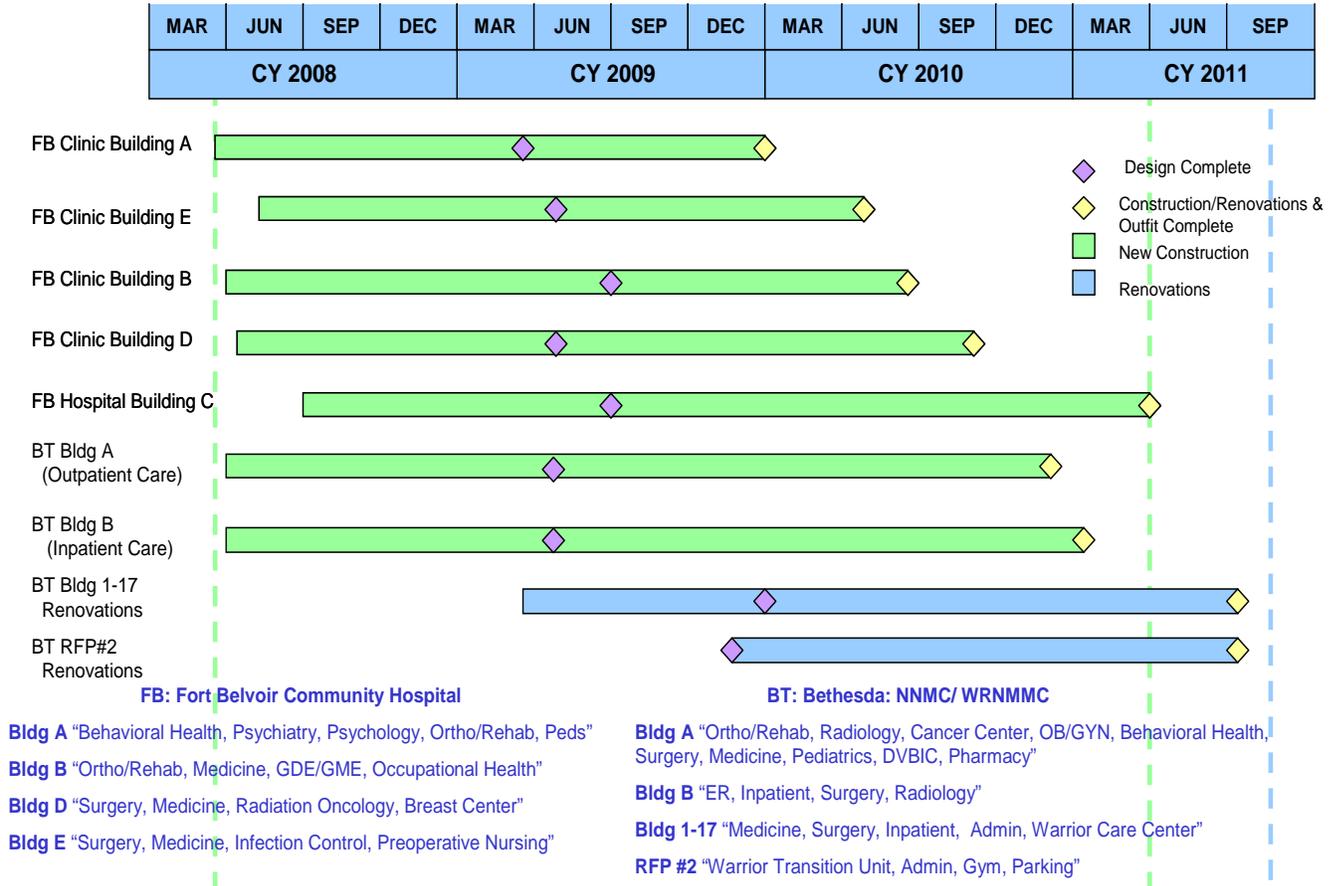
Figure 3. Construction and Outfitting Schedules with Major Milestones for Fort Belvoir Community Hospital and Walter Reed Military Medical Center

Courses of Action Scoring Criteria

All teams answered questions to assess the three transition options based on established criteria. These criteria provided a common lexicon for success and help teams select the best COA for the transition. Table 2 lists these criteria.

Table 2. Transition Course of Action Criteria

Criterion	Definition
Maintain Patient Safety and Quality of Care	▪ Provide quality healthcare that is free from accidental injury due to medical care or medical errors ▪ Remain compliant with the Patient Safety and Quality Improvement Act of 2005 ▪ Maintain and utilize qualified staff ▪ Promote an environment that maintains patient confidentiality ▪ Develop and implement activities that will improve patient safety and the quality of healthcare delivery
Provide Full Access to Services Throughout	▪ Provide a full range of services to all patients (ability and capacity), which may include, but is not limited to, specialty services, diagnostic testing, and substance abuse treatment
Minimize Impact on Graduate Medical Education/Health Professions and Education	▪ Maintain quality education and training programs for interns, residents, and fellows ▪ Remain compliant with all policies and procedures with the Accreditation Council for Graduate Medical Education's (ACGME) Institutional and Program Requirements
Promote Patient Satisfaction	▪ Provide a patient-centered environment that exudes trust, professionalism, responsiveness, and quality care
Promote Transition	▪ Minimize disruptions and adverse impact on staff ▪ Meet all targeted dates and construction deadlines

Wargame Assumptions

Key assumptions guided the wargaming event and included the following:

▪ Continuity of care will be 100 percent assured throughout the transition with minimum interruption in health service delivery.

▪ The WRNMMC and FBCH will be governed and operated as joint integrated facilities.

▪ Both military treatment facilities (MTFs) will not exceed BRAC and environmental impact statement (EIS) staffing caps.

▪ All certification, equipment testing, equipment training, and support system setup will be completed before the first patient day.

▪ Accreditation will be maintained or achieved.

▪ All staff training, including conducting "day in the life" exercises (as necessary) will have been completed before the first patient day.

▪ A strategic communication plan will be executed, ensuring that patients receive full and advance notification of pending moves.

▪ Resources ensuring the viability of the preferred COA will be provided, i.e., funding supporting an extended weekend move, increased staffing during transition, extra shuttle services for patients, etc.

▪ Transition moves will occur over the weekend, and/or during times of lower hospital capacity, minimizing patient and staffing disruptions to the greatest extent possible.

- All WRAMC primary beneficiaries will be accommodated in their final healthcare "home" by the BRAC deadline.

Challenges and Limitations to the Approach

While the wargame process and outcome were successful, there were several mitigating limitations:

- Wargame was limited to clinical transition planning. Effectively transitioning to a new hospital requires patience, planning, perseverance, and coordination of two types of activities:

    - Clinical transitioning – Ensuring that people, processes, and technology come together in a way that provides seamless, effective, high-quality care, from day one of occupancy in the new location

- Physical transitioning – Managing the activities associated with the "physical" move of patients, people, furnishings, and equipment to receiving locations.

    The JTF CapMed wargame focused solely on aspects of clinical transitioning, with the emphasis on sequencing the transition of services in a way to ensure continuity of care and patient safety. Additional planning and wargaming will take place in the coming months and years to assess and finalize the manner in which the physical move will occur.

- Not all data was available to inform decision making. While considerable data was available regarding the construction schedule, service locations, workload, and staffing requirements, data was not available to fully assess specific capacity scenarios and options, including wounded warrior care needs and options, equipment reuse opportunities, etc.

    In lieu of such data, assumptions were made based on clinical and administrative expertise with the understanding that further analyses will be completed over the next few months to validate assumptions and refine the clinical transition plan.

Wargame Analysis

The insights presented in this section represent a summary of discussions that took place during the wargame. These insights represent major findings, concerns, and opportunities, as raised by or resulting from participant engagement in this dynamic activity.

Most discussion focused on challenges associated with moving services in a phased approach. While some services such as the OR and cardiology *could* move as early as January of 2010, related and interdependent services such as the inpatient medical surgical services, and cardiac rehab will not be constructed and outfitted until August of 2011. Examples of such interdependencies are depicted in the chart below.

WRAMC to WRNMMC Challenges

Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

PACU
ORs
Anesthesia

Radiology
Pharmacy

Cardio Thoracic
Cardiology
Cardiac Cath

OB/GYN Services

Adult Inpatient Psych

Adult Outpatient Psych
Adolescent/Children's
Partial Hospitalization

All Outpatient
Physical Medicine

Outpatient Pediatrics
& NICU

50 ICU Beds
Historic Peak = 23

FBCH
Comes On-line

>200 Med/Surg Beds
Historic Peak <200

Med/Surg Units

Neuro-Surgery
Vascular-Surgery
Organ Transplant

Cardiac Rehab
Pulmonary
ICHP

Women's Invitro

Preventive/Consultative
Psychology

WTC Dorms
WTC Case Mgt
WTC Support Ctrs

Inpatient Phys Ther

Inpatient Pediatrics
Sedation/Procedures

Admin Facilities

Booz | Allen | Hamilton

21
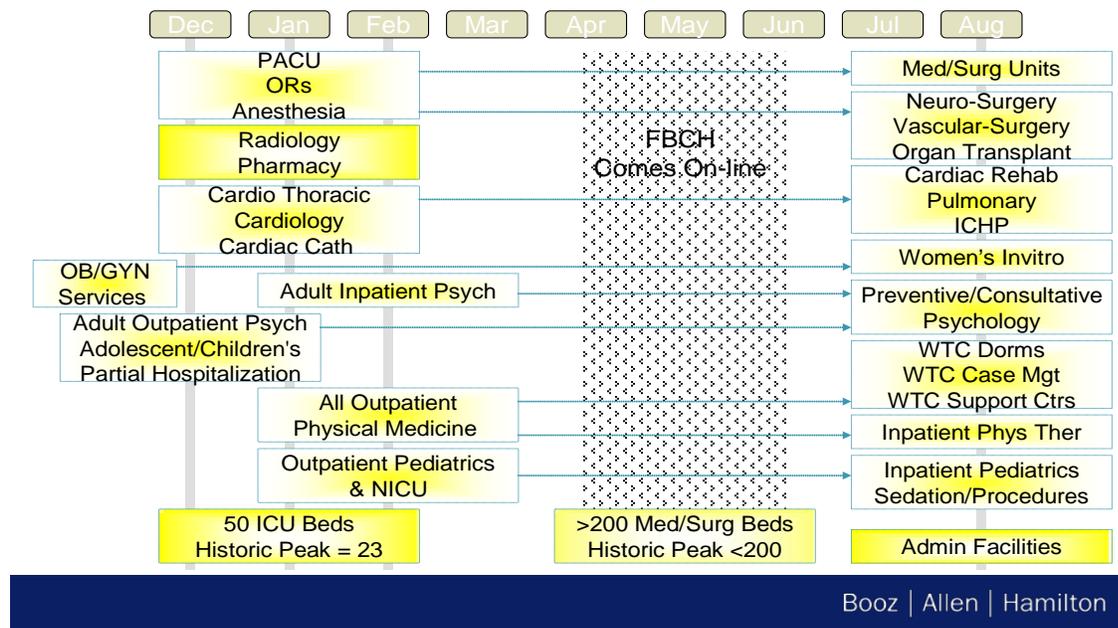
Considerable analysis and discussion resulted in the following comparison of COA 1 and COA 3, as well as their preferred COA for the transition.

Summary of Team Analyses

Various risks and mitigation efforts surrounding an incremental move were discussed during the wargame, which gave way to strategic thought and critical planning needs. Such discussion included the risk of losing Residency Review Committee (RRC) accreditation due to the loss of procedural volume, loss of staff supervision, and the loss of interdependencies at WRAMC. Basically, the consensus was that the longer the transition, the more the risk. A coordinated and synchronized clinical transition plan that ensures consideration of interdependencies could mitigate such risk. Another mitigating effort includes incorporating input from the RRCs into the "staff" plan to make certain that accreditation requirements are being met.

Similarly, another risk with an incremental move is the risk of losing clinical accreditations (e.g., blood bank, radiology, The Joint Commission, etc.). Again, the consensus was that the longer the transition, the more risk is involved with losing accreditation. In addition to involving accrediting agencies in the "staff" transition plan, another mitigation effort would be to have a single governance for the two MTFs. This solution would help in standardizing communication and developing common NCR-wide policies and procedures.

In addition, COA 1 spreads out the "inconvenience factor" for access to clinical services over a five-month period. This transition spread has the potential of decreasing patient satisfaction, decreasing the continuity of care, and increasing patient loss to civilian providers. Mitigation efforts for the inconvenience of a spread-out transition include developing a central appointing system and implementing effective STRATCOM messages to both internal and external community stakeholders (a longer move would require more STRATCOM messages to be sent out).

In contrast, the reuse of equipment is a somewhat more challenging risk during the COA 3 transition option. Because of the compact nature of COA 3, the process of reusing equipment would be under a tighter deadline and could potentially lead to less opportunity for re-use. Spreading out the transition timeline would increase the ability to reuse equipment.

After four days the consensus among all stakeholder groups was that WRAMC functions transitioning to Belvoir and Bethesda should take place over a compressed timeframe, ideally across a long weekend, in late August/early September, following completion of key trigger activities. The wargame participants noted the many benefits of a compressed timeframe the WRAMC transition and identified next steps to successfully execute such a transition. In addition, the groups conceded that as a part of this strategy, the Belvoir and Bethesda internal moves should occur as new and renovated space comes online.

Inpatient Team Analysis

The Inpatient stakeholder team analyzed the first and second phases of COA 1 and then COA 3; compared COA 1 and COA 3; and recommended its preferred COA subject to its suggested modifications.

COA 1 Analysis

Discussions about COA 1, a multiphased approach that spreads the transition from WRAMC over a 6–8 month period, centered on the timing of new construction and when new buildings and renovated space would become available. During these discussions, the Inpatient team referred to a large map with a timeline identifying when services would be able to move into their new locations and several resources capturing floor and building availability and interdependencies, which informed their discussions and shaped their decision-making process. Their overall discussions assessed the advantages and disadvantages of COA 1, discussed the implications of its multiphased approach, and examined the ramifications of a proposed modification to compress its timeline from 10 months to 5 months.

The Inpatient team identified the following advantages of COA 1 during early wargame sessions:

- **COA 1 provides an opportunity to "learn as you go."** By extending out the transition from WRAMC and moving services into new buildings and renovated spaces at FBCH and WRMMC as buildings and space become available, this COA provides an opportunity to "pilot" services or departments as they move into their new facilities. Additionally, COA 1 establishes a platform for identifying challenges and obstacles relatively early and allowing for intervention prior to moving multiple services all at once.

- **COA 1 enables the capture of lessons learned.** Fusing three medical centers into one integrated "world-class" medical center offers an innovative opportunity to enhance quality healthcare in the NCR. The medical integration will combine a new with an existing network of healthcare systems that will enable coordinated collaboration among healthcare providers and supporting staff. However, such integration is also unprecedented within military healthcare. Because COA 1 incorporates four or five planned executed moves, it provides adequate time in between moves to leverage knowledge gained from "doing" and to strategically forecast issues that would otherwise impede transition progress and success.

- **COA 1 makes it easier to account for equipment and better utilize reused equipment.** With patient safety being the primary success criteria, the need to have all major equipment—new or reused— installed and online at the new facility or renovated space is paramount. COA 1, with its multiphased moves, would sustain quality care by ensuring that all equipment is operational and fully functional, and will make sure that all medical equipment and supplies will be readily available. According to the logisticians who were a part of the Inpatient team, trying to move equipment simultaneously and "all at once" would not accommodate equipment error and therefore would impede patient safety and needs.

- **Under COA 1, administrative staff can focus on one place and then monitor and hire staff from FBCH and WRNMMC.** Because of the more protracted moves under COA 1, each facility has time to establish robust policies and procedures for hiring staff to sustain quality healthcare.

Although discussions highlighted several promising advantages of COA 1, the Inpatient team also identified the following disadvantages associated with this COA:

- **An extended move, under COA 1, raises patient safety issues and concerns.** Ensuring patient safety is the most important challenge facing healthcare today and the primary agenda for the JTF CapMed: providing quality healthcare in a state-of-the-art and patient-safe environment. Therefore, a primary concern about COA 1 is the increased probability of jeopardizing patient safety. Orchestrating four or

five moves over time would create an extended "state of confusion" for patients and would require more time for them to become acclimated to their new surroundings. Additionally, increasing the number of employees and integrating staff may present challenges and vulnerabilities that could jeopardize lives. In addition, significant patient safety risks may be raised if staff do not receive adequate "day-in-the-life" training and orientation to their new environment. Moreover, this COA would heighten the probability of problems with moving patients too many times.

- **COA 1 presents accreditation risks.** Advancing the quality of healthcare through education and excellence is one of the JTF CapMed missions. However, the primary concern for participants with this particular COA is that with each move, ACGME must be notified of any programmatic change and to maintain a solid medical infrastructure, COA 1 must meet and support all accreditation requirements. Additionally, the ongoing movement of patients during the designated timeframe might create major concerns and raise "red flags" with each accreditation committee.

- **Patient and staff satisfaction may be compromised with a multiphase move, as proposed under COA 1.** Given the need to create a holistic and positive environment, all construction facilities and space must be completed before patients are moved. One of the most significant problems with this COA is the concern that the parking garage and various spaces would not be ready in a timely fashion. An incomplete parking garage would produce an insurmountable amount of congestion, anxiety, and inconvenience for both patient and staff and would, in turn, decrease patient and employee satisfaction.

  Moreover, there is some concern about staff receiving adequate "day-in-the-life" training and orientation to the new facility, which would considerably impact the staff's ability to maintain a comfortable environment for both patients and staff and could lower overall patient and staff satisfaction.

- **Certain procedural specialties and equipment must remain at both locations for the duration of the transition to sustain quality care.** Because of the extended move proposed under COA 1, a critical mass of procedural specialties and equipment (and the people and systems that support them) would need to remain functional at two locations for the duration of the transition.

Other discussions, in particular during the third breakout session, focused on the implications of COA 1's proposed multiphased approach, namely the duration of the transition. One of these implications relates to accreditation. It is clear that multiple moves over a long duration of time might affect patient safety and, as a result, hospitals might not meet all accreditation requirements. Although both FBCH and NNMC have many of the subspecialties that would be moving out of WRAMC at their current facilities and could accommodate a portion of the workload, this notion might also have a negative impact on GME programs, which are exacerbated by heightened case numbers and reduced staff levels.

To counter these shortcomings, the team recommended a modification to COA 1 to mitigate these vulnerabilities. In short, the team recommended that all inpatient moves begin in April 2011, as opposed to December 2010, and end by August 2011. This recommended change compresses the timeline, reducing a 10-month to a 5-month time frame.

Compressing the timeline would ensure that all patients have the same quality of services; with full capability and capacity at all sites (i.e., outpatient and ancillary services would be readily available at all locations). A compressed timeline could also minimize risks; enable effective communication amongst all providers, staff, and patients; and promote an effective, positive, and organized accreditation status compliant with all accreditation goals.

Additionally, a compressed timeline converts WRAMC into a "community hospital" role due to the transition of services. By reducing the capabilities and availability of certain specialty services, patients would be motivated to migrate to the new and renovated facilities to maintain quality and fully accessible healthcare with their current healthcare provider.

Yet, a compressed timeline is not without its challenges. One of the major concerns expressed with this timeline is the need to sustain exceptional care at WRAMC for certain complicated patients (i.e., organ transplantation, neurosurgery, wounded warrior unit, etc.) until their service space or facility is completely ready and all interdependencies are well supported. Similarly, diagnostic and ancillary services would have to remain at WRAMC, as well as at the new locations, Bethesda and Fort Belvoir, to ensure rapid patient results.

Additionally, determining how to support services when the equipment reuse policy requires many moves presents significant challenges. For example, radiology is a department that has the highest dollar value in equipment, and under COA 1, while some of this equipment would be reused, much of it would be newly procured. For a compressed timeline to work, the workload will need to be carefully distributed and trained.

As part of its proposed modification to the timeline of COA 1, the Inpatient team recommended using a checklist to decide which clinical services could move to their new space during the earlier months of the COA 1 transition. This checklist would determine if a service could move when a building was available and when the clinical interdependencies could move. The checklist would use the following criteria to ensure that an "early" move would be beneficial to the overall transition:

- Availability of space. The number of staff and beds that are available will determine whether a space can move early.

- The number of patients per day, or the patient census. If there were a reduced number of patients during a particular time frame, then the ability to move would be advantageous.

- Acuity. All hospitals must have a patient acuity system to determine staffing. Therefore, they must meet specific minimum nurse-to-patient ratios. With a compressed timeline, it provides an opportunity to ensure that the nurse-to-patient ratio remains at an adequate level, or higher, to ensure quality health care, patient safety, and full access of care. An extended move timeline may stress hospitals' ability to manage appropriate staffing levels.

- Fellowship and resident workload and requirements. The impact on the GME and Health Profession Education (HPE) would need to be modified under COA 1's compressed timeline to ensure that fellowship or resident workload and requirements would continue being met. On the other hand, a compressed timeline would provide an opportunity for trainees to explore and identify alternatives to completing their rotation.

COA 3 Analysis

Discussions of COA 3 were made in light of prior discussions of COA 1 and focused on the requirements for making COA 3 work optimally. For COA 3 to work and be fully executed, the following must occur:

- WRAMC garrison and support functions need to remain in place

- There must be a single command in the North before moving into Bethesda or Fort Belvoir to take the necessary mitigation actions, relay and facilitate information, and ensure that all roles and responsibilities are carried out

- The clinical operation transition team needs to consider the time it takes to move equipment to align the logistical movement plan with the clinical operations transition plan.

As part of its consideration of COA 3 during the wargame, the Inpatient team also responded to a question the Control Team posted about adjusting the COA 3 transition timeline for an optimal transition. The team responded by proposing that the timeline be compressed and executed from June 2011 through September 2011, as shown in Figure 4.

2010   **2011**

| November-December | January-February | February-March | April-May | June-July | August-September |
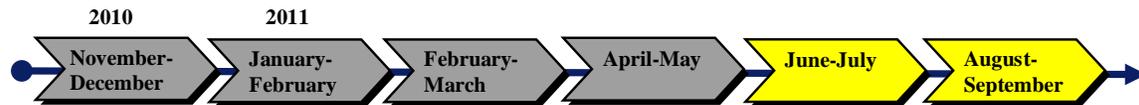
Figure 4. Proposed Compressed Timeline for COA 3

By compressing the execution of COA 3, several risks must be mitigated, however, to ensure that patient safety and continuity of quality healthcare can be sustained. The Inpatient team advocated for several of the following plans to be fully developed and implemented to ensure patient safety and quality of care:

- Well-developed inpatient attrition and clinical transition plans must be in place to allow logisticians and administration functions to be properly positioned, supported, and carried out to minimize risk

- A clearly defined human resource (HR) plan needs to be fully developed and in place before the "final move." This comprehensive and well-articulated plan must be implemented to determine the number of available staff and reserved volunteers to assist with the transition process and maintain quality healthcare

- A robust and well-developed marketing plan to provide internal and external communication and promote community corroboration is needed. This plan would enhance patient and employee satisfaction and promote a transparent transition process

- Other plans such as enhanced operating procedures/emergency preparedness plans (EPP) and contingency plans and a modified A/E distribution plan would need to be implemented prior to the transition process.

Comparison of COA 1 and COA 3

The Inpatient team compared COA 1 and COA 3 using the scoring criteria of patient safety and quality of care, full access to services, impact on GME/HPE, patient satisfaction, and transition success.

Patient safety and quality of care. Maintaining patient safety and quality of care throughout the transition takes precedence and is the most imperative priority for any effective COA. Although moving all of the patients once all buildings are fully operational and completed would be ideal (COA 3), transporting all patients simultaneously increases the probability of medical errors and adverse events. For this reason alone, COA 3 would increase patient safety risks due to a higher number and acuity of patients to transport. On the other hand, with COA 1, there are facility and safety issues that are unknown, which could also present patient safety issues. Moreover, IM/IT coordination presents additional concerns under both COAs due to the variability and different inpatient electronic medical record (EMR) systems in place at each facility. Standardizing systems at all facilities would enhance coordinated care and potentially the quality of care.

Furthermore, to sustain quality of care, all policies and procedures must be aligned and standardized amongst all facilities for all staff and employee to adhere, effectively execute, and strategically maintain

consistency, while at the same time providing incomparable healthcare. The policy concern applies to both COAs.

Full access to services. Both COAs present a potential risk for services to momentarily be offline at various times. Full coverage and access to services must be retained at all facilities until the final move is complete.

Impact on GME/HPE. To minimize the impact on GME/HPE, COA 3 would present the most ideal situation because it conducts a massive movement of clinical services between July 2011 and August 2011. A synchronized move would ensure that all new and renovated spaces, employee and facility training sessions, and installation of new and reused equipment are completed. In this way, COA 3 provides an opportunity to reduce vulnerabilities that could surface during a multiphased move (COA 1), stifle communications, and promote a stressed workplace environment.

Patient satisfaction. Patient satisfaction is a critical measurement component to determine healthcare success and drive accountability. Capturing patient safety data and collecting quality measures and outcomes play a pivotal role in ensuring that quality healthcare and services are strategically delivered. COA 3, with its end-load move, would promote an environment that decreases patient chaos and confusion and increases the probability of patient satisfaction and retention. Conversely, COA 1 would create a platform of confusion for employees to integrate and become fully acclimated into their final assigned location. Participants expressed concern that the extended timeline of COA 1 with its multiple moves would foster a culture that produces undue stress and jeopardizes patient safety. "Communication is critical," and a shorter timeline, as found in COA 3, would provide ample opportunity for the Joint Manning Document to be completed and to assign personnel to their final location; to promote sufficient notice to all employees regarding assignments, leave, comp time, and overtime during the summer months; and to limit the need for personnel to move multiple times during the transition process.

COA 3 would also allow for healthcare providers and staff to know the number and acuity of patients, to bring patients into a "completed" care environment, and to better control inpatient attrition (e.g., A/E coordination, stopping admissions to WRAMC, and not scheduling elective surgery).

Transition success. Staffing assignments would be harder under COA 1 than under COA 3, as clarified in the Joint Manning Document.

The Inpatient team compared COA 1 and COA 3 by responding to the question, "Is COA 3 harder or easier than COA 1 (as it evolved from your team's perspective) and why?," as shown in Table 3.

Table 3. Comparison of COA 1 and COA 3, by Inpatient Team

Criteria	Is COA 3 Harder or Easier Than COA 1 (As It Evolved from Your Team's Perspective) and Why?
Maintain Patient Safety and Quality of Care	Safety ▪ COA 3 is harder because there is a higher number and acuity of patients to transport ▪ In COA 1, there are facility safety issues that are unknown ▪ IM/IT concerns (different inpatient EMR systems) Quality of Care ▪ New policies and procedures at each facility (e.g., standardized SOP) would potentially affect quality of care under both COAs
Provide Full Access to Services Throughout	▪ Access is affected for both COAs at different time periods
Minimize Impact on	▪ COA 3 is easier because its end-load transition is easier to schedule around

GME/HPE	and orient new trainees
Promote Patient Satisfaction	▪ COA 3 would be easier because it provides less confusion for the patient about the availability of services
Promote Transition Success	▪ Staffing assignments are harder in COA 1 than in COA 3, as clarified in the Joint Manning Document

Team Recommendation

At the end of the wargame, the Inpatient team selected COA 3 as its preferred option subject to its suggested modifications. The following are considerations for successfully executing COA 3.

For COA 3 to work, the purchasing of more new equipment is likely necessary. Given its shorter timeline, new equipment would decrease the amount of time it may take for a larger piece of equipment to become online and fully operational. The caution with using reused equipment could greatly impact the timeline for when the equipment is ready. With reused equipment, especially larger reuse equipment, an extended timeline must be taken in account to prepare for usage. Some reused equipment may require several days before it becomes fully functional and operational. If reused equipment is necessary, a shorter timeline would increase the likelihood that it would not be operational to accommodate both personnel and patient needs.

Additionally, several clinical services could potentially be moved earlier in the transition process, prior to August 2011. The following clinical services were discussed for early moves. The current consensus on these potential early moves is by exception only.

Table 4. Potential Clinical Services for Early Move under COA 3

Phase 1: May–June	Phase 2: July–August	Additional Candidates Not Recommended Due to Risks
▪ 3D Modeling ▪ Substance Abuse* ▪ Dermatology ▪ Allergy/Immunology ▪ Behavioral Health* ▪ General Gynecology ▪ (Outpatient) ▪ Podiatry ▪ Breast Center Services	▪ Inpatient Internal Medicine* ▪ (Two Teams) ▪ Physical Therapy/Occupational Therapy ▪ Rheumatology, Endocrinology ▪ Medicine (Outpatient) ▪ Neurology*	▪ Hematology/Oncology (Inpatient and Outpatient) ▪ Pediatrics (Inpatient and Outpatient) ▪ Psychiatry (Inpatient) ▪ Occupational Health ▪ Gynecology Subspecialties ▪ Neurosurgery (Adult) ▪ Prostate Center Services

Potential exists to move some of these functions to FBCH completely/partially depending on the staffing at the time

Several modifications were also proposed to sustain patient safety and quality of care, address "low hanging fruit," and allow logisticians and the administration function to run on their own timeline to support the clinical transition plan. The following conditions and "critical enablers" must be taken into consideration for COA 3 to be carried out successfully:

▪ Some services may be able to move early in part once space is available.

▪ Staff must move to both North and South facilities simultaneously to minimize personnel anxiety, ensure that all services are fully accessible and operational, and maintain quality healthcare

▪ The Joint Manning Document must be completed and in effect to minimize the probability of personnel moving multiple times and at various times

- The Warrior Transition Unit (WTU) Chain of Command must be complete

- Parking garages, for both patients and staff, must be completed to satisfy patients and personnel

- Firewalls must be "broken down" by a specified date to ensure that all network systems are fully functional, synchronized, and accessible for all healthcare providers to view patients' information independent of the providers' immediate location

- A finite date for each service needs to be determined to allow all personnel (i.e., healthcare providers, logisticians, engineers, etc.) to have ample preparation for a successful transition

- Common business rules for clinical information management and operating environment (e.g., standardized policies and procedures) must be accomplished by a specified date.

Outpatient Team Analysis

The Outpatient stakeholder team analyzed the first and second phases of COA 1 and then COA 3; compared COA 1 and COA 3; and recommended its preferred COA subject to its suggested modifications.

COA 1 Analysis

The Outpatient stakeholder team evaluated COA 1 using the scoring criteria of patient safety and quality of care, full access to services, impact on GME/HPE, patient satisfaction, and transition success.

Patient safety and quality of care. Under COA 1, the team noted that inpatient and outpatient services with accompanying small services and subspecialties would be challenged during this move option. Currently, all departments are not fully staffed, and they would be spread even more thinly during this move. The team also expressed concern with losing patients to the private sector because patients would not be able to make appointments as quickly during the COA 1 transition. Other patient safety and quality of care concerns they expressed surrounded staffing shortages, losing HR capacity and efficiency, and the possibility of civilian staff encountering longer commutes once reassignments are made.

Full access to services. With respect to access to care, COA 1 does indeed have some advantages. COA 1 offers more scheduling flexibility, as well as increased parking availability, because two locations would be open during the multi-phased transition. On the other hand, patient confusion and frustration may be extremely high under COA 1, with some services being in operation at one location and other services being in operation at other locations. Also, IT support would be greatly needed to create one appointment line if COA 1 were to be implemented because services would be in operation and would need appointment/scheduling capabilities at two distinct locations.

Impact on GME/HPE. The outpatient team thought COA 1 would generate an unstable feeling for residents and for the GME programs. With COA 1, there would also be major issues for residents needing to commute to multiple facilities over a longer period of time. The team member observed that the more change a program or facility faces or endures the more chance there will be for review or audit by accreditation programs. Therefore, any accreditation changes to the GME program could potentially trigger review.

Patient satisfaction. COA 1 would not be the optimal transition option from a patient satisfaction perspective. Patients might be confused about appointment scheduling and where services would be rendered, which could lead to patient attrition to the private sector. This attrition could, in turn, lead to a decrease in provider productivity. Patient exposure to more noise and construction over the duration of the transition is another disadvantage of COA 1.

Transition success. The outpatient team thought COA 1 represented a more prolonged approach, which would lead to overall staff and patient dissatisfaction. They reasoned that if COA 1 were to be implemented, there must be a push to move outpatient services that do not have a strong inpatient component first (e.g., dermatology, ophthalmology, endocrinology, etc.) and to avoid moving procedural subspecialities separate from their outpatient components. One advantage of COA 1 is the potential to learn from experiences over the multiphased move and being able to "work out the bugs" over time.

The group also examined COA 1 with respect to the moves taking place in three phases: Phase 1 – April 2011, Phase 2 – June 2011, and Phase 3 – August 2011. During Phase 1, April 2011, FBCH would receive nonprocedural outpatient services from WRAMC, including primary care, dermatology, endocrinology, and rheumatology. It was noted that subspecialties with inpatient interdependencies cannot be moved prior to the opening of the inpatient units.

During Phase 2, June 2011, FBCH inpatient units would be open and would be receiving "slices" of procedural outpatient services from WRAMC. These services would include gastroenterology, pulmonology, orthopedics, and surgical subspecialties. Phase 2 would also include the WRNMMC receiving procedural outpatient services and surgical subspecialties from WRAMC based on the availability of the inpatient units to support. Not all medical/surgical inpatient beds would be available at WRNMMC at this time; therefore, services with interdependencies needing inpatient support could not be moved. Any remaining footprint at WRAMC through August would need to be determined by the WTU mission.

In Phase 3, August 2011, the expanded inpatient capacity units at WRNMMC would now be open and all remaining outpatient and inpatient services would move to WRNMMC from WRAMC. There was great discussion around whether the Emergency Department (ED) should remain in operation at WRAMC. The team consensus was that the WRAMC ED must remain open until the final closure to support remaining outpatient clinics for acute illnesses, to receive service for incoming transfers for admissions, and to support (along with the Warrior Care clinic) WTU, including after-hours care. A behavioral health services footprint would need to remain at WRAMC and would be defined by the relative WTU workload.

The outpatient stakeholder group further analyzed COA 1 and discussed possible modifications to its approach. As part of these modifications, the team made certain assumptions it felt were necessary to progress with COA 1:

- FBCH will begin patient care no earlier than April 2011
- FBCH inpatient service will be fully operational by June 2011
- WRNMMC inpatient services will be fully operational no earlier than August 2011
- WRAMC WTU will be moved August 2011
- Clinical services currently at WRAMC will be moved to the new Bethesda location and to Fort Belvoir when space/support is available and operational.

Other modifications that would need to take place for COA 1 to be successful include the availability of new critical care space that would be becoming available at WRNMMC. There will be two critical care units opening at the new WRNMMC, each with 25 available beds. Because the current daily intensive care unit (ICU) census at NNMC is about 20, the remaining 30 beds would be available for use. The team agreed that the newly available critical care space (the 30 available beds) could be used to accommodate certain inpatient and outpatient services that would be moved from WRAMC.

With some modifications, the following services could potentially move into the available critical care space:

- **Pediatric inpatient and outpatient services.** These services would utilize about 15 inpatient beds and 4 pediatric intensive care unit (PICU) beds. The new critical care space would need to be locked and secure to accommodate pediatric inpatient policies and procedures; the pediatric inpatient population cannot be mixed with the adult inpatient population.

- **Neurology.** This service would need 11 beds prior to the clinics being moved over. There would also need to be a neurology cell at WRAMC for WTU patients.

- **CT surgery and cardiology.** These services combined would need about 25 beds. The group had some concern with the availability of catheterization laboratory and vascular surgery space.

- **Ear, nose & throat (ENT), urology, gynecology, neurosurgery, and other small surgical services.** These services could all be moved; however, there was some scrutiny around whether space would be available.

After identifying services that could potentially occupy the new critical care space at WRNMMC, the team listed services that were potential "low hanging fruit." Such services include clinical and/or administrative services or subspecialties that could move "early" ("early" is defined as moves that can take place as soon as space is available and ready for operation). These "low hanging fruit" services include the following:

- Pediatric primary care
- Primary care medicine
- Primary care gynecology
- Dermatology
- Rheumatology
- Endocrinology
- Allergy/immunology
- Ophthalmology
- Optometry
- Breast Center services
- Prostate Center services (if urology moves)
- Podiatry
- Chiropractic services.

The Outpatient stakeholder group, in analyzing COA 1, also recognized that certain inpatient and outpatient interdependencies exist and such services would need to remain at WRAMC until the decommissioning of space. These services include occupational health, dental readiness, nephrology, gastroenterology, pulmonology, ED, infectious disease, and organ transplantation (with nephrology). In addition, another set of services related to supporting the WTU mission would need to stay at WRAMC through August 2011: general surgery (including trauma), orthopedics, orthopedic rehabilitation, neurology, behavioral health, anesthesia, pain clinic services, maxillofacial services, plastics, and ancillary services such as radiology, laboratory, and pharmacy.

COA 3 Analysis

Discussions of COA 3 were made in light of prior discussions of COA 1 and focused on executing this transition option. The team decided to divide its approach by each service represented in the group: neurology, behavioral health, and surgery. From a neurology perspective, all video equipment must be in place and functioning at WRNMMC before the move to Bethesda can begin. The six pieces of mobile

neurology equipment will need some modifications to fit in the new location rooms and will also need to be on the network's backbone. The team determined that there was not a large ancillary impact with this COA and, from a neurology viewpoint, moving this service all at once would decrease the impact to GME.

With respect to behavioral health, the team felt there was a need to maintain a "footprint" of inpatient and outpatient services at WRAMC for the Warriors in Transition until the move was complete. This population of patients would be the very last to move. Also, a gradual shift in staff is highly recommended if COA 3 were to be executed. As staff rotates into the NCR during the PCS cycles, staff could be assigned to their new place of employment, diminishing staff confusion during the transition. In addition, various legal issues would need to be clarified with respect to involuntary patients crossing state lines, which would happen during the move regardless of COA. The legal ramifications mostly concern dependents and reservists and should not affect active duty servicemen. The team discussed whether a behavioral health inpatient move should be considered to Fort Belvoir in the May/June time frame; however, after further discussion and concerns with having to hire staff, as well as patients having to endure ongoing construction, the group quickly came to a consensus to let attrition take care of the WRAMC population and to delay the move to the July/early August time period.

From the surgery perspective, execution of COA 3 would need to include proper planning. Actions to achieve proper staffing and credentialing could be taken immediately to prepare for the actual move. The outpatient services that could potentially move to Bethesda in July would lead to a natural attrition occurring in Bethesda and Fort Belvoir, decreasing the inpatient census at WRAMC and leaving fewer patients to move in August. The team also noted that most of the construction for operating rooms (ORs) will take place at night, so extending the length of the daily surgery schedule would not be safe. Trauma, joints, physical therapy, and occupational therapy all need to be functioning at Bethesda before the transfer of patients from WRAMC can occur. The group also identified central material supply (CMS) as a service that is being "pushed to the side." The team was adamant about bringing CMS issues to light, even though CMS is not in the BRAC plan. It believes CMS needs more space in Bethesda and overall acknowledgment in the clinical transition plan.

As part of its consideration of COA 3, the Outpatient team also responded to a question the Control Team posted about adjusting the COA 3 transition timeline for an optimal transition. The team decided that neurology services could be moved to Fort Belvoir in the June/July 2011 time frame, while the move to Bethesda could take place in August 2011. For behavioral health, it was determined that all services could be moved in July or early August 2011 and that telepsychology could be moved at any time. The team also identified that outpatient surgical services could be moved from WRAMC once the OR complex at Bethesda is ready to receive patients; however, a surgical "footprint" must remain at WRAMC to provide surgical care for the Warriors in Transition.

The team also considered general concerns associated with the execution of COA 3. First, to mitigate HR issues with an August move, PCS staff may want to be delayed until September. Doing so would lessen the confusion and disruption for incoming employees. To supplement staffing for the move, incoming staff could report earlier to minimize risk and confusion. Furthermore, reservists could be brought on staff early. Another concern for the team was the risk of losing civilian staff during the transition period (especially at WRAMC and Fort Belvoir). One recommendation for staffing issues is to issue a stop-loss until the move is complete. The team also thought clinics should not schedule appointments during the move. Although a temporary inconvenience, this practice would prove to be much safer for patients. Additionally, all IT resources must be preloaded to enable building in the changes for all services prior to any move.

In addition, the team discussed mitigation efforts for potential risks associated with COA 3. Clarifying the Joint Manning Document and the procurement of equipment are musts for a smooth transition. In

addition, formalizing the OR schedule and establishing equipment steering committees for planning purposes must occur to ease the trials of such a major move. The team thought it was also imperative to communicate with users to fully understand outstanding issues and concerns. The team also identified steps to mitigate the potential risks associated with an end-load move. With respect to inpatient EHRs, standardized documentation is currently being developed. The sharing of staff across facilities and across military services is already occurring, and standardization of the credentialing process is currently in progress. Furthermore, the integrated service chiefs are working on joint business practices, policies and procedures, and the procurement of equipment and staff.

Comparison of COA 1 and COA 3

The Outpatient team compared COA 1 and COA 3 using the scoring criteria of patient safety and quality of care, full access to services, impact on GME/HPE, patient satisfaction, and transition success.

Patient safety and quality of care. With regards to patient safety and quality of care, the team concluded that COA 3 reduces the risk of fragmented care. However, any "stumbling blocks" seen during the move would have more significant impact. Overall, from a patient safety and quality of care perspective, there are minimal outpatient concerns. That being said, if COA 3 were to be implemented, the outpatient group felt strongly that standard operating procedures (SOPs) would need to be established and in place to ensure that the safety of all patients was maintained during transition.

Full access to services. With providing full access to care during the move, COA 3 seemed to be a less confusing option for beneficiaries. Although COA 3 would provide some temporary decrease in accessibility during the immediate move, over the long term, it would have less of an impact on access.

Impact on GME/HPE. The same holds true for GME impact. COA 3 would make it easier to schedule residencies, making the whole transition process less confusing for residents. Residents would feel more stable during the transition process, and COA 3 would be less likely to raise flags among the certifying bodies.

Patient satisfaction. From the patient satisfaction perspective, not only would COA 3 be less confusing for the patients, but it would also be easier to market to the public and community.

Transition success. Because COA 3 recommends a quick, end-load move, the outpatient team envisioned completing all moves successfully and quickly and then having grand opening ceremonies at both FBCH and WRNMMC. This scenario would allow for the tangible acknowledgement of the entire integration effort throughout the NCR.

The Outpatient team also examined risks and mitigation strategies for COA 3. The team decided that the outpatient risks were relatively small. However, some outstanding risks have the potential to affect all stakeholders and populations during COA 3; these risks include loss of equipment, verification of the functionality of all equipment and systems, limited or no opportunity for lessons learned, the large administrative effort of moving IT users to their proper locations, and the occurrence of unexpected events (e.g., bad weather, a sudden/large deployment, or emergency events in the NCR). A mitigating effort was identified to move the "low hanging fruit" one month prior to the August move.

The Outpatient team compared COA 1 and COA 3 by responding to the question, "Is COA 3 harder or easier than COA 1 (as it evolved from your team's perspective) and why?," as shown in Table 5.

Table 5. Comparison of COA 1 and COA 3, by Outpatient Team

Criteria	Is COA 3 Harder or Easier Than COA 1 (As It Evolved from Your Team's Perspective) and Why?
Maintain Patient Safety and Quality of Care	▪ **Pros:** Risk for fragmented care is reduced; minimal outpatient concerns ▪ **Cons:** Any stumbling blocks in the move have more significant impact; services from WRAMC to FMCH need SOPs
Provide Full Access to Services Throughout	▪ **Pros:** Less confusion for beneficiaries; over the long term, less impact on access ▪ **Cons:** Temporary decrease in accessibility (not seeing full patient clinic load for approximately two weeks)
Minimize Impact on GME/HBE	▪ **Pros:** Easier to schedule resident time, decreasing confusion and promoting a sense of stability; less visible to certifying bodies and less likely to raise flags; easier to support staffing ▪ **Cons:** None identified
Promote Patient Satisfaction	▪ **Pros:** Less confusion; easier to market (grand opening); tangible manifestation of integration effort ▪ **Cons:** North beneficiary population is inconvenienced temporarily during move
Promote Transition Success	▪ See above

Team Recommendation

At the end of the wargame, the Outpatient team selected COA 3 as its preferred option subject to its suggested modifications. The team decided that COA 3 was the preferred option because it had the least effect on equipment, facilities, and patient safety; it focused the effort on the actual move without prolonging the event; it was the least confusing and least disruptive to patients, and it best supports GME. COA 3 also fits best with the renovations being done at Bethesda and the WTU housing.

Diagnostic and Ancillary Services Team Analysis

The Diagnostic and Ancillary Services stakeholder team analyzed the first and second phases of COA 1 and then COA 3; compared COA 1 and COA 3; and recommended its preferred COA subject to its suggested modifications.

COA 1 Analysis

The overall discussions of the Diagnostic and Ancillary Services team assessed the advantages and disadvantages of COA 1; discussed the implications of COA 1 in terms of patient services, safety, and overall satisfaction; and defined the minimum requirements to make COA 1 work.

The Diagnostic and Ancillary Services team identified some of the advantages of COA 1 during the wargame sessions. Some advantages of COA 1 included a potential savings in the reuse of equipment and the ability to maintain proper quality of care and access to care. Additionally, COA 1 is advantageous because it would limit the probability of outsourcing certain services, as well as maximize the opportunity to re-think the transition, providing chances to learn lessons, build on previous successes, and improve the move forward. By beginning the transition process, people would be concentrating on the actual moves taking place instead of re-thinking certain moves and stalling plans. The last advantage the team identified was that patients and staff may more easily tolerate a multiphased transition, possibly allowing for learning opportunities along the way.

Disadvantages and potential derailers of COA 1 were also noted. One disadvantage uncovered is that, with a multiphased approach, the potential for complications to accumulate and snowball into grander

issues is more apparent. Possible derailers included a failure of choreography (patients getting lost in the system and a lack of contingency plans) and the lack of a patient-centric focus.

The diagnostic and ancillary services stakeholder group also analyzed COA 1 in relation to patient services, safety, and overall satisfaction experienced at WRAMC during the transition. The team thought there was great potential for degradation during COA 1 if diagnostics and ancillary services were sharply reduced or absent over an extended period of time. This degradation could be mitigated if all support services were retained in skeletal form, or otherwise, until the last patient was discharged or moved. However, this retention would require the availability of normal or scaled down services that align with the census decline; the maintenance of staffing in all services despite the lack of a critical mass of patients; and/or the need for more transports to obtain imaging, laboratory, and other critical services. The team also identified likely diagnostic and/or treatment delays and an escalated need for patient transports as potential concerns that could occur if COA 1 were implemented. Consequently, this COA could result in lower patient and family satisfaction, timeliness issues, and a higher risk for safety concerns related to transports (which would necessitate additional staffing and costs).

In identifying the advantages and disadvantages of COA 1, the diagnostic and ancillary team also uncovered general thoughts that would help make COA 1 a successful option. First, diagnostic and ancillary services (e.g., laboratory, radiology, pharmacy, etc.) must precede the clinical moves. These services cannot move in a "silo" fashion, and policies and procedures need to precede any and all actual moves. Furthermore, transition success requires IM/IT system integration. For instance, the e-mail system needs to cross all services (Army, Navy, and Air Force) for optimal communication.

As part of this effort, the team defined the following minimum requirements necessary to make COA 1 work:

- Patient-centered decisions on the sequencing of moves (although no two patients have exactly the same service needs)
- Retention of all patient services, at scaled-down levels, for the duration of the multiphased move
- Elevated staffing levels
- Cutoff dates for new admissions
- Maintenance of a robust and unified communication process, including a strategic communication plan, enabling tools, and software (e.g., pagers, JTF website), ongoing multimodal education and marketing (to staff, patients, families, and other stakeholders), and uniform policies, procedures, and practices.

The diagnostic and ancillary stakeholder group also identified services that could potentially move early under COA 1 if need be. These services were called "low hanging fruit" services. The team wanted to emphasize that it thought readiness was based on the care environment, not necessarily on the calendar. Therefore, for the diagnostic and ancillary team, minimum requirements of the COA 1 transition option include space availability, early decision on manning for both campuses, staff alignment flexibility, equipment, IM/IT support (a unified Picture Archiving and Communication System (PACS) across the Joint Operating Area [JOA], Composite Health Care System (CHCS)/Armed Forces Health Longitudinal Technology Application [AHLTA], Defense Medical Logistics Standard Support [DMLSS]), environmental and support services, and logistics supply chain.

Additionally, the team created a tentative timeline for services to be moved during a multiphased approach and generated a set of earliest potential available dates for both the North and South campuses. For the North campus (WRNMMC), the team recognized the following as earliest potential available dates for certain services:

- Parking – August 2010
- Building A
  - Pharmacy –December 2010
  - Laboratory – April 2011
  - Radiology – February 2011
- Building 9/B
  - Pharmacy – February 2009
  - Laboratory – May 2010 (Phase I), August 2011 (Phase II)
  - Radiology – January 2011

For the South campus, the following earliest available dates were noted:

- Laboratory – April 2011
- Radiology – April 2011
- Pharmacy – April 2011

Like the Outpatient team, the Diagnostic and Ancillary Services team listed a few of the "low hanging fruit" services, those clinical or administrative services or subspecialties that could potentially move early. All of the "low hanging fruit" services it identified were based on the need to support clinical services and the earliest move dates referred to above. The group recognized 3D modeling as a system that could be moved early without difficultly and with the least disruption. In addition, outpatient counseling services could also be considered a "low hanging fruit" service. Services like clinical nutrition, behavioral health (excluding WTU), and wellness and prevention could all move early in the transition process.

Additional overall concerns and considerations were discussed when contemplating COA 1 as a potential transition option. These considerations were identified as possibilities for any COA option or hybrid solution. First, there may be a need for the use of internal or external Project Management Professionals (PMPs) or transition consultants. Ultimately, these types of consultants or contractors could provide support to the entire, comprehensive clinical transition effort. Second, an overall "air traffic control" mechanism would be needed to manage and support the move. This mechanism would need to survive staff turnover, oversee the multitude of ongoing processes, tabulate and communicate lessons learned, and provide a 1-800 resource for all transition stakeholders.

COA 3 Analysis

Discussions of COA 3 were made in light of prior discussions of COA 1 and focused on executing this transition option. However, as part of this analysis, the team determined that a pure COA 3 option is not supportable. Some transitional moves would be necessary to make the transition a success. Prerequisites to a successful move include determining final manpower statistics, defining the logistics/procurement process, and establishing the commonality of IM/IT/PACS systems across the JOA.

For this reason, some time was spent discussing how to adjust the transition timeline of COA 3 for optimal performance. In the end, the team decided that flexibility was the key factor during the entire clinical transition. It stressed the importance of effective communication, coordination, and cooperation among all involved. Expectations must be defined, and a clear pathway for inpatient and outpatient information flow should be mutually understood. The team also identified mitigation efforts for COA 3 and again highlighted the need for proactive and flexible planning; the fulfillment of transitional manpower requirements to avoid service decrements, and the meeting of prerequisites mentioned earlier with regards to common IM/IT/PACS systems and logistics/procurement processes.

Part of the discussions of COA 3 centered on identifying possible earlier moves for both the North and South campuses. In the South, pharmacy, with its outpatient component, laboratory, radiology, and food could all move as early as April 2011. Pharmacy and food, with their respective inpatient components, could move soon thereafter. With regards to the North, 3D modeling, Building A – Pharmacy, and Building A – Laboratory could move as early as February 2011. And Building B – Diagnostic and Interventional Radiology and breast care could move next. There was also discussion about whether early movement of some services provided only an illusory benefit. Some thought if a service were so easily moved, its early transfer might not materially impact the final move.

From the plenary sessions earlier during the wargame, a list of critical enablers was established to which the team added the following additional enablers:

- JTD is finalized and populated; military personnel stabilization strategy is developed (i.e., assignments, key leaders)
- JOA policies, SOPs, and governances are established prior to clinical occupancy
- Command groups are in place and are functioning at WRNMMC and FBCH prior to initiation of clinical occupancy
- Deployment requirements are avoided during transition
- There is IM/IT fielding and commonality
- Acquisition support contracts are awarded
- Transition STRATCOM occur throughout
- Transition planning and processes are the same for North and South: site-specific groups (e.g., logistics, training, occupancy, etc.) with central coordination
- Temporary staff can be hired versus expectation management (Building A –Pharmacy)
- Additional departmental staff can be identified depending on which COA is choosen
- Existing laboratory, radiology, and pharmacy functional integration teams need to be expanded or refocused to the JOA
- One hundred percent of the reuse equipment is in laboratory, radiology, and pharmacy

The Diagnostic and Ancillary Services team recognized that a slice of all ancillary services will need to remain at WRAMC until the building closes due to the growing needs of the WTU.

Comparison of COA 1 and COA 3

Using the scoring criteria as a basis, the Diagnostic and Ancillary Services team thought COA 3 would be an easier option to implement. With respect to providing full access to care, the group thought COA 3 was easier because the move would not occur unless the infrastructure/ancillary services were already in place. COA 3 would also be easier in terms of the impact on GME/HBE. Less disruption to the residency program would be seen with one, large move taking place in August 2011 than with multiple moves over a longer time frame. With respect to patient satisfaction and overall transition success, the team saw advantages as having services turned off for a shorter period of time, more opportunities for learning, and a better chance to market and communicate the transition efforts to both internal and external community stakeholders.

In contrast, the group identified COA 3 as being harder to implement in relation to patient safety and quality of care, indicating there would be less time to benefit from lessons learned, which could directly affect patient well-being. The Diagnostic and Ancillary Services team compared COA 1 and COA 3 by responding to the question, "Is COA 3 harder or easier than COA 1 (as it evolved from your team's perspective) and why?," as shown in Table 6.

Table 6. Comparison of COA 1 and COA 3, by Diagnostic and Ancillary Services Team

Criteria	Is COA 3 Harder or Easier Than COA 1 (As It Evolved from Your Team's Perspective) and Why?
Maintain Patient Safety and Quality of Care	▪ **Harder** – Less time to benefit from lessons learned, multiple switches turned on at same time
Provide Full Access to Services Throughout	▪ **Easier** – Move would not occur unless the infrastructure/ancillary services are already in place
Minimize Impact on GME/HBE	▪ **Easier** – Less disruption to the residency program
Promote Patient Satisfaction	▪ **Easier** – Services turned off for a shorter period of time, opportunities for learning curve and marketing/communication
Promote Transition Success	▪ Quick band-aid has multiple advantages

The team also identified the following potential risks associated with COA 3:

- Multiple players who have not worked together
- Various cultural issues
- Extensive pre-planning concerns
- Needed training
- Establishment of policies for new space
- Rapid service expansion
- Any form of delay
- Concurrent responsibilities
- Quality and satisfaction concerns across the NCR
- Expectations
- Impact of staff
- Physical constraints
- "Fast" band-aid

Mitigating efforts were also discussed, including what it would take to make COA 3 happen. The Diagnostic and Ancillary Services team thought pre-planning and effective communication were two important mitigating factors. In addition, proper cross-training and cultural exchanges were noted as being significant mitigating factors. Lastly, hiring temporary contract staff could potentially mitigate the risk of being understaffed during the transition, which directly impacts patient safety and the quality of care.

Team Recommendation

At the end of the wargame, the Diagnostic and Ancillary Services team selected COA 3 as its preferred option subject to its suggested modifications. The team stated the following reasons for choosing COA 3 as its preferred method of transition: a shorter period of split services, a longer preparatory phase, and fewer interim changes to support clinical moves.

Administration Team Analysis

The Administration stakeholder team analyzed the first and second phases of COA 1 and then COA 3; compared COA 1 and COA 3; and recommended its preferred COA subject to its suggested modifications.

COA 1 Analysis

The overall discussions of the Administration team assessed the advantages and disadvantages of COA 1; discussed the implications of COA 1 in terms of patient services, safety, and overall satisfaction; and defined the minimum requirements to make COA 1 work.

The Administration team identified some of the advantages and disadvantages of COA 1 during the wargame sessions. These advantages included creating positive political energy by displaying progress, allowing a staggered effort for clinical moves to ease tension during the training and certification requirements, and having space in the new FBCH to allow for increased staffing prior to large patient moves. From an administrative perspective, the general consensus of the team was that a phased approach, such as described in COA 1, would lend itself to a less stressful move and would have several key advantages. These advantages would include the ability to observe and harness lessons learned, relieve the anxiety of all stakeholders and staff of one massive move, spread emergency risk over a period of time in lieu of having the risk burden all in one weekend, and "cushion time" to react to changes in the timeline or strategy if circumstances steered the COA off the original course.

Some of the team's concerns with COA 1 included the necessity to "beef up" personnel effort and additional administration resources during transition periods, the need to phase in satellite operations center (SOCs) by building, the complex and thinned distribution of staff during a non-cycle period, and the need to quickly establish governance/authority on an earlier timeline with a phased approach. In addition to these concerns, the Administration team identified that the timelines to procure equipment and to implement a single education platform would be compressed. The drawbacks to COA 1 most directly impact quality of and access to care—from the thinning of staff over multiple locations during phases to potential delayed access to care to a higher potential for referral management errors and patient confusion. Because of the number of early moves outlined in COA 1, the group identified that the success of the transition would require a robust and complex strategic communications plan.

While the transition impact of COA 1 from an administration perspective would stretch staff and expertise resources thin, there would also be a greater opportunity to capitalize on lessons learned from early moves. Employing COA 1's phased strategy would enable the services to potentially improve their risk management approach throughout the BRAC timeline, as well as ease the logistical strain of clinical moves. However, the transitions in COA 1 do occur during the middle of the training cycle and would make training and billeting more complex for trainees.

As part of its analysis of COA 1, the Administration team made additional observations about COA 1 related to the promotion of transition success. These observations included the timing of medical/surgical beds moving needing to coincide with ICU and Post Anesthesia Care Unit (PACU) beds moving (not currently coinciding in COA 1), the COA producing a need for more equipment in the HPE area, and the COA having a positive impact on beneficiaries by giving them "early" access to new and improved facilities.

The Administrative team spent some time developing suggestions for administrative and logistical risk mitigation correlating to its concerns with COA 1. Risk mitigation was a focus of this team and the following is a list of mitigation strategies/actions the team determined to be necessary for COA 1 (or any phased approach) to be executed successfully:

- Conduct aggressive marketing strategy and communications plan to all stakeholders
- Develop improved wayfinding program in new facilities
- Promote early identification of pre- and post-transition staffing requirements
- Author separate transitional concept of operations (CONOPS) to bridge healthcare delivery operations

- Ensure the ability of leaders to interview candidates for key/replacement positions
- Distribute "rules of engagement" for present and future staffing
- Review and reclassify (if necessary) all physician positions
- Develop support contracts immediately.

The Administration team also identified "low hanging fruit," or services that could in fact be moved more easily than others preemptively of the BRAC deadline, to ease COA 1's time crunch effect in the final months. The team's general perspective was that administration as a support function, such that no matter how difficult the scenario, it would be the team's mission to "make the moves work."

COA 3 Analysis

Discussions of COA 3 were made in light of prior discussions of COA 1 and focused on modification to the timeline for the transition to make COA 3 "truly work" and the related risk mitigation strategies. As part of these discussions, the Administration team split administration into specific administrative functions, which included IM/IT, StratCom, Logistics, Training, SOPs/Business Processes, Patient Admin, HR, and Security. After identifying these functions, mitigation strategies were identified to best address the unique complications associated with each of the functional areas. The following list contains those strategies considered as having the highest priority:

- Implement joint SOPs, business processes, and policies – No later than October 2010
- Ensure the proper functioning of the IM/IT Infrastructure – Resource commitment required
- Develop robust joint marketing and communications plan for all stakeholders
- Finalize the equipment reuse plan – Immediate
- Put in place an equipment acquisition strategy and contracts with the capacity to support the transition – 60 days
- Develop a joint orientation and training plan for staff moving to a new facility
- Ensure full execution of all DHMRSi modules for the Joint Commands
- Establish single privileging authority
- Finalize JTD immediately
- Implement DOD civilian manning model – In October 2010
- Identify essential military staff that would stabilize (freeze) and stop-move.

The Administration team also looked at what would it take to make COA 3 work and summarized the overall strategy of risk mitigation perceived as having the most impact on feasibility. In short, the team suggested that integrated policies and procedures be implemented at WRAMC, NNMC, and DACH and that predecessor administrative functions be phased and consolidated prior to October 2010. The best ways to improve the feasibility of COA 3 were identified as creating an advanced party strategy, spreading the major moves over two weekends instead of one, phasing primary care out of WRAMC ahead of time, and moving the WTUs earlier in the timeline when the necessary housing becomes available.

In addition to the overall risk mitigation strategy presented above, the Administration team prioritized its recommended mitigation strategies. Table 7 lists these mitigation strategies that need to be implemented for COA 3 to work from an administrative point of view.

Table 7. Prioritized List of Mitigation Strategies for COA 3 to Be Successful

Action	Priority	Deadline Date
Finalize equipment reuse plan	1	February 2009
Approve funding for IM/IT plan execution	1	March 2009
Resource REQ Plan (Staff). For North and South June 2009 – Onboard March 2009	1	March 2009
Put in place equipment acquisition strategy and contracts with the capacity to support transition – 60 days	1	April 2009
Finalize JTD	1	April 2009
Ensure EBD Technology and Lifecycle Management (ACQ Plan for equipment APR 2009)	1	April 2009
Develop MHS Network Infrastructure (Fiber Optic Ring) Plan	1	April 2009
Ensure DACH Data Center Design and Procurement	1	June 2009
Implement joint business plan for healthcare operations	1	July 2009
Test and refine software system for referral management and patient appointing	1	July 2009
Establish single privileging body	1	September 2009
Develop a JOA-wide enrollment plan	1	October 2009
Renovate North Data Center Project – March2009–April 2010	1	April 2010
Identify essential military staff that would stabilize (freeze) and stop-move	1	June 2010
Renovate South Data Center Project – June 2009–September 2010	1	September 2010
Implement joint (mirror) SOPs and business processes no later than October 2010	1	October 2010
Assign common governance to maintain accreditations	1	October 2010
Ensure that all clinical areas document care in single electronic system	1	October 2010
Ensure JOA portfolio integration, including applications and systems by January 2011	1	January 2011
Implement and/or expand joint recruiting and retention plan – ASAP	1	
Set up a StratCom joint planning group within the next 30 days	2	March 2009
Finalize WRAMC migration plan for North and South	2	March 2009
Develop strategy to mitigate patient health information (PHI) and personally identifiable information (PII) risk	2	May 2009
Finalize DACH migration plan	2	June 2009
Develop new position descriptions for the new campuses	2	June 2010
Develop JOA IM/IT standard business rules and policies by June 2010	2	June 2010
Draft COA 3 logistical execution plan	2	July 2010

Action	Priority	Deadline Date
Fully execute all modules of DMHRSi	2	July 2010
Implement DOD civilian manning model	2	October 2010
Deliver training and orientation plan for staff moving to a new facility	3	July 2010
Create hospital ID badges in advance (security)	3	January 2011
Attempt to purge and archive files/records/inventory proactively	3	March 2011

Comparison of COA 1 and COA 3

The Administration team evaluated COA 3 independently from COA 1 to ensure that an unbiased analysis was offered based on the merits of COA 3 and not in the light of previous biases uncovered when evaluating COA 1. The COA 3 observations that weighed most heavily in the team's evaluation were dealing with a steep learning curve, less opportunity to identify risks, a greater burden of risk in gaining locations, success dependent on a concentrated effort of credentials and processing, and the benefit of a more simplified strategic communication message to market to the stakeholders. Perhaps the greatest hesitance of an endorsement for COA 3 was attributed to the massive amount of effort and risk being placed on one weekend of clinical service moves. The Administration team compared COA 1 and COA 3 by responding to the question, "Is COA 3 harder or easier than COA 1 (as it evolved from your team's perspective) and why?," as shown in Table 8.

Table 8. Comparison of COA 1 and COA 3, by Administration Team

Criteria	Harder or Easier Than COA 1 (As It Evolved from Your Team's Perspective) and Why?
Maintain Patient Safety and Quality of Care	▪ **Harder than COA 1** – Steep learning curve; not a phased approach; environment of care training; great for WRAMC but much more difficult for two other locations; less of an opportunity to ID risk; security risks
Provide Full Access to Services Throughout	▪ **Harder than COA 1** – Very dependent on concentrated effort of credentials and processing; common referral management cell necessary to meet access to care; greater burden of risk to gaining locations; cutoff days necessary for inpatient services
Minimize Impact on GME/HBE	▪ **Easier than COA 1** – Minimal disruption to GME/HPE
Promote Patient Satisfaction	▪ **Easier than COA 1** – More time for StratCom and marketing; simple message to sell; not as much back and forth for patients
Promote Transition Success	▪ **Easier than COA 1** – More time to prepare and execute mitigations with respect to the common concerns and observations between both COAs

Team Recommendation

At the end of the wargame, the Administration team selected COA 3 as its preferred option subject to its suggested modifications. These modifications included creating an advanced party strategy, spreading the major moves over two weekends instead of one, phasing primary care out of WRAMC ahead of time, and moving the WTUs earlier in the timeline when the necessary housing becomes available.

Patients Team Analysis

The Patients stakeholder team analyzed the first and second phases of COA 1 and then COA 3; compared COA 1 and COA 3; and recommended its preferred COA subject to its suggested modifications.

COA 1 Analysis

As part of its analysis, the Patients team identified the different types of patients who receive care from the hospitals involved in the transition (WRAMC, NNMC, and DACH). The team categorized patients into three high-level groupings—Wounded Warriors, retirees, and all others—although it acknowledged several additional subgroups of patients. The team felt that it was important from the outset to clarify the types of patients who would be affected as each patient group could potentially favor a different COA.

The patient group then discussed where the Wounded Warrior would be housed at WRNMMC and FBCH. The group reviewed the COA diagrams and the WRNMMC and FBCH construction and staging documents to gain an understanding of when housing would be complete. At this point, the group sent the following question to the control group, "Will early housing be available for Warriors and families? Without it, this is a clear disadvantage to the patient." The group learned that the barracks would not be complete until April 2011 for FBCH and August 2011 for WRNMMC. However, there would be a shuttle that was available for Warriors to take them to WRNMMC and FBCH. The group did not feel a shuttle was an adequate option as Warriors often have several appointments daily and would tire quickly.

A closing thought on this topic from the group was that possibly a nearby hotel could be used for a short period of time to help facilitate Warrior transition.

The Patients team also discussed the advantages and disadvantages of COA 1 during the wargame. From a patient perspective, COA 1 is not ideal. By spreading the move over several months, there is a concern that patients would be confused about what services were at available at which hospital. Also, patients might be inconvenienced by having to visit multiple locations in one day. Another disadvantage is the manpower needed to shuttle Wounded Warriors from WRAMC to either WRNMMC or FBCH because Wounded Warriors may have two or three appointments in a day and five or six appointments in a week. The Patient team determined that patients would want a "one-stop shop" instead of having to go to multiple locations for care.

Additionally, the Patients team pointed out several items that should be kept in mind when considering the implications of a phased transition on patients. For a military patient, it is more comforting to go to a MTF because the doctors speak the same "language." Civilian doctors, while totally capable, do not often completely understand the military environment. This lack of understanding results in a struggle between the availability of medical services and the comfort of the military patient. Currently, DACH cannot handle some of the most serious patients. During the transition, these patients would have to go to WRAMC or NNMC. Lastly, the Patient team felt that surgical operations do not drop in June, which might affect assumptions about a census drop during that time frame.

The Patients team also looked at which services needed to be moved together as part of a phased transition. The team thought that patients in the general population would be fine with COA 1 as is. For WTU and elderly patients, the team proposed the following changes to COA 1:

- Move all these services early (April 2011), which is equivalent to COA 2 (eliminated).
- Move all these services late (August 2011), which is equivalent to COA 3.

If services are moved across time periods in COA 1 (April–August 2011) then "split operations" are needed—in other words, services at each location (WRAMC, NNMC, and DACH). From a WTU/family

and elderly patient perspective, this arrangement is not satisfactory. These patients unfortunately already have difficultly getting from place to place, and having services in different locations would only compound this problem.

The Patients team went through the move schedule floor by floor for Building A to gain a comprehensive understanding of what services could move on which dates. In addition, the team looked at what services do not involve Wounded Warriors. Based on this in-depth look at the move schedule, the Patients team indicated that the patient parking lot must be done before patients can begin being moved to WRNMMC. The team also discussed when the appropriate time would be to transfer appointments for new patients. This transition would not entail moving the services. People who grew up by going to a MTF are used to one-stop shopping. From a patient perspective, it will be tough to adapt to a different working model, even if it is for only a short period of time.

COA 3 Analysis

Discussions of COA 3 were made in light of prior discussions of COA 1, and the Patients team indicated that COA 3 is preferable because it offers the most predictability, the greatest flexibility, the least confusion, and the greatest confidence that quality, access, and safety will be maintained.

For this reason, discussions among Patients team stakeholders focused instead on developing a comprehensive list of stakeholders and an initial communication plan for the transition—how it should be conveyed.   Due to limited time, the team concentrated its efforts on a few key audience groups. The ad hoc communication plan the team developed includes the audience for the communication, the information to be conveyed, when it should be conveyed and by which medium the communication should take place. The ad hoc communication plan is shown in Appendix A: Communications Plan.

Comparison of COA 1 and COA 3

The Patient team evaluated COA 1 and COA 3 by considering which COA would present the most challenges during the transition and the most risks to a patient. It defined the "most challenges" in terms of the associated risk.

For COA 3, the first risk identified was the hospitals not providing care during the four-day move-in time period. To mitigate this risk, the patient group offered several mitigations:

- Use the network to treat patients; diverting ER patients
- Plan for the attrition of patients
- Communicate the move to the patients, providers, and community using town hall meetings, newspapers, internet sites, television, hospital bulletin boards, and local unit Public Affairs Offices
- Move inpatients with nursing teams, move patients with providers without moving equipment until patients are transferred
- Maintain functionality until all inpatients are moved
- Hold or divert aerovacs from Germany to ensure quality care and patient safety
- Have a system in place to care for emergency walk-ins at WRAMC (it was noted that there are contracting companies that perform this function).

Another risk the team identified was that the Warrior Transition Brigade (WTB) Cadre and Warrior Care Clinic are still located at WRAMC. To mitigate this risk, the eam thought that all WTB Cadre and WTs could be moved to North and South prior to the four-day move.

The third risk identified was the concern of the unknown. The Patients team expressed strong feelings about minimizing any confusion for the patients and identified the following mitigation strategies to address this concern:

- Expectation management for patients (groups include pregnant women and the very seriously ill)
- Expectation management for staff (taking leave and minimal temporary duty [TDY]) for two-week timeframe around move
- Expert planning down to the lowest level
- Facility tours
- Operational IM/IT prior to he move (this is the patients' lifeline)
- Working pager system
- Availability of PHI
- Ancillary services in place and functional

The Patients team also expressed interest in ensuring an emergency operations center (EOC)/Operation Cell is operational during the four-day move to coordinate care and services (track patients and use Campus Center for Appropriate Technology [CCAT] model).

The Patients team compared COA 1 and COA 3 by responding to the question, "Is COA 3 harder or easier than COA 1 (as it evolved from your team's perspective) and why?," as shown in Table 9.

Table 9. Comparison of COA 1 and COA 3, by Patients Team

Criteria	Harder or Easier Than COA 1 (as it evolved from your team's perspective), and Why?
Maintain Patient Safety and Quality of Care	- Easier because split operations are not preferred; focus move during a short period of time
Provide Full Access to Services Throughout	- Easier because split operations are not preferred; focus move during a short period of time
Minimize Impact on GME/HPE	- N/A
Promote Patient Satisfaction	- Easier because COA 3 provides predictability of where services are provided and allows for greater flexibility
Promote Transition Success	- Easier because of the transition of all patients from WRAMC to either North or South

Team Recommendation

At the end of the wargame, the Patients team selected COA 3 as its preferred option subject to its suggested modifications. It was the team's preferred option because it offers the most predictability, the greatest flexibility, the least confusion, and the greatest confidence that quality, access, and safety will be maintained.

Wargame Results and Next Steps

On Friday, February 6, 2009, the Transition COA Decision Briefing was presented to JTF and JOA leaders. This briefing described the JTF CapMed transition wargame, offered analysis of the COAs by group, and identified constraints. The following constraints were presented as limiting factors or possible restrictions to transition progress:

- FBCH outpatient care begins no earlier than April 4, 2011
- FBCH inpatient services are operational by June 2011
- WRNMMC full inpatient services are operational no earlier than late August 2011
- The RFP 2 is unfunded, but includes WTU barracks, staff parking, gymnasiums, and administrative office space.

In addition to identifying the constraints during the brief to the JTF and JOA leadership, the working groups presented preparatory activities that need to be implemented for the transition to be a success under either COA. These activities include furniture installation, issuance of ID/access cards for transitioning staff members, and proper training for staff. Equipment preparatory activities include the transfer, installation, and certification of reuse equipment, as well as the installation and certification of all new equipment. IT preparatory activities include the installation of IT equipment, the mapping of staff members to new computers, and ensuring the access to and functionality of inpatient and outpatient EMRs for staff members. Also critical is execution of the mitigation strategies presented in Table 7.

Taking into consideration the analysis of each group, the assumptions, constraints, and required preparation, COA 3 was recommended to the leadership as the preferred COA because of several key advantages.

The first major advantage is that by waiting until August 2011 to begin the major clinical moves, the Department can avoid having to leave a shallow complement of services at WRAMC across the last five and a half months of the BRAC timeline. By waiting until August 2011 to migrate the bulk of operations transitioning from WRAMC to the new WRNMMC, construction congestion can be avoided. This strategy would also best serve the beneficiaries by minimizing patient confusion derived from multiple care locations.

The second major advantage of an August move of functions is that it would allow for focus on "internal" campus moves from old to new space (i.e., from DACH to FBCH and from NNMC to WRNMMC). In doing so, the challenges of merging the staffs of multiple facilities are not overlaid upon the challenges of working the bugs out of the new space and systems.

Another key advantage of COA 3 is that once FBCH and WRNMMC are completed, all equipment will be installed in the new facilities, all bugs will be worked out in the new additions, and all training will be accomplished. Then, all WRAMC services should be able to transition in one concentrated wave. This

strategy mitigates the need for excessive transportation of materials, equipment, or equipment from WRAMC to WRNMMC or FBCH across the transition.

Table 10 contains the decision support template presented to the JTF and the JOA leaders according to the predetermined weighted success criteria.

Table 10. Decision Support Template Comparing COA 1 to COA 3

Criteria	Criteria Weight	COA 1 "Modified" (Multiple Moves)	COA 3 (End Move)
Maintain Patient Safety and Quality of Care	3	1/3	2/6
Provide Full Access to Services Throughout	2	1/2	2/4
Maintain Clinical and Training Accreditations	1	1	2
Promote Patient Satisfaction	2	1/2	2/4
Promote Transition Success and Staff Satisfaction	1	1	2
Equipment Reuse Supportability	1	2	1
Weighted Score		**11**	**19**

As a result of the decision brief, COA 3 received the approval and endorsement of the JTF and the JOA leaders. As a part of their endorsement of COA 3, the JTF and JOA leadership reached consensus that two additional assumptions must be added to the previously compiled list of wargame assumptions. These two assumptions are that all DACH to FBCH and NNMC internal moves will be based on the release of space for occupancy and that a comprehensive strategic communications plan will be implemented.

After approving COA 3, the JTF and JOA leadership agreed upon the following "next steps" as critical action items that should take place to prepare for and successfully execute the transition:

	Action
1	Develop transition benchmarks and milestones
2	Communicate the move to the patients, providers, and community using town hall meetings, newspapers, internet sites, television, hospital bulletin boards, and local unit Public Affairs Offices
3	Have a system in place to care for emergency walk-ins at WRAMC (it was noted that there are contracting companies that perform this function).
4	Develop coordinated and staffed Integrated Master Schedules (IMSs) for and between WRAMC, NNMC, and DACH
5	Establish decision triggers
6	Initiate occupation of FBCH
7	Move Wounded Warriors, their cadre, and their C2 to Fort Meade/Kimbrough AHC, FBCH, and their C2 to WRNMMC
8	Vacate WRAMC
9	Develop and populate the JTD
10	Identify resource requirements
11	Develop "pre-flight," transition, and "post-flight" checklists

12	Integrate WRAMC and NNMC clinical, clinical support, and administrative log areas
13	Integrate Fort Belvoir with WRAMC/NNMC
14	Integrate Malcolm Grow and Kimbrough with WRAMC/NNMC and Fort Belvoir
15	Collect After Action Reports (AARs), journal reports, and objective transitional criteria from civilian and military MTFs
16	Analyze and fully staff the concept of beta testing of small clinic moves
17	Plan for the attrition of patients
18	Finalize equipment reuse plan
19	Approve funding for IM/IT plan execution
20	Resource REQ Plan (Staff). For North and South June 2009
21	Put in place equipment acquisition strategy and contracts with the capacity to support transition – 60 days
22	Develop, populate and finalize JTD
23	Ensure EBD Technology and Lifecycle Management (ACQ Plan for equipment APR 2009)
24	Develop MHS Network Infrastructure (Fiber Optic Ring) Plan
25	Ensure DACH Data Center Design and Procurement
26	Implement joint business plan for healthcare operations
27	Test and refine software system for referral management and patient appointing
28	Establish single privileging body
29	Develop a JOA-wide enrollment plan
30	Renovate North Data Center Project – March2009–April 2010
31	Identify essential military staff that would stabilize (freeze) and stop-move
32	Renovate South Data Center Project – June 2009–September 2010
33	Implement joint (mirror) SOPs and business processes no later than October 2010
34	Assign common governance to maintain accreditations
35	Ensure that all clinical areas document care in single electronic system
36	Ensure JOA portfolio integration, including applications and systems by January 2011
37	Implement and/or expand joint recruiting and retention plan – ASAP
38	Set up a StratCom joint planning group within the next 30 days
39	Finalize WRAMC migration plan for North and South
40	Develop strategy to mitigate patient health information (PHI) and personally identifiable information (PII) risk
41	Finalize DACH migration plan
42	Develop new position descriptions for the new campuses
43	Develop JOA IM/IT standard business rules and policies by June 2010
44	Draft COA 3 logistical execution plan
45	Fully execute all modules of DMHRSi
46	Implement DOD civilian manning model
47	Deliver training and orientation plan for staff moving to a new facility
48	Create hospital ID badges in advance (security)
49	Attempt to purge and archive files/records/inventory proactively
50	Complete the Warrior Transition Unit (WTU) Chain of Command

Appendix A: Construction Schedule First Available Move Date

WRNMMC- Bethesda Campus

Service	1st Available Move Date
Orthopedics Rehabilitation Medicine, Amputee Care	Dec-10
Orthopedics Rehabilitation Medicine, Occupational Therapy	Feb-11
Orthopedics Rehabilitation Medicine, Orthopedics	Dec-10
Radiology, Radiation oncology	Dec-10
Orthopedics Rehabilitation Medicine, Chiropractic	Feb-11
Orthopedics Rehabilitation Medicine, Orthotics	Feb-11
Pathology, Blood	Dec-10
Pharmacy, Outpatient Pharmacy	Dec-10
Medicine, Internal Medicine	Dec-10
Medicine, Internal Medicine	Dec-10
Orthopedics Rehabilitation Medicine, Orthopedics	Feb-11
Orthopedics Rehabilitation Medicine, Podiatry	Feb-11
Radiology, Radiographic procedures	Dec-10
Medicine, Dermatology	Dec-10
Medicine, Hematology Oncology	Feb-11
Medicine, Optometry	Feb-11
Medicine, Rheumatology	Dec-10
OBGYN, GYNONC	Dec-10
Prostate Center, Prostate Center	TBD

Surgery, General Surgery	Dec-10
Behavioral Health, Child and Family	Dec-10
Medicine, Allergy Immunology	Dec-10
Medicine, Allergy Immunology	Dec-10
Pediatrics, Adolescent Medicine	Feb-11
Pediatrics, Hematology Oncology	Feb-11
Pediatrics, Primary Care	Feb-11
Pediatrics, Subspecialties	Feb-11
Medicine, Endocrinology	Dec-10
Surgery, Audiology Speech	Dec-10
Surgery, ENT	Dec-10
Behavioral Health, Adult Outpatient Behavioral Health	Dec-10
Behavioral Health, Partial Hospitalization	Dec-10
Neurology, Adult Neurology	Dec-10
Emergency, ER	Jan-11
Radiology, Diagnostic radiology	Jan-11
Medicine, Cardiology	Jan-11
Radiology, Radiographic procedures	Jan-11
Surgery, CT Surgery	Jan-11
Surgery, Vascular surgery	Aug-11
Critical Care, Inpatient Units	Jan-11
Surgery, Anesthesia	Jan-11
Critical Care, Inpatient Units	Jan-11
Executive Services, Executive Services	Not Moving
Radiology, 3-D Medical Applications	May-10
Housekeeping, Housekeeping	May-10
Dental Readiness, Dental Readiness	Aug-10

Behavioral Health, Family Advocacy Program	TBD
Executive Services, Executive Services	Not Moving
Medicine, Infectious Disease	Mar-11
Medicine, Infectious Disease	Mar-11
Dental Readiness, Dental Readiness	Aug-10
Occupational Health, Occupational Health	Not Moving
Behavioral Health, Substance Abuse	Not Moving
Substance Abuse Prevention, Substance Abuse Prevention	Not Moving
Library, Library	TBD
Surgery, Ophthalmology	Mar-10
Radiology, Radiographic procedures	TBD
Central Distribution , Central Distribution	Not Moving
Medicine, Infectious Disease	Aug-11
Pathology, Anatomical	Oct-09
Pathology, Clinical	Oct-09
Medicine, Gastroenterology	Not Moving
Medicine, Nephrology	Aug-11
Medicine, Pulmonary	Aug-11
Radiology, Diagnostic radiology	Jan-11
Surgery, General Surgery	Feb-09
Surgery, Neurosurgery	Aug-11
Surgery, Organ transplant	Aug-11
Clinical Investigations (Pharmacy), Clinical Investigations (Pharmacy)	Aug-11
GME, GME	Aug-11
Medicine, Cardiology	Jan-11
Medicine, Cardiology	Aug-11
OBGYN, General OB/GYN	Not Moving

OBGYN, Maternal Fetal Medicine	Not Moving
OBGYN, Repro. Endo and Infertility	Apr-10
OBGYN, Repro. Endo and Infertility	Apr-10
OBGYN, Service Chief	Apr-10
OBGYN, Uro/Gynocology	Apr-10
Pharmacy, Clinical	Not Moving
Surgery, CT Surgery	Jan-11
Surgery, Oral Max Facial S	Aug-11
Surgery, Plastic surgery	Aug-11
Surgery, Urology	Mar-11
Surgery, Vascular surgery	Aug-11
Adult Medical-Surgical, Inpatient Units	Aug-11
Inpatient Units, APU	Mar-11
Inpatient Units, APU	Aug-11
Inpatient Units, MOR	Jan-11
Inpatient Units, PACU	Dec-10
Surgery, Anesthesia	Aug-11
Surgery, Urology	Mar-11
Adult Medical-Surgical, Inpatient Units	Aug-11
Orthopedics Rehabilitation Medicine, Physical Therapy	Aug-11
Pediatrics, Inpatient Units	Aug-11
Pediatrics, Inpatient Units	Aug-11
Adult Medical-Surgical, Inpatient Units	Aug-11
Adult Medical-Surgical, Inpatient Units	Aug-11
Inpatient Units, Antepartum	Not Moving
Inpatient Units, L&D	Not Moving
Inpatient Units, NICU	Not Moving

Behavioral Health, Adult Inpatient Psychiatry	Jan-11
Behavioral Health, Behavioral Health Consultation	Aug-11
Executive Services, Executive Services	Aug-11

FBCH- Fort Belvoir Campus

Service	1st Available Move Date
Behavioral Health, Child Partial Hospitalization	4/1/2011
Medicine, Internal Medicine	4/1/2011
Pediatrics, Adolescent Medicine	4/1/2011
Pediatrics, Primary Care	4/1/2011
Pediatrics, Subspecialties	4/1/2011
Behavioral Health, Adult Outpatient Behavioral Health	4/1/2011
Behavioral Health, Behavioral Health Consultation	4/1/2011
Behavioral Health, Child and Family	4/1/2011
Behavioral Health, Family Advocacy Program	4/1/2011
Behavioral Health, Substance Abuse	4/1/2011
Orthopedics Rehabilitation Medicine, Chiropractic	4/1/2011
Orthopedics Rehabilitation Medicine, Occupational Therapy	4/1/2011
Orthopedics Rehabilitation Medicine, Orthopedics	4/1/2011
Orthopedics Rehabilitation Medicine, Orthotics	4/1/2011
Substance Abuse Prevention, Residential Substance Abuse	4/1/2011
Medicine, Allergy Immunology	4/1/2011
Primary Care, Family Practice	4/1/2011
GDE, GDE	4/1/2011
Medicine, Cardiology	4/1/2011
Preventive Medicine, Community Health Nursing	4/1/2011

Orthopedics Rehabilitation Medicine, Physical Therapy	4/1/2011
Orthopedics Rehabilitation Medicine, PMR	4/1/2011
Orthopedics Rehabilitation Medicine, Podiatry	4/1/2011
Orthopedics Rehabilitation Medicine, Sports Medicine	4/1/2011
Central Distribution , Central Distribution	4/1/2011
Clinical Investigation, Clinical Investigation	4/1/2011
Customer Support, Customer Support	4/1/2011
Equipment Management, Equipment Management	4/1/2011
Facilities Mgmt, Facilities Mgmt	4/1/2011
Housekeeping, Housekeeping	4/1/2011
Inpatient Units, CMS	4/1/2011
Laundry Service, Laundry Service	4/1/2011
Medical Records, Inpatient Records	4/1/2011
Medical Records, Outpatient Records	4/1/2011
Nurse Consultant/Pre-Cert, Nurse Consultant/Pre-Cert	4/1/2011
Pathology, Anatomical	4/1/2011
Pathology, Clinical	4/1/2011
Pathology, Service Chief	4/1/2011
Patient Accountability, Admin & Dispositions	4/1/2011
Preventive Medicine, Environmental Health	4/1/2011
Preventive Medicine, Industrial Hygiene	4/1/2011
Transportation, Transportation	4/1/2011
Clinical Dietetics Branch/Division, Clinical Dietetics Branch/Division	4/1/2011
Clinical Investigations (Pharmacy), Clinical Investigations (Pharmacy)	4/1/2011
Education & Training, Education & Training	4/1/2011
Education & Training, Hospital Education	4/1/2011
Education, Training & Research Branch, Education, Training	4/1/2011

& Research Branch

Emergency, Ambulance	4/1/2011
Emergency, ER	4/1/2011
GME, GME	4/1/2011
Hospital Dentistry, Hospital Dentistry	4/1/2011
Library, Library	4/1/2011
Medicine, Hematology Oncology	4/1/2011
Medicine, Infectious Disease	4/1/2011
OBGYN, General OB/GYN	4/1/2011
OBGYN, GYNONC	4/1/2011
Pharmacy, Clinical	4/1/2011
Pharmacy, Inpatient	4/1/2011
Pharmacy, Outpatient Pharmacy	4/1/2011
Primary Care, Adult Primary Care	4/1/2011
Surgery, Oral Max Facial S	4/1/2011
Critical Care, Inpatient Units	4/1/2011
Inpatient Units, APU	4/1/2011
Inpatient Units, MOR	4/1/2011
Inpatient Units, PACU	4/1/2011
Medicine, Critical Care	4/1/2011
Pathology, Blood	4/1/2011
Radiology, Nuclear medicine	4/1/2011
Radiology, Radiographic procedures	4/1/2011
Surgery, Anesthesia	4/1/2011
Surgery, CT Surgery	4/1/2011
Surgery, General Surgery	4/1/2011
Surgery, Vascular surgery	4/1/2011

Medicine, Gastroenterology	4/1/2011
Surgery, Anesthesia	4/1/2011
Psychiatry, Psychiatry	4/1/2011
Inpatient Units, Antepartum	6/1/2011
Inpatient Units, Couplet Care	6/1/2011
Inpatient Units, L&D	6/1/2011
Inpatient Units, NICU	6/1/2011
OBGYN, Maternal Fetal Medicine	6/1/2011
Pediatrics, Inpatient Units	6/1/2011
Adult Medical-Surgical, Inpatient Units	6/1/2011
Radiology, Radiation oncology	4/1/2011
Medicine, Nephrology	4/1/2011
Surgery, Audiology Speech	4/1/2011
Surgery, ENT	4/1/2011
Surgery, Plastic surgery	4/1/2011
Surgery, Urology	4/1/2011
Discharge Planning, Discharge Planning	4/1/2011
HCOPS, HCOPS	4/1/2011
Neurology, Adult Neurology	4/1/2011
Surgery, Neurosurgery	4/1/2011
Medicine, Dermatology	4/1/2011
Medicine, Endocrinology	4/1/2011
Medicine, Optometry	4/1/2011
Medicine, Rheumatology	4/1/2011
Primary Care, Health Promotion and Wellness	4/1/2011
Medicine, Pulmonary	4/1/2011
Surgery, Ophthalmology	4/1/2011

Appendix B: Transition Options
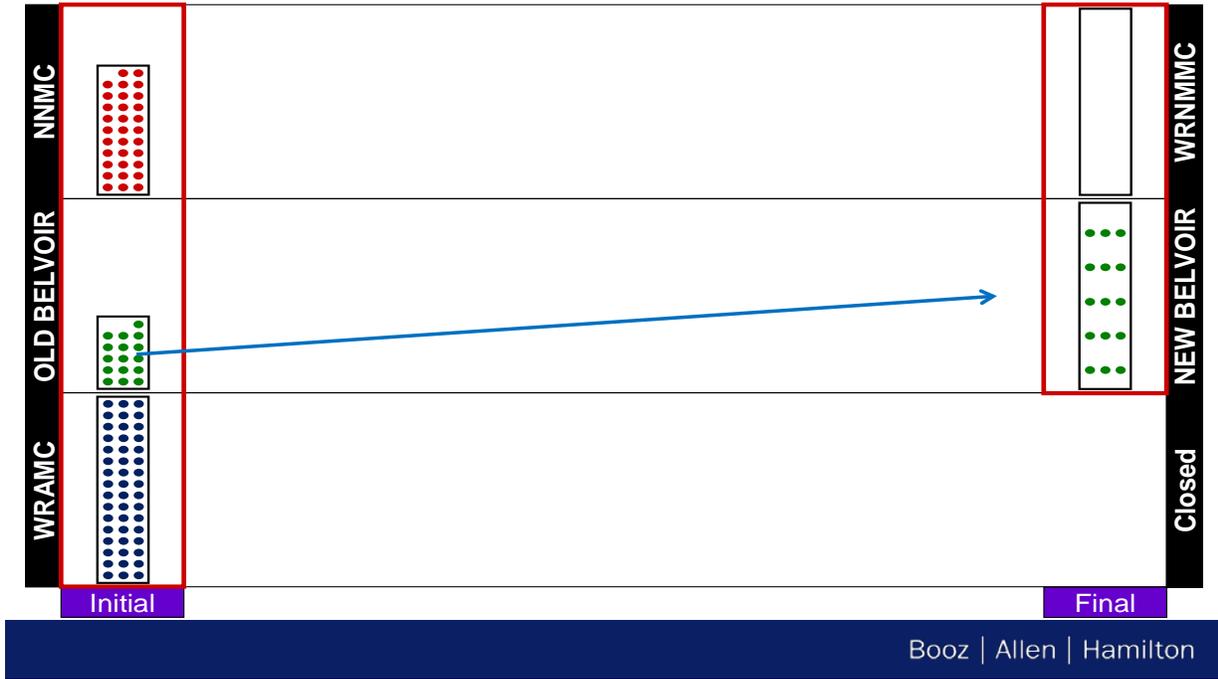
NCR BRAC Clinical Transition

From Old Belvoir

From WRAMC

MTP v. 1.0 Appendix D: Transition Wargame Report 2009

From NNMC

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Full Transition

* Andrews Participation Could Be
Pre-Positioned at WRAMC, Old
Belvoir, and NNMC

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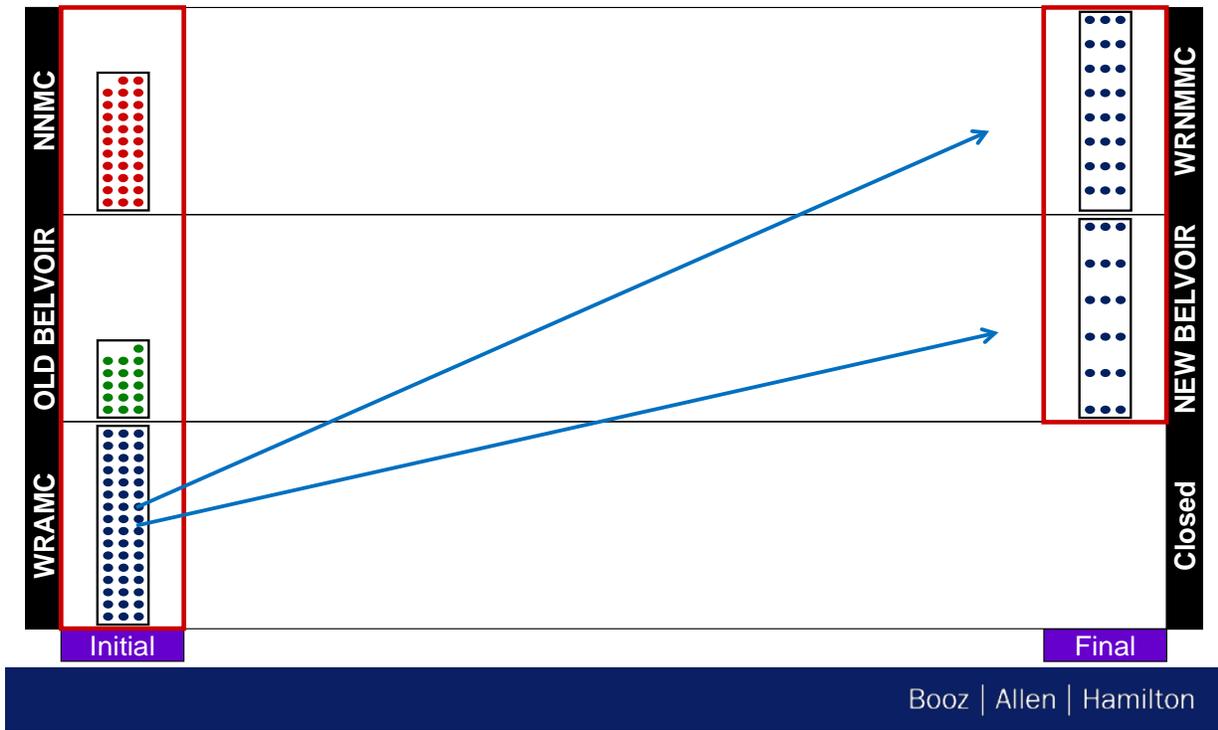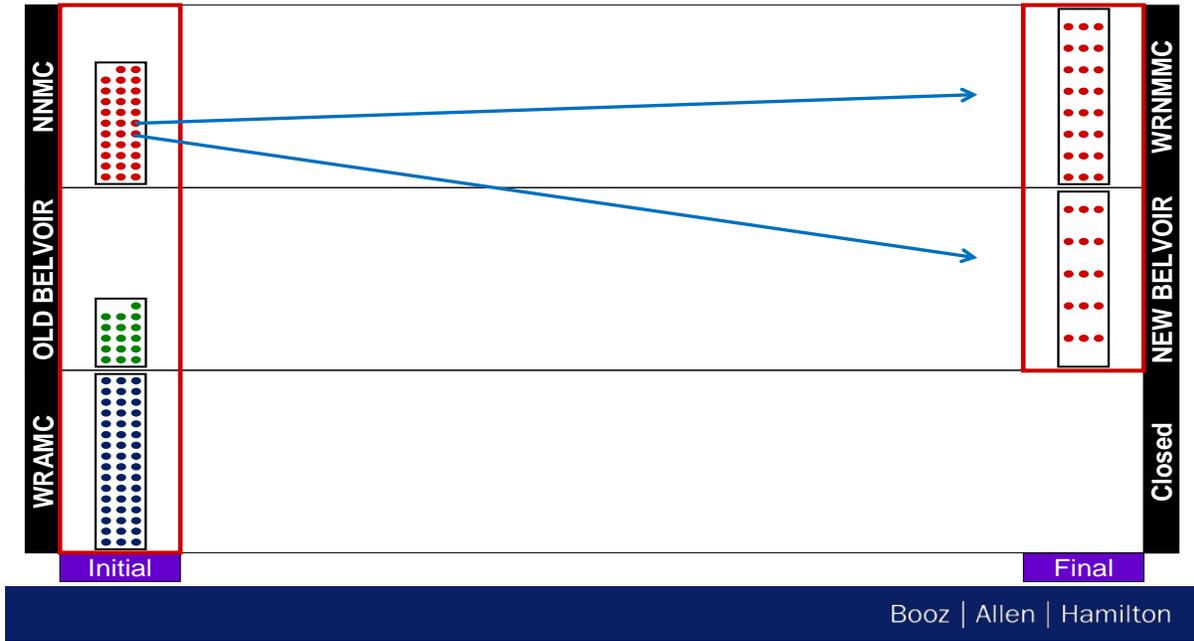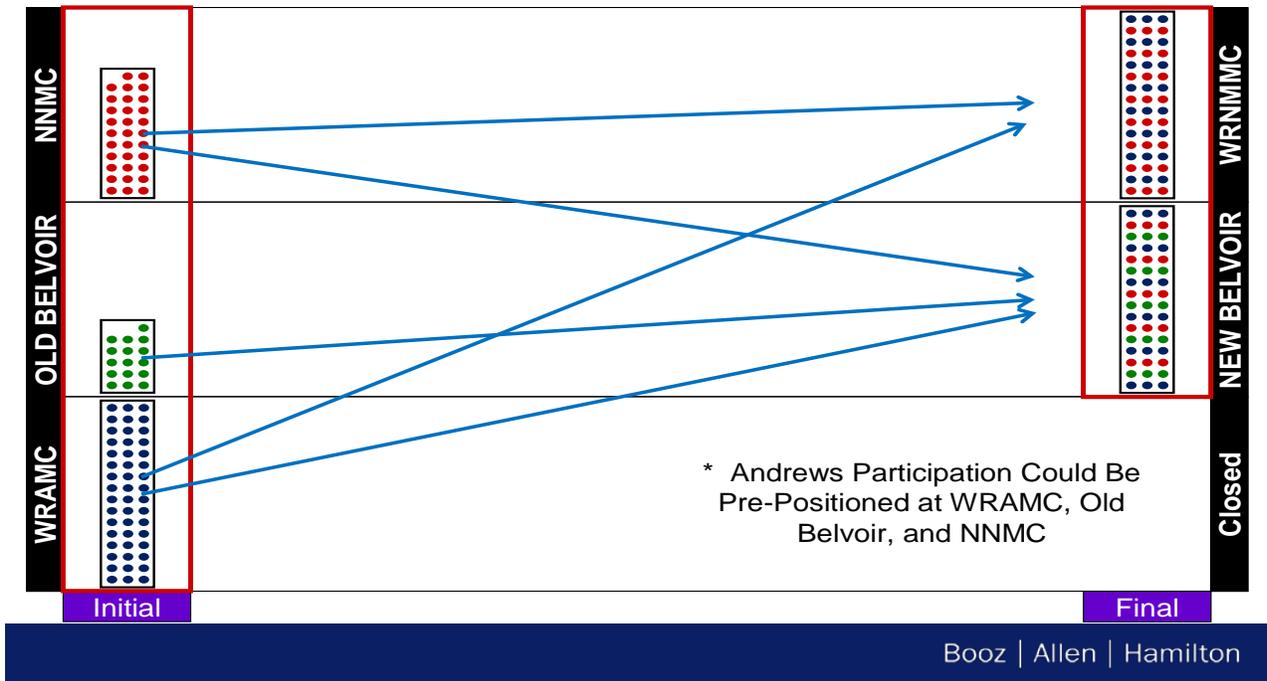
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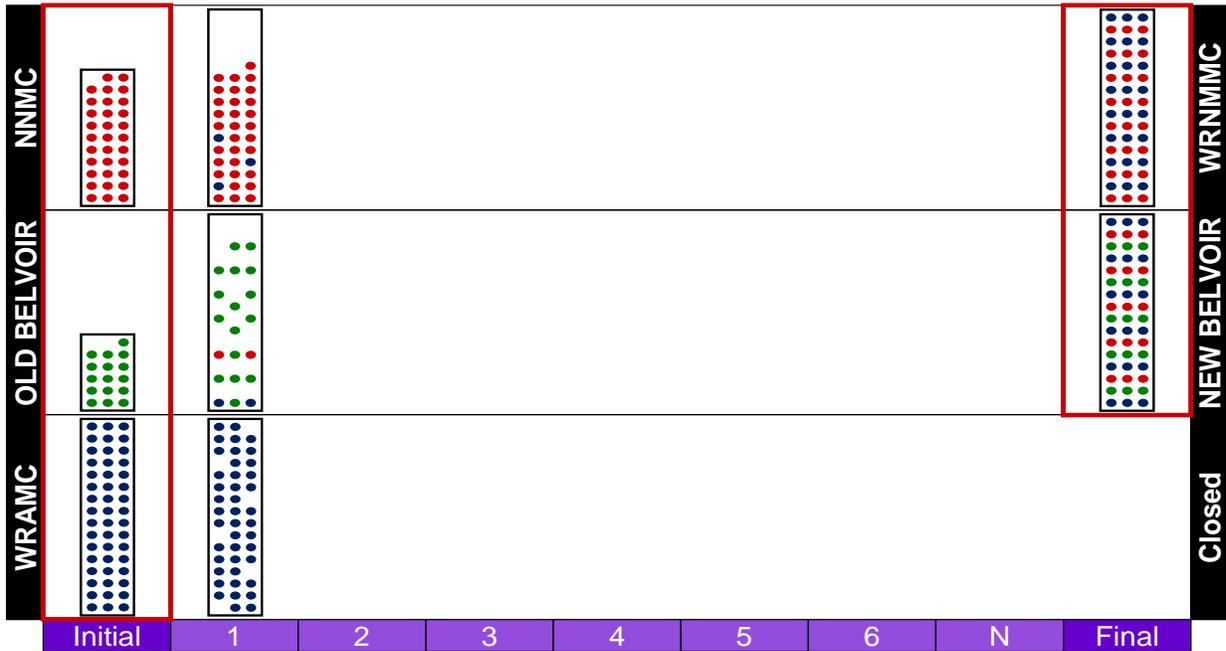
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COA 1 – Multiple Moves

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MTP v. 1.0 Appendix D: Transition Wargame Report 2009
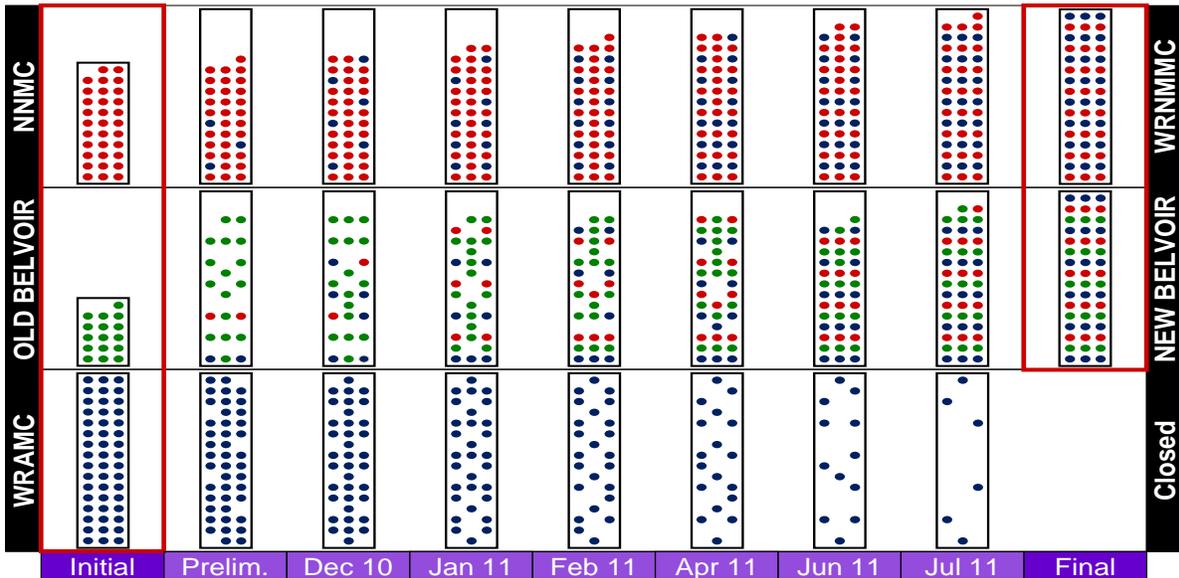
COA 2 – Two Moves
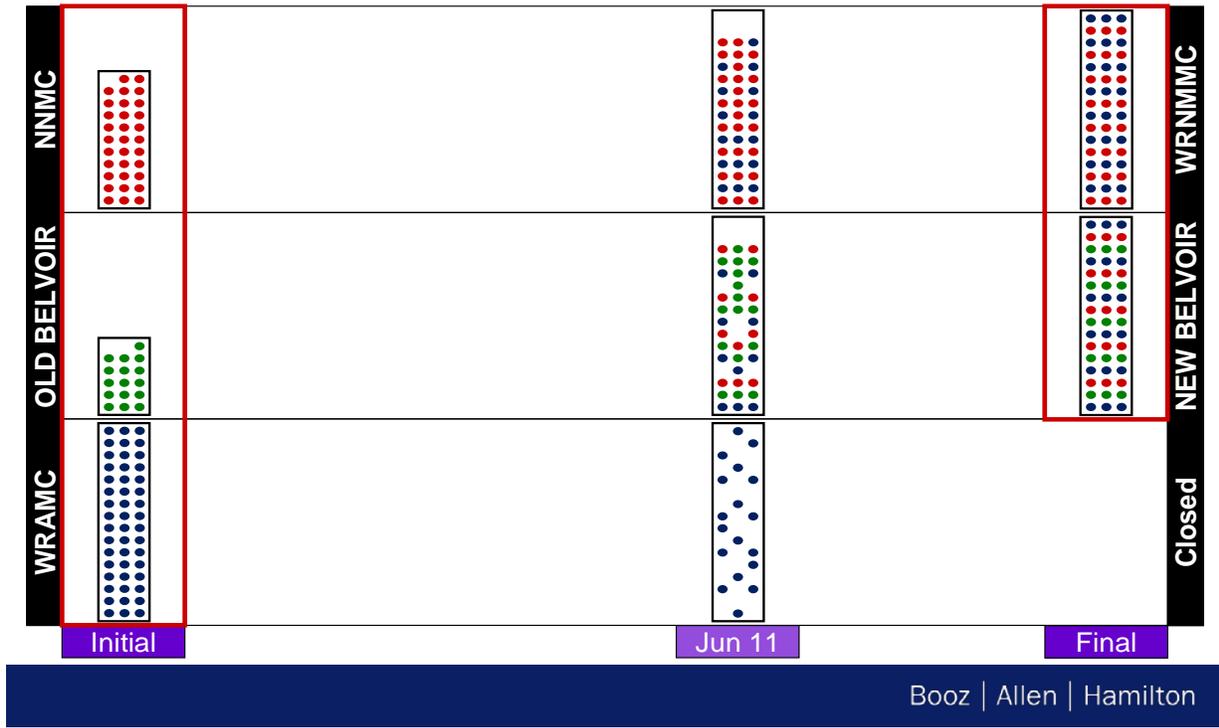
COA 3 – One Move – Late August 2011

MTP v. 1.0 Appendix D: Transition Wargame Report 2009
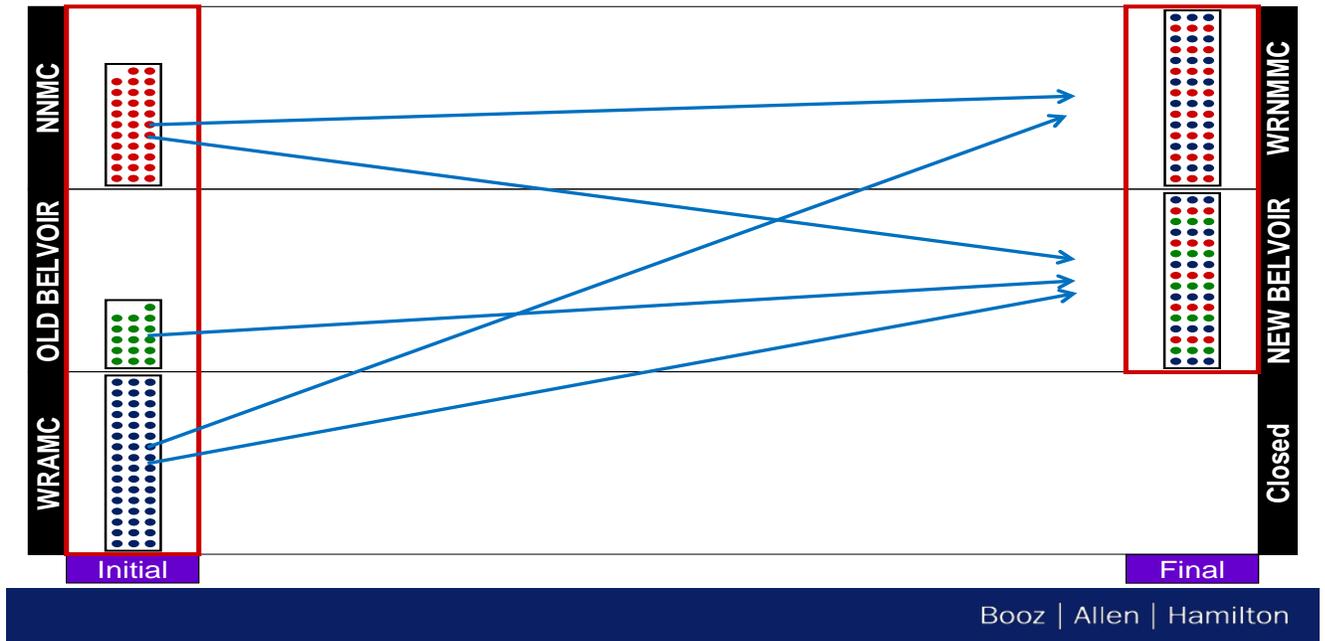
Fort Belvoir Construction Update

Labels in image:
- Hospital Building C
- S Garage
- 4 Clinics
- N Garage
- **1.275 M GSF** Hospital Complex
  120 inpatient beds
  Central Utility Plant (CUP)
  Helipad
  Ambulance shelter
  3500 parking spaces
      - 3100 garaged/400 surface
- 10/29/08
- 1

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1

Bethesda Construction Update

Square Footage:
Addition: 637,000
Alteration: 321,000
Support Facilities: 590,000

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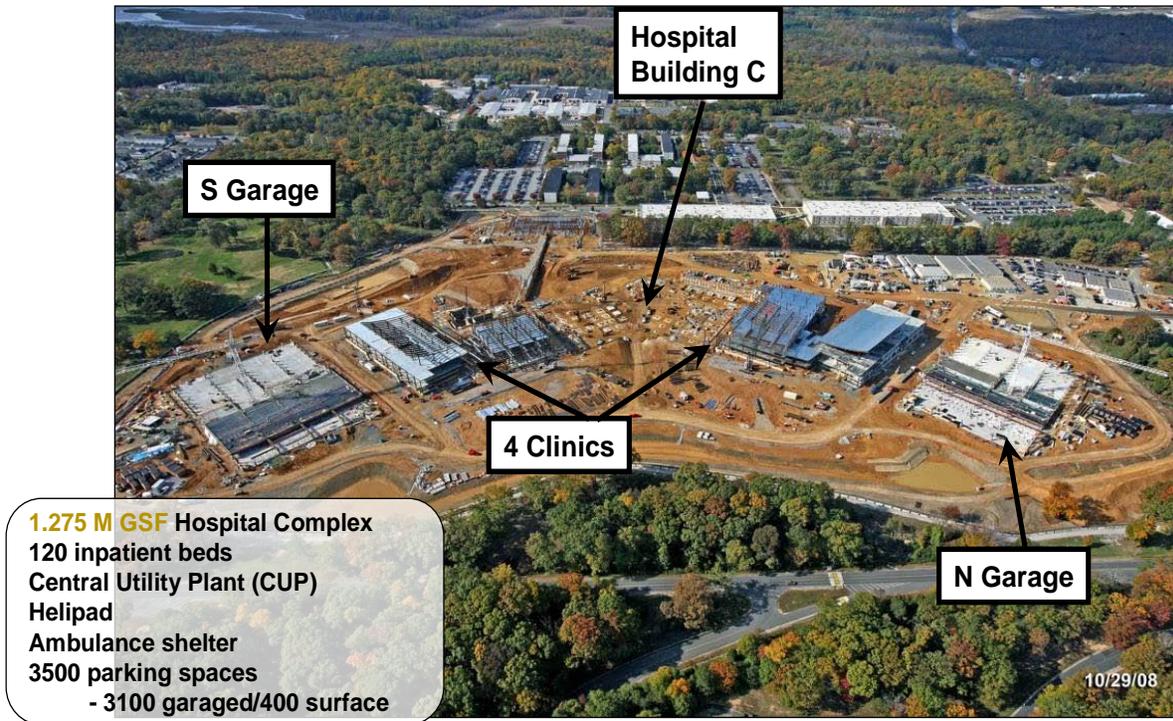
Booz Allen Hamilton

Best Practices in Facility Moves

Lessons Learned in Executing Successful Facility Moves from High-Performing Hospitals and Health Systems

Best Practices in Facility Moves

Lessons Learned in Executing Successful Facility Moves from High-Performing Hospitals and Health Systems

Table of Contents

Research Methodology

To inform the transition planning effort, Booz Allen conducted an examination of recent high-profile facility moves, with a goal of extracting a common set of lessons learned and best practices in merging and moving hospitals. Hospitals and health systems selected for the study were chosen for their similarity to WRNMMC/Fort Belvoir's situation. Most selected hospitals represent major, tertiary care facilities, whose move involved the relocation of a large number of patients, furniture and equipment to a renovated or replacement facility located considerable distance from the original facility; some institutions involved the consolidation of multiple sites into one, and several had robust teaching programs. While multiple institutions were contacted, seven ultimately agreed to participate, providing valuable information and lessons learned:

Institution	Bed Size and Teaching Status	Square Footage	Total Duration of Move*	Length of Inpatient Move**	Key Details
Baptist Health South Florida: Homestead Hospital *Homestead, Florida*	120-bed, not-for-profit community hospital	375,000	July 30th to August 3rd, 2006 (4 days)	1 day	Relocation of surgical (OR, Day Surgery, Labor and Delivery), medical (cardiology), and administrative (performance improvement, HR, services from existing hospital to replacement facility 8 miles away
Catholic Health Initiatives: St. Joseph's Medical Center *Reading, Pennsylvania*	200-bed, not-for-profit, teaching hospital, part of Catholic Healthcare Initiatives	750,000	November 12th to 18th, 2007 (6 days)	7:00 AM to 1:22 PM (6 hours)	Relocation of entire tertiary care medical center from existing to destination facility, located 8 miles away.
Firelands Regional Medical Center *Sandusky, Ohio*	205-bed, not-for-profit teaching hospital	500,000	July 19th-July 26th, 2008 (7 days)	1 day	Relocation of surgical (OR, PACU, ICU), medical (Cardiac Rehab, Oncology), and administrative (financial counselors, admission, registration) services relocated to 500,000 sq. ft. tower adjacent to hospital
Minneapolis VAMC Minneapolis, MN	845-bed teaching VA Medical Center	1,500,000	Approx. 6 weeks	75 minutes	Relocation of full set of clinical, administrative and support services from existing to adjacent replacement facility.
Peterborough Regional Health Center *Peterborough, Ontario*	360-bed, not-for-profit teaching hospital	800,000	May 20th to June 9th, 2008 (20 days)	7:00 AM to 3:00 PM (8 hours)	Transfer of two disparate facilities' resources and patients into a single hospital
Portsmouth Naval Medical Center *Portsmouth, Virginia*	250-bed Navy teaching hospital	2,000,000	February-April 1999 (6 weeks)	1 day	Complete consolidation of two acute care facilities into a replacement facility located adjacent to one facility and a block away from other. Moved involved the careful sequencing of a full set of outpatient clinics and over 100 patients
UCLA Medical Center *Los Angeles, California*	581-bed, not-for-profit AMC	1,300,000	June 16th to June 30th, 2008 (14 days)	7:00AM to 12:00 PM (5 hours)	Full relocation of all hospital functions to new facility across the street from existing building

*__Total Duration of Move__—Refers to the entire period preceding and including the inpatient move. For all hospitals profiled, this period included the relocation of "soft" areas such as patient administration, logistics and accounting
**__Length of Inpatient Move__—Refers specifically to the amount of time required to move all inpatients from existing to replacement facility. Unless otherwise noted, all facilities began offering their inpatient and outpatient services on the same day as the inpatient move was completed

Key Considerations and Challenges in Facility Moves

The following challenges and strategies were distilled from interviews with administrators overseeing facility moves and discussions with firms managing facility moves:

Consideration #1—Carefully sequence inpatients during physical move—Numerous hospital administrators, in addition to representatives from facility moving companies stressed the importance of carefully sequencing inpatients to ensure a safe and timely execution of the physical move. It is imperative for the transition planning team to develop a prioritization scheme for patients in the transport queue, rather than simply transporting inpatients whenever staff and resources become available to move them. While interviewed administrators differed in their specific approaches towards sequencing patients, they all examined some combination of the following criteria in developing their plan:

- Patient acuity
- Patient resource intensiveness (i.e. what is the extent of the supplies and equipment needed to move a particular patient)
- Patient location in the replacement (destination) facility
- Patient location in the existing facility

Consideration #2—Minimize length of patient move to 1-2 days— Administrators were nearly unanimous in their assertion that, in order to minimize risk to patients, the actual length of a physical patient move should be limited to a maximum of two days (and ideally accomplished in a single day). Administrators mentioned that a limited move timeframe ensures that hospital staff will not lose the necessary momentum and energy required to move a large number of patients. This is particularly relevant to moving critically ill patients (i.e. those in the ICU and NICU), which require a heightened attention to detail, synchronization of resources and staff, and a large amount of resources. It should be noted that, while there is a potential financial incentive to move patients in a timely fashion—which would be particularly relevant to the private sector—the substantiation offered by all interviewed administrators behind their short move periods was described in terms of patient safety—rather than economic—terms.

Consideration #3—Move as many "soft areas" as possible prior to date of patient move—All administrators and representatives from Healthcare Relocations converged on the importance of transitioning as many "soft areas," that is, all the administrative and support functions not explicitly related to maintaining clinical care, as possible before beginning to move patients. By doing this, administrators are able to limit the number of

supplies physically moved on patient move day and guarantee that areas in the destination hospital are fully operational prior to moving patients to the destination facility. Furthermore, administrators consistently cited the importance of minimizing confusion related to the location of an administrative function (i.e. the location of the medical records department) in the period surrounding the move. Administrators can circumvent this potentially dangerous ambiguity by deciding to move all soft functions at a pre-set date prior to the actual move.

Consideration #4—Perform a department-specific requirements analysis prior to executing the move—For a move to be successful, administrators posited, the team organizing the move must have a granular and exhaustive knowledge of the full array of resources being moved by each department—from durable medical equipment (DME) to office supplies. To obtain this level of detail, administrators must be prepared to meet independently with each department head to answer questions surrounding what should move and what can be replaced, to categorize all equipment and supplies to be moved, and to collaboratively develop a physical checklist that can be used by hospital staff on move day.

Consideration #5—Plan and host orientations, walkthroughs, and forums to ensure high physician satisfaction—Administrators consistently cited that one of the largest potential impediments to a smooth move is the failure to secure adequate physician buy-in. For a move to work well, administrators must go beyond merely achieving complacency among physicians—physicians should be perceived as valuable "agents of change" and become actively engaged in the move process. To obtain this level of participation, administrators have a variety of tools at their disposal:

- *Hosting physician orientations and walkthroughs—*Physicians are furnished with building maps, allowed to experiment with new equipment and technology, and are able to walk the halls of the new hospital as construction is completed. During these orientations and walkthroughs, physicians are able to take photos of their new areas that will help them plan how they will use their space
- *Staging clinical department forums—*In a series of regularly recurring meetings, physicians are able to put forth their comments and concerns regarding the move to the move/transition board. Following a standardized process for complaints, a point of contact from the board will provide a timely answer to all comments.

Consideration #6—Designate a dedicated move leader to maintain central oversight over the entire move—Given the sheer number of individuals typically involved in a move, it is imperative to grant oversight of the process to a single senior hospital administrator. The importance of this single point of contact is two-fold: it is vital to have one person able to answer difficult questions and provide on-the-spot resolution to disputes during the planning process, and to serve as a critical liaison between all moving parts during the actual move. Among the various roles the move leader may assume are:
- Maintaining the move plan (discussed in the following strategy)
- Delegating authority to the various move team leaders

- Coordinating/limiting the media's involvement in the move
- Interfacing with relevant regulatory/accrediting bodies (i.e. JCAHO, ACGME, State Department of Health) before, during and after the move

Consideration #7—Develop a robust move plan, containing explicit role delineations, timing expectations, and contingency scenarios—Consistent with the theme of ensuring central oversight over the move is the requirement for developing a robust physical move plan that assigns staff roles for the move, sets clear hour-by-hour expectations for what is to occur, and provides several contingency plans for a variety of "what-if" scenarios. While the depth and breadth of institutions' respective move plans varied, all administrators agreed that the move plan should be outlined in as much detail as possible.

Consideration #8—Stage a mock move to simulate moving experience—To appreciate the complexities and experience of the actual patient move, several administrators cited their experiences staging a mock patient move in the weeks leading up to their respective move dates. During one mock moves, hospital staff were moved out of the existing institution on stretchers and transported to the new hospital in ambulances, large pieces of equipment were hauled down hallways and elevators, and the local police department set up road blocks along the move route. Apart from testing the move plan for any unforeseen pitfalls, these mock moves serve an important role in building confidence among hospital staff in the feasibility of successfully executing such a move.

In addition to employing a variety of common strategies, interviewed administrators shared several ***challenges*** that they believe to be endemic to all moves. These are listed below:

Challenge #1—Ensuring that all department heads faithfully execute their specific move plans—All interviewed administrators articulated the ideal of a move as a well-choreographed exercise, in which departments work collaboratively, and individuals diligently fulfill their role delineations. Due to the sheer number of moving pieces,a single department or hospital administrator who does not comply with the move plan can serve to seriously derail the effort. administrators cited individuals at the hospital who failed to comply with the move plan. For example, one director of transition planning mentioned a clinical department director that failed to adhere to the labeling methodology outline in the move plan. As a result, numerous items were lost.

Challenge #2---Convincing staff to depart with supplies and furniture labeled for disposal—Administrators roundly stressed the importance of deciding (as early in the move process as possible) precisely what furniture and supplies should migrate to the new facility and which ones should be disposed. However, during the execution of the move, interviewed administrators found that staff members tended to cling to certain supplies intended for disposal. Ultimately, this confuses the inventorying and tracking of goods and increase the possibility of losing items during the move. To overcome this

challenge, it is important to be vigilant about enforcing the policy governing what is to be moved and what is to be thrown away.

Challenge #3—Managing the media's involvement with the move—Administrators mentioned that there is no way to circumvent the media attention that is invariably generated as the result of a hospital move. That being said, those interviewed underscored the importance of carefully coordinating the media's involvement at the facility to maximize positive media coverage. Administrators found it advantageous to designate a public affairs officer (or move coordinator) to serve as a "gatekeeper" for all media requests before, during, and after the move. By doing so, the hospital's administrative team is able to exact more control of the image that will be portrayed of the move in the media.

Challenge #4—Maintaining patient-centered care in any lingering clinical services at old facility—While all administrators mentioned that the ideal way to relocate patients from one facility to another is within a single day, an unforeseen delay may cause the movement of select services to be delayed. In these situations, it is crucial to make every effort to ensure that there is no degradation in patient service. One administrator mentioned that, due to unexpected troubles relocating linear accelerators, the radiation oncology inpatient ward and outpatient unit had to remain at the old facility for several days. As such, administrators had to make significant efforts to provide all the non-clinical hospital amenities (i.e. cafeteria food, entertainment, CAM therapy, etc) to ensure that there was no perceived drop in patient service.

Challenge #5—Securing patient and family buy-in to the move—An often-neglected—but nonetheless imperative—challenge for administrators to resolve is securing patient and family buy-in to the move. Administrators cited several strategies to overcome this, including:
- Providing patients with cameras during the move to document their experiences
- Sending out mailings to patients and their families with as much advance notice as possible, to ensure clear communication of move date
- Staging patient and family forums to field questions about the move
- Granting families the opportunity to participate as "receivers" in the move process

The following case studies reflect the experiences of hospital administrators conducting facility moves at large teaching and community hospitals throughout the US and Canada.

Case Study A : Peterborough Regional Health Center

Background
On June 8th, 2008, administrators at Peterborough Regional Health Centre, a 500-bed, public teaching hospital in Ontario, Canada executed a large-scale facility move, relocating nearly 400 inpatients from two separate hospitals into a newly-constructed facility. The merger, which was mandated by Ontario's Central East Local Health Integration Network, the local regional planning commission, was largely driven by efficiency considerations: decision-makers deemed it wasteful to be operating two public hospitals in a community of approximately 70,000 people, and a catchment area of just over 5,000. As such, a directive was issued to close Civic and St. Joseph's Hospitals (located 8km and 1 block away from the new hospital site) and to construct a new hospital in the same urban area.

Facility: Peterborough Regional Health Center

Description: 500-bed, public teaching hospital

Move Distance: 2 existing facilities merge into replacement facility:
- St. Joseph's Hospital (8 km from new hospital)
- Civic Hospital (adjacent to new hospital)

Total Length of Move: 20 days

Total Length of Patient Move: 8 hours

Key Challenges:
- Securing full staff and physician buy-in to the move process

Key Recommendations:
- Perfect in-move communication processes to allow for real-time conflict resolution

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Assembling the Transition Team and Scheduling the Move
After receiving the charge to phase down operations at Civic and St. Joseph's hospitals and plan their transition to Peterborough Regional Health Center, administrators began to develop a Transition Team. This team was assembled approximately 18 months prior to the move and was composed of the new hospital's executive suite, in addition to a dedicated Move Commander (who was hired separately and explicitly for the purposes of the move). *The importance of the decision to designate a single point person to manage the move was consistently underscored by our contact as valuable*: having a designated Move Commander hardwires accountability into the move process, provides hospital staff with a single point to which they can direct their questions, and streamlines communication with regulatory bodies and the media.

The first task of the move team was to decide upon a move date. Ultimately, the selection of the June date was motivated both by the nursing school/graduate medical education (GME) cycle, and the "substantial completion" of the new hospital's completion. As administrators were concerned that the move might cause some nurse and physician turnover, they wanted to ensure that they had access to a steady pipeline of clinical talent from the local schools that could *offset any losses due to attrition at the time of the move.*

Drafting the Move Plan
Having settled upon a move date, administrators began to draft a formal move plan. Meeting with each department, the Move Commander tasked department heads with sketching out an outline for how they planned to operate in the new facility—with a focus on how they would plan to reorganize their furniture, supplies and resources in their newly allocated space. Additionally, department heads were asked to draft a comprehensive list detailing what they planned to move on and before move day. Departments were afforded three weeks to conduct this process.

After all departmental move plans were drafted, the Move commander conducted an executive-level review. During this two week review, the director screened plans to ensure that all equipment to be moved was fully accounted for and that staff were not making misguided assumptions regarding future space utilization (i.e. that all equipment a department planned to reuse/transport would fit in the new space). Plans that needed revision were returned to the department director, and second and third rounds of Move Commander revisions ensued. At the end of two months, all departments had a finalized move plan that satisfied the Move Commander.

Selecting a Mover
Simultaneous with the development of the move plan, the Move Commander and the hospital's administrative team selected a vendor to partner with the health system for the facility move. Since Peterborough is a public, Canadian hospital, administrators are required to place all acquisitions over $25,000 up for competitive bid. As such, the four leading North American health care moving firms were brought in to provide an overview of the services they provide. Ultimately, administrators chose to contract with a particular moving company because the firm's prior experience was best aligned with the hospital's particular situation (a large, multi-site move within a public health system) and because the firm provided the best value.

Once the firm was selected, the Move Commander allowed the firm to review the move plan that had been developed in collaboration with the individual departments. After reviewing the move plan and touring the existing and destination facilities, HCR began to outline the logistics of and the schedule for both the "soft" (involving all areas not directly related to the clinical delivery of patient care) and patient (involving the physical relocation of inpatients) moves.

Executing the "Soft" Move
Following the plan outlined by the moving company, administrators began to transition all soft areas out of the facility *three weeks prior* to the June move date, with the entire soft move lasting two weeks. Areas involved in the soft move included, but were not limited to: Patient Administration, Accounting, Medical Records, Housekeeping, Patient Access, Nutritional Services, Biomedical Engineering, and Materials Management Administration.

The purpose of beginning this transition prior to the patient move was threefold:
- Moving as many people, equipment, and supplies out of the hospitals' hallways as possible prior to patient move day minimizes the number of physical stumbling blocks that the movers have to avoid
- Setting up the IT systems needed for administrative and support functions well in-advance of the patient move allows the new hospital to be (nearly) fully-operational on patient move day
- Transitioning administrative and support functions to the new hospital three weeks prior to move allows ample time for on-site staff training and orientation to new systems and processes

The soft move began three weeks prior to the patient move date and lasted two weeks.

Training and Orientations
During and after the soft move, administrators hosted a variety of equipment training sessions and facility orientations for staff at the new hospital. Each department reserved a two-hour time slot for a walkthrough of the new facility, which consisted of a guided tour of the entire hospital and a more detailed overview of that department's area (including an explanation of the location of power outlets, filing cabinets, building exists, restrooms, and adjacent departments). Additionally, all equipment end-users individually scheduled equipment training sessions with that particular system's administrator (for new IT platforms) or with vendor representatives (for new clinical technology). The Move Commander was charged with the onerous task of scheduling all departments for training and orientation within a 14-day window.

Executing the Patient Move
Prior to the Patient Move, the Move Commander and the movers walked through the facilities, measuring the number of paces and time needed to walk from each clinical department to the facility's exits. Additionally, the team rode in ambulances from Civic Hospital to Peterborough Regional Health Centre, measuring length of time and number of kilometers between facilities on several different routes. Finally, the team measured the time spent walking between St. Joseph's and Peterborough Regional Health Centres. Equipped with this data, administrators estimated that they could accomplish the entire facility move within eight hours, from 7:00 AM to 3:00 PM, with an average of 24 minutes spent transporting each patient from Civic to Peterborough Regional Health Centres. The role delineations and move trajectory are provided on the following page.

- Care Team (Civic Hospital)—Provides patient with pre-move nursing care and preparation
- Lift Team (Civic Hospital)—Lifts patient from old bed onto stretcher, hands off to Transport Team
- Transport team—Transports patients from ward through elevator downstairs to the dispatch area, hands off to Ambulance Team
- Ambulance Team—Takes patient from Civic to Peterborough Health Center, hands off to transport team
- Transport team (Peterborough Regional Health Center)—Receives patient from Ambulance Team, documents arrival electronically via handheld tablet, transports patient from entry point up to wards
- Lift Team (Peterborough Regional Health Centre)—Lifts patient from stretcher and places on their new bed
- Care Team (Peterborough Regional Health Centre)—Provides patient with post-move nursing care

At St. Joseph's hospital, which is located adjacent to the new facility, a canopy was constructed that lead to an entrance to Peterborough Health Center. Seventy patients were transported through this canopy following the same process outlined above, with a canopy transport team replacing the Ambulance team.

Careful orchestration of move teams minimizes patient move time to 24 minutes

Existing Facility   **New Hospital**

| 0 minutes | 6 minutes | 12 minutes | 18 minutes | 24 minutes |

6 minutes: Nurse team preps patient, lift team moves patients onto stretcher, transport team moves patient to loading dock, and transfers to ambulance team

12 minutes: Ambulance team transports patients 8 km to new facility

6 minutes: Transport team receives patient at loading dock, brings to ward; lift team moves patient into bed; nurse team provides post-move care and supervision

Following this process, administrators were able to finish the move in six hours, ending two hours earlier than planned.

Key Challenges
The biggest challenge administrators encountered was securing widespread buy-in from the hospital's staff and administrators for the move effort. Ideally, during a facility move, physicians and department heads should serve as enthusiastic "team captains," rallying their staff behind them in executing their move plan and leading by example. This dynamic is typically important during the move planning process. Extra meetings and longer-than-average work days can exhaust staff. To boost morale and improve buy-in, administrators recommend developing a system to ensure that all physician questions and comments are tracked and responded to promptly, and to improve the length, frequency and quality of physician orientations. By investing time and resources in physician relations on the front-end, all will benefit greatly during the actual patient move.

Key Recommendations
Administrators recommend developing a robust in-move communication plan to resolve on-the-spot conflicts as they occur and to negotiate unforeseen events. By having the Move Commander directing a central operations center during the move, tracking the transportation of patients among the three facilities electronically, and communicating to the move team captains (of the Care, Lift, Transport, and Ambulance Teams) wirelessly, administrators were able to accomplish this successfully. Administrators stressed that such a communication plan obviates the need for intensive disaster/mass casualty planning. If the Move Commander is successful in acquainting himself with a variety of "what-if" scenarios, he should be able to delegate roles and responsibilities effectively to staff in the event that such a scenario occurs; this is preferable to forcing staff to endure lengthy, additional, disaster training.

Additionally, administrators stressed the importance of vetting and approving individual departmental move plans as far in advance of the actual move as possible. The work that the Move Commander accomplished during the two month Move Plan review process, revising and editing move plans, ensured that each department had a clear, near-flawless course of action to accomplish on move day. Any questions surrounding a department's move plan were answered well in advance of the actual move, and, as a result, staff were not subject to any "surprises" during or after the move.

Case Study B: St. Joseph's Hospital

St. Joseph Medical Center
CATHOLIC HEALTH INITIATIVES

Background
On May 15, 2006, St. Joseph's Hospital, a 200-bed, not-for-profit teaching hospital in Reading, Pennsylvania moved 8 miles from a 135-bed, 100 year-old facility to a brand new 225-bed medical center located across town. The Catholic Healthcare Initiatives' (CHI's) corporate office dictated the transition involving the movement of 70 patients through an urban area in a single day. Responding to an increased regional patient population, administrators deemed it advantageous to upgrade facilities and move to a more strategically situated location. As such, the new St. Joseph's medical center was built and a move was scheduled. The move, which became a major local media event, involved heavy community participation and has become a model for other facility moves in the CHI health system.

Facility: St. Joseph's Hospital, Reading, PA

Description: 200-bed, not-for-profit teaching hospital, part of Catholic Healthcare Initiatives

Move Distance: 8 miles

Total Length of Move: 14 days

Total Length of Patient Move: 7 hours

Key Challenges:
- Managing the culture change associated with the facility move

Key Recommendations:
- Designate a single administrator as Move Coordinator to expedite move and manage media's involvement

Assembling the Transition Team and Scheduling the Move
12 months prior to the move, administrators began planning the planning process. As a first step, administrators assembled a multidisciplinary move team, consisting of:
- Move Coordinator
- Corporate health system planning administrators
- Representatives from community organizations
- Patient advocate
- Social worker
- Facility Planner/Construction Representative
- Hospital's VPs

In selecting this team, administrators wanted to ensure that the move was being planned with patient needs as a first priority, with respect for the community, with the goals of the health system and the hospital in mind, and with the insight of the facility planners.

Meeting bi-weekly, the move team settled on the May 15, 2006 move date mainly out of construction considerations: the team estimated that they would need a maximum six weeks to conduct all equipment testing, orientation, and outfitting after the end of construction (which was projected to be in April). This schedule satisfied all representatives.

Drafting the Move Plan
To inform the development of a move plan, administrators were encouraged by the health system's corporate office to observe a CHI move in Durango, Colorado. As such, a subset of the Move Team travelled to the Durango facility to gain insight into how to conduct a successful move. In Durango, the team met with hospital administrators observed and took notes on the move, and produced a report for the Reading Move Team profiling their insights. Ultimately, the biggest "lesson learned" from the Durango experience was that *a large-scale patient move in a semi-urban area can be accomplished in a single day*, given the appropriate preparation and the full compliance of the hospital's staff. In Durango, the team observed a well-orchestrated move with explicit role delineations, widespread municipal involvement, and positive energy.

In developing the move plan—which was initiated six months prior to the move— the Move Team followed a similar process to that in place at Peterborough. Each department head was asked to develop a list of all equipment and supplies that needed to be moved to the new facility, in addition to developing a conceptual outline for how the department planned to operate in their new space. This latter task required considerable effort: as the new facility differed greatly from the old facility, almost all departments had to conduct significant workflow process re-engineering.

Working with the Move Coordinator, an engineer, each department mapped out existing and future workflow maps for the major activities associated with their department (for instance, Patient Administration mapped out patient registration, patient admitting, and patient accounting). In these process redesigns, administrators sought to preserve as many of the old, effective processes as possible, to minimize disruption to the workflows the staff was already acclimated to, while fixing the processes that were inefficient. After three months, all departments had successfully executed a move plan, including both a Move Checklist and a set of revised processes. These move plans were collected into a single transition document, which would become the play book" of the move effort.

Selecting a Mover
As administrators began the process of selecting a moving company just 12 months prior to the move, there was a considerable sense of urgency guiding the process. Ultimately, the team settled upon a moving company for the depth of their healthcare-specific expertise, and for the positive experiences reflected to the hospital by the firm's references.

When the moving company became involved in the process, administrators were intent on acquainting the firm as thoroughly as possible with the unique particularities of the hospital's situation: an antiquated urban facility moving into a completely new medical center, with a very different layout. Additionally, the Move Coordinator furnished the firm with the Move Bible, and called attention to the most significant process redesigns that were to be implemented in the new facilities. The movers took the transition plan and began developing a schedule for the soft and patient moves.

Additionally, the movers met with each department chief and went through the department's equipment list, encouraging staff to purge everything except for items that were absolutely necessary to the department's functionality.

Executing the "Soft" Move
Three weeks prior to the patient move, administrators began conducting a preliminary move, which involved the movement of all "non-100% patient-essential" (what were classified as the "soft" areas: non-clinical support and administrative services, including Patient Financial Services, Hospital Accounting, Medical Records, Housekeeping, Logistics, Nutritional and Food Services, Hospital Restaurants, Chaplain, and others) from the old to the new hospital. Following the moving company's direction, administrators conducted this move in several phases: interdependent administrative and support services were moved in groups.

This movement of interdependent soft areas was deliberate, to minimize ambiguity and confusion for patients and staff prior to the move. For example, the bundling of Patient Financial Services and Patient Registration into one move ensured that any issues that potentially encompassed both areas (such as an insurance dispute) could be effectively routed to the single, appropriate facility, rather than split between two hospitals. Within two weeks the soft move was completed.

Training and Orientations

Beginning a couple weeks before the soft move, the training and orientation period involved a similar set of walkthroughs and department-specific orientation sessions to those conducted at Peterborough Regional Health Center: each department had a time slot scheduled to tour the new facility and to hear a detailed description of their specific area. Additionally, a series of equipment training and certification courses were held at night to ensure that all end-users would be able to attend.

In addition (and prior) to these walkthroughs, a series of physician and administrator-specific orientation sessions were also held at the new facility. Understanding that the key to a successful move was getting the physicians and department heads on board, the move team began to hold lunch-n-learns for physicians at the conclusion of construction. Additionally, administrators were allowed to begin setting up their new space in their respective departments. Ultimately, this fostered enthusiasm among both groups and persuaded them to take a more active role in the move process.

Executing the Patient Move
Administrators perceived the move as an evacuation effort, with the goal being to relocate as many patients and supplies as quickly and safely as possible. As a first step in executing the patient move, administrators opted to cancel elective surgeries at the existing facility on the Wednesday before the move. This brought their inpatient census to approximately 70 patients on the Saturday of the move (although they had the initial goal of reducing the census further, to 50 patients). Additionally, administrators

augmented their ambulance fleet with several rented ambulances from the city, boosting the number of ambulances on-hand to 30, and enlisted the help of the local police force to close roads and escort ambulances. With the support of the police and the city, administrators were able to ensure that the move would proceed as smoothly as possible.

The evening before the move, at 8 PM, administrators closed the ED at the old hospital and opened the ED at the new hospital. At 8 AM, the patient move began in a similar manner to Peterborough Regional Health Center, with staff assuming well-defined roles:

- Nurse Team—Prepared patient for move, administering necessary sedations and dressing patient appropriately
- Lift Team—Lifts patient from bed onto stretcher
- Porter Team—Transports patient to elevator, hands off patient to ambulance team
- Ambulance Team—Transports patient to destination hospital, hands off to destination hospital's porter team
- Patient Advocate—Stands at front door of hospital to meet with families of transported patient
- Social Worker—Accompanies patient advocate, provides consultations with family

Administrators were able to successfully execute the move within the 8 hours they had allotted, with no OR or ED down time. Administrators attribute their success to the careful harmonization of seemingly inconsequential (but actually vital) details, such as ensuring that all elevators were sent up with an empty stretcher and down containing a patient, as outlined on the following page:

Synchronization of elevators key to reducing move time

No elevator departs without patient or stretcher
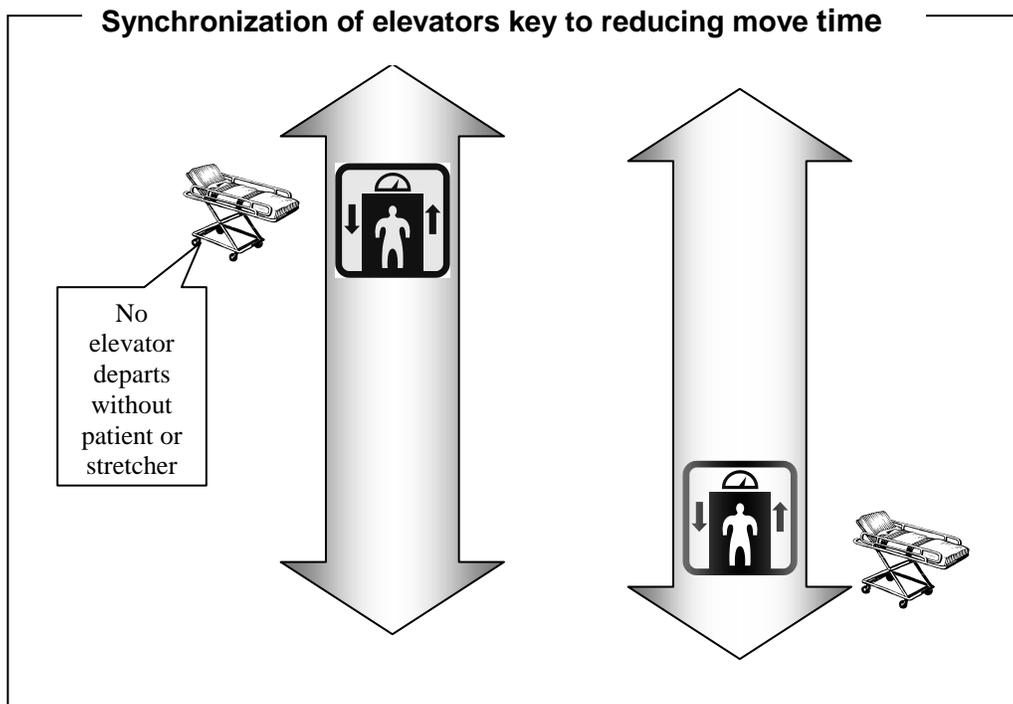
Key Challenges
Among the key challenges administrators cited with the move were:

- *Managing the culture change to the new facility*—Even with the extensive amount of pre-move preparation, and the enlistment of staff in the redesign of their workflows, administrators encountered considerable difficulty in getting staff to take ownership of their new space and become enthusiastic supporters of the move. The dedicated effort to secure buy-in from physicians and administrators during the pre-move did prove to be helpful in developing some influential advocates for the move.

- *Coordinating with accrediting bodies*—While administrators had been braced for the presence of JCAHO, ACGME and the Department of Health, there was considerable ambiguity as to what the organizations' presence would entail, and when they would arrive on the move site. Having researched this earlier would have been helpful to the move, especially since the state's department of health arrived within 48 hours of the transition to the new facility.

Key Recommendations
Administrators offered several recommendations to other hospitals contemplating facility moves, including those listed on the following page.

- ***Research and visit other hospitals conducting facility moves***—The entire basis of the move plan was predicated on the example that the Move Team had observed at the health system's facility in Durango, Colorado. Speaking with like-minded administrators and/or viewing similar facility moves is a necessary first step in designing a move plan.
- ***Designate a Move Coordinator and vest him/her with significant authority***—As the health system began the move planning process just 12 months prior to their expected move date, it was vital for them to create a move governance structure that hardwired efficiency into the move planning process and ensured the timely completion of the move by the deadline. Designating a single person in charge of the move team allowed for the timely decision making and goal-oriented discussions that allowed administrators to complete the move quickly and successfully.
- ***Follow the move sequence outlined by the moving company***—Administrators called attention to the fact that clinically-savvy hospital personnel (mainly, doctors and nurses) are frequently impelled to offer their insight into what they believe the "safest" way to move patients is. Ultimately, however, it is rare that these vocal elements have the depth of experience that the moving company brings to the hospital. As such, to preserve the efficiency and safety of the move, it is crucial to abide by the instruction provided by the move company.

Case Study C: Baptist Health South Florida

Baptist Health South Florida

Background
On August 4th 2007, administrators relocated Homestead Hospital, a 120-bed not-for-profit community hospital of Baptist Health South Florida, into a brand-new replacement facility located four miles away. The move, which involved the movement of 100 patients and a 16-bed ED was dictated by the health system's corporate office: to better respond to the health needs of the region and increase market share, it was advantageous to upgrade facilities and reposition the hospital at a new site across town. Under Florida State Law, if moving, a hospital must relocate to a replacement facility of approximately the same size. As such, a new facility was constructed of comparable scope and the move was planned.

Assembling the Transition Team and Scheduling the Move
Approximately 1 year prior to the move, the hospital's CEO assembled a transition team consisting of a:

- Move Director
- VP, Strategic Planning
- Facility Planner/Construction Representative
- Other Hospital VPs
- Health System planning representatives

Once assembled, the move team decided to execute the move four weeks after the conclusion of construction of the new hospital, which was scheduled for October. However, due to a variety of postponements and scheduling difficulties surrounding the holidays, administrators decided to perform the move in April. Once the date was finalized, a communication was sent out to employees exactly one year in advance, stating that all vacation time would be closed off one week prior to and one week after the scheduled move date. All requests for emergency time off had to be approved by a VP.

Facility: Homestead Hospital

Description: 120-bed, not-for-profit teaching hospital located in Homestead, Florida

Move Distance: 4 miles

Total Length of Move: 4 days

Total Length of Patient Move: 5 hours

Key Challenges:
- Ensuring full departmental compliance with the pre-decided move plan

Key Recommendations:
- Flex staff up during move to allow for greater flexibility between facilities

Drafting the Move Plan

Having selected a move date, administrators began to draft a move plan. As a first step, the Move Director tasked department directors with providing a variety of information regarding how they plan to utilize their new space and resources, in addition to cataloging all the equipment and supplies they plan to move vs. what they plan to throw away. Templates, such as that found below were submitted to each department:

Department directors develop individualized move plans

Department Move Plan

Operations
- How do you plan to utilize your new space?
- What workflow changes will you need to make in order to operate in the new facility?
- Are there any pressing concerns you have regarding your ability to function in the new facility?

Move Preparation
- Please list all equipment you plan to bring with you to the new facility
- Please list all equipment you plan to dispose of prior to the move
- Is there any unlisted, needed equipment that you require after the move.

Administrator Approval: _____

The move director reviewed the departmental move plan and provided comments and revisions. Within three months, all department directors had finalized a move plan that was approved by the move director. These move plans, which became the foundation of the Move Manual, were supplemented by a set of contingency plans for unexpected and disaster events (i.e. a broken elevator), and a contact list of key stakeholders in the move process.

While departments were finalizing their move plans, the move team developed a "Transition Staffing Plan," which took into account the added nursing and logistical workloads that would be generated by the move. This was approved by the hospital's VP of planning and an announcement was made to the staff at-large regarding the plan.

Selecting a Mover
Over the course of four months, the move team invited a variety of moving firms in to provide a presentation to the hospital's CEO, Chief of Engineering, Move Director, VP of Planning and Comptroller. Ultimately, the team decided to select a firm that had moved the most number of comparably-sized healthcare facilities.
.

Executing the "Soft" Move
The entire move—including all administrative, clinical, and support areas and patients—took place over a four day period, in three distinct waves: Monday, Wednesday and Saturday. The phasing of the move, the prioritization of supplies and services moved, was done according to direct relevance to patient care. Accordingly, those services which were least directly associated to patient care—such as HR, patient administration, and logistics—were moved on Monday. Other services, more closely related to patient care but able to be transitioned to the new (remote) site for 48 hours (such as radiology, lab and pharmacy) were transitioned on Thursday, with the large patient move occurring on Saturday.

Within each clinical department's aforementioned move plan, department directors were asked how they would plan to move their entire service, including patients, within the four day period. Department directors typically chose to move books, office supplies, and rarely used equipment on the first day, medical equipment not currently used by patients on the second day (i.e. IV poles, extra needles, medications, etc), and reserving the final Saturday just for the unit's patients.

Training and Orientations
As few truly new systems were put into place at the new facility, the amount of equipment training was minimal (as compared to the other facilities profiled). That being said, staff was provided with a variety of orientations to their new space as soon as construction was finished. A kick-off event was held soon after the building was finished in which groups were taken for walkthroughs of the new facility, and a presentation on the construction was delivered. A variety of question-and-answer forums were provided for hospital staff. All questions that were asked were carefully recorded to ensure that they were responded to in a timely fashion.

Executing the Patient Move
On move day, administrators began moving patients at 8:00 AM, with the goal of concluding by 1 PM. A caravan of ambulances, some borrowed from neighboring facilities and others belong to the hospital, was assembled outside the facility. The roles assigned to staff during the move paralleled those found at Peterborough Regional Health Centre and St. Joseph's Hospital:

- Nursing Team--Provides patient with pre-move nursing care and preparation
- Lift Team—Lifts patient from old bed onto stretcher, hands off to Transport Team
- Transport team—Transports patients from ward through elevator downstairs to the dispatch area, hands off to Ambulance Team

- Ambulance Team—Takes patient from old to new, hands off to transport team

While administrators were told that the move would take between four and five hours, they were able to successfully execute the move in 3 hours, 45 minutes, with only 4 hours downtime total between the two hospitals. During the move, administrators were able to successfully ensure that all ambulances remained productive (full of patients) for the entire duration, with no down time between trips.

Another important indicator of the move's success was in that nothing was lost during the move, except for a single office chair (which was later recovered). Administrators attribute their success in keeping track of materials to the uniform labeling methodology they employed (under the direction of the mover). While seemingly simple, requiring staff to populate floor, department, and room number in a common notation on *every* box, represents an effective method of materials management during the move.

Key Challenges
While administrators regard their move as an unqualified success, the move director regards **ensuring that departments faithfully execute their move plans** as a key challenge for any administrator overseeing a facility move. During the move, one department failed to follow the three-phased move plan that they had submitted to the move director, waiting until the final move Saturday to move all supplies and patients. As such, equipment was hastily thrown into boxes at the last minute, office supplies were poorly packaged, and, as a result, the department director couldn't find what he needed to be operational in the new facility on the day of the move. If he could do the move over again, the Move Director would develop some mechanism to ensure that departments execute the move plans they had previously outlined.

Key Recommendations
Administrators regard the importance of proper practice to be an undervalued element in the move planning process. In preparation for the move, administrators conducted a serried of "mock moves" in which hospital staff were transported from the old to the new facility in ambulances, with police escorts. These mock moves provided staff with the confidence they needed to be successful in executing a facility move—and are recommended to any administrator overseeing a move.

Case Study D: Firelands Regional Medical Center

FIRELANDS
Regional Medical Center

Background

On July 26th, 2008, Firelands Regional Medical Center relocated a broad set of surgical (OR, PACU, ICU), medical (Cardiac Rehab, Oncology), and administrative (financial counselors, admission, registration) services from the main hospital building to a 500,000 square foot tower adjacent to the facility. Given the scope of the services transitioned, the "East Tower Move" was treated by administrators and movers alike as a full hospital move, with a year-long planning process, a dedicated effort to coordinate media relations, and collaboration with local municipal agencies.

Assembling the Transition Team and Scheduling the Move

> **Facility**: Firelands Regional Medical Center
>
> **Description**: 205-bed, not-for-profit teaching hospital
>
> **Move Distance**: 1 block
>
> **Total Length of Move**: 7 days
>
> **Total Length of Patient Move**: 1 day
>
> **Key Challenges:**
> - Maintaining patient centered care for those patients not moved on move day
>
> **Key Recommendations:**
> - Minimize risk by moving patients and equipment as quickly as possible from old to replacement facility

In assembling a team to coordinate the move, administrators wanted to ensure that all clinical services were represented, that media relations were handled effectively, and that non-clinical/logistical functions were given an opportunity to weigh in on the move. As such, the move's Project Manager developed a multi-disciplinary organizational structure to govern the move:

Move Team's Organizational Structure Adequately Represents Relevant Stakeholders
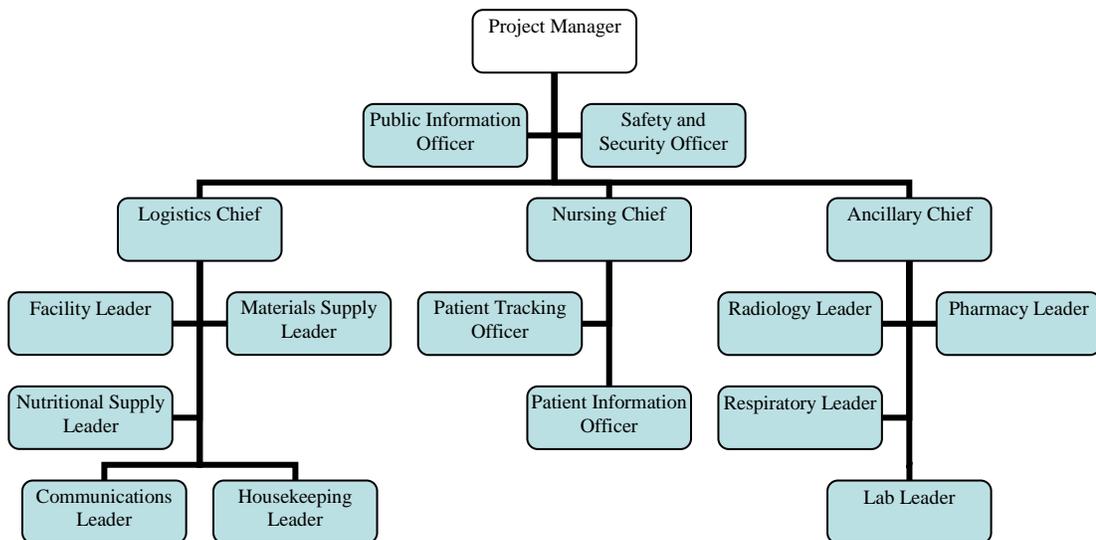
The move team's decision to move on July 26th was based on the conclusion of construction (in late June), a seasonally low inpatient census that facilitated the move, and the conclusion of the GME/nursing school cycle (which would produce local clinical talent in search of hospital jobs). Once a move date had been decided upon, a communication was sent out to hospital staff, so that they could coordinate planned vacation time accordingly.

Drafting the Move Plan
As in other hospitals profiled in this report, the Project Manager at Firelands Regional Medical Center tasked moving clinical departments to develop a plan explaining what they are planning to move and how they plan to operate in their new space. Departments were afforded 3 weeks to complete the plan, and 2 weeks to incorporate the Project Manager's edits. At the end of 6 weeks, a formal move plan had been drafted, which became the basis for the move manual (which was used during the actual move).

Selecting a Mover
Over the course of two months, Firelands Regional Medical Center brought in a variety of facility movers to provide demonstrations to the move team. While representatives from the move team all brought different priorities into the deliberations (logistics, for example, may have been adamant on a mover with experience in configuring IT systems), the team shared a common goal of wanting to select a mover with hospital-specific experience and extensive references.

Executing the "Soft" Move
Unlike some other facilities, which require an extensive amount of time and coordination to accomplish the preliminary soft move, the relatively short distance of Firelands' move allowed administrators to transition services over gradually from one facility to the other. During the seven days prior to the move, all equipment and supplies associated with the administrative and support services were brought over from the main hospital, with the final patient move being reserved for the Saturday of the move. On move day, only patients and the supplies and equipment directly associated with them were moved, which effectively minimized total move time.

Training and Orientations
- In the week prior to the move, every staff member had to undergo an orientation and training process, whose goal was to familiarize staff with new space, provide a base understanding of all new systems in the facility, and build enthusiasm for the move. Components of this orientation include:

- *Unit Scavenger Hunt*—Location of key items in each unit, such as restrooms, telephones and water fountains are the items to be found in a scavenger hunt
- *Communication System Orientation*—Staff are given the opportunity to test out new communication systems in East Tower, including wireless phones and nurse call system

- *New Equipment Orientation*—All new equipment used by nursing staff in the new hospital (such as new holter monitors and IV pumps) are previewed for hospital staff
- *New Process Review*—Key new workflow processes are explained for hospital staff, such as patient admission, discharge, walking rounds, and role of the CN.

Executing the Patient Move

On patient move day, administrators followed a similar process to the other hospitals we have mentioned. Staff roles were divided into several distinct categories a nurse Team—prepares patient for move, administering necessary sedations and dressing patient appropriately, while the lift team moves patient from bed onto stretcher. The porter was charged with transporting patient to elevator, and coordinating the hand off to the ambulance team, who transports patient to destination hospital.

Apart from those physically transporting patients, administrative staff were located in several distinct "command posts":

- **Command Center**—Functional during the move and for 72-hours post-move, the Command Center serves as a communication hub for the entire move process. Additionally, the Command Center initiates and terminates the Patient Move Plan, assesses the hospital's readiness to safely transport patients, and ensures that all other command posts are communicating amongst each other.
- **Resource Pool/Staff Hospitality**—Provides hospitality services to staff during the move
- **Contractor**—Communication center for physical movers; contractor team lead housed in Contractor Center
- **Media**—Public Information Officer stationed with media representatives in media center
- **Surgical Team Room**—Central location for the coordination of surgical supply move
- **Cafeteria**—Serves food to patients and families
- **Facilities Conference Room**—An area for the directors of facilities and materials management to caucus during the move
- **Hospitality Center/Families**—An area in which families are provided with information regarding patients being moved
- **Critical Care Waiting Area**—Waiting area for the families of critical care patients

Ultimately, administrators were successful in accomplishing the move in under four hours, two hours short of their estimate.

Key Challenges
The key challenge administrators faced in conducting the facility move was ***maintaining patient centered care for those patients not moved on move day***. Due to planning complications, administrators failed to recognize that the linear accelerators associated with the radiation oncology patients could not be readily moved into the new hospital. As such, the entire radiation oncology unit had to remain in the existing facility, in a virtually empty ward with few hospitality services, for several days. Administrators struggled to maintain a high standard of patient-centered care for these patients and were forced to leave a hospitality "footprint" back at the old hospital for longer than desired—an outcome that could have been circumvented if planned more effectively.

Key Recommendations
Given the key challenge described above, administrators would recommend any administrator attempting a facility move to move patients, supplies and equipment as quickly as possible to minimize risk to patients. According to interviewed administrators, when a move is stretched out over an extended period of time, the opportunity for "small, potentially disastrous failures (such as tripping over a door jam when transporting a critical care patient) is heightened. As such, an ideal move would be one in which patients are served breakfast at one facility and then lunch at their destination facility.

Case Study E: UCLA Medical Center

UCLA Medical Center

Background

On July 29th, 2008, UCLA Health System conducted one of the largest hospital facility moves in US History, relocating 342 patients from in four hours from an existing medical center to a replacement facility across the street. The move which involved 2,300 hospital staff and volunteers, 30 ambulances and a four year planning process, was motivated by the heavy damage that was incurred to the 53 year-old existing facility during a 1994 earthquake. On the same day of the move, all 1.3 million square feet of space at the destination facility (Ronald Regan UCLA Medical Center) was fully operational.

Facility: UCLA Ronald Regan Medical Center

Description: 581-bed, not-for-profit academic medical center (AMC)

Move Distance: 1 block

Total Length of Move: 14 days

Total Length of Patient Move: 5 hours

Key Challenges:
- Achieving consensus on all individual departmental move plans

Key Recommendations:
- Manage the media as vigilantly as possible before, during and after the move

Assembling the Transition Team and Scheduling the Move

Four years prior to the facility move, administrators began the move planning process. A team was assembled consisting of key administrators throughout the hospital and health system, including:

- Hospital CEO
- Chief architect
- Patient representatives
- Hospital's executive suite (CFO, CMO, CMIO, CIO)
- Community Representatives
- Moving Company representatives
- Move Director (a Planning VP from the Health System)
- Law Enforcement and Security

The move plan's sole criteria in selecting a date to transition patients was the conclusion of the new medical center's construction, which was scheduled for Spring/Summer 2008. With an 8-week window to accomplish "soft" moves, administrators reasoned, there should be adequate time to prepare the hospital for a June patient move.

Drafting the Move Plan

Over 12 months, administrators and moving company representatives met with each clinical department chief and asked them to inventory what equipment and supplies they planned to transport to the new hospital, and what were the chief issues that they faced with their new space. Departments were provided with blueprints of their future space as

early as two years prior to the move, and were therefore able to contemplate their projected concept of operations well in-advance of drafting the move plan.

When disputes arose surrounding equipment and supplies, the move director would tour each department and examine the equipment and supplies in question, and suggest an alternate strategy. After several months working through individual departmental move plans, a finalized set was produced for the official move manual.

Selecting a Mover
Having heard of the positive experiences that several companion facilities had had with a particular move company, UCLA medical center opted to contract with them. 4 years prior to the move, UCLA reached out to the firm to begin dialogue. As such, the moving company was involved in reviewing the destination facility's space as it was being designed and built. The move plan that was put into place therefore include a detailed analysis of the structure of the new and old facilities; the color teams—which are discussed in a subsequent paragraph—reflect this intimate knowledge of the medical center's infrastructure.

Executing the "Soft" Move
Approximately 60 percent of all equipment, supplies and furniture were new in the new facility, with the remainder transported from the old hospital to the new facility. Given the size of the new facility, administrators had initially intended to begin relocating administrative services and supplies several months prior to the patient move. However, due to an unexpected 6 month delay in obtaining the Certificate of Occupancy, administrators were put in a position to move all soft areas within 14 days.

Training and Orientations
Training sessions and orientations began at the old facility and lasted several weeks after the move. To acquaint staff with the new facility, administrators initiated a similar program to that found at Firelands Regional Medical Center: all staff were provided with scavenger hunt-like activities to retrieve different items located in different areas throughout the new hospital. Additionally, orientations and demonstrations were given to relevant end users for all new IT platforms and clinical technologies at the new facility.

Executing the Patient Move
The true complexity of the move is reflected on the execution of the patient move. Three to four weeks prior to the scheduled move, administrators cancelled elective surgeries, which brought the inpatient census down from 500 to 342 patients, including 18 NICU patients and 14 critically and Seriously Ill ICU patients (including two awaiting organ transplant).

On Move day, the moving staff broke into three color teams (Gold, Blue and Red), with all members required to wear a shirt of their team's color displaying their specific role on back. The Gold and Blue Teams had assigned floors from which to move patients, and dedicated entry/exit points and elevators to use throughout the move, with the goal being that no Gold or Blue Team member should ever run into a representative from another

team. The Red Team, whose members were skilled in caring for the critically ill, managed the transportation for all ICU and NICU patients, staying with them through their journey to the new facility. Within each team, roles mirrored those found at other facilities profiled in this report:

- Care Team (Old hospital)—Provides patient with pre-move nursing care and preparation
- Lift Team (Old hospital)—Lifts patient from old bed onto stretcher, hands off to Transport Team
- Transport team—Transports patients from ward through elevator downstairs to the dispatch area, hands off to Ambulance Team
- Ambulance Team—Takes patient from old to new hospital, hands off to transport team
- Transport team (New hospital)—Receives patient from Ambulance Team, documents arrival electronically via handheld tablet, transports patient from entry point up to wards
- Lift Team (New hospital)—Lifts patient from stretcher and places on their new bed
- Care Team (New hospital)—Provides patient with post-move nursing care

Additionally staff with question marks on their shirts were found at every intersection of the new facility, providing direction on where to go for those not yet familiar with the facility's layout.

Administrators were able to move all 342 patients within 5 hours, meeting their goal.

Key Challenges
One of the unpredictably difficult aspects of the move planning process was achieving full consensus on departmental move plans. All departments voiced seemingly similar concerns regarding insufficient space, insufficient equipment, or inability to move all equipment in supplies in a timely fashion. It is the responsibility of the move director to prioritize such concerns, dismiss unreasonable complaints, and move forward expeditiously in developing the move plan.

Key Recommendations
To ensure the seamlessness of a facility move, an administrator must manage all aspects of the move, including the press/media coverage. To do this, UCLA administrators severely limited the media's presence at the actual move to a few key areas. Instead, they hired a film maker to make a short documentary film of the move, which was disseminated to local news stations and placed on the internet. By doing this, administrators effectively took control of the "official story" and were able to ensure that what would inevitably become a major media event was portrayed positively.

Case Study F: Minneapolis VAMC

In 1975, Minnesota Senators Hubert Humphrey and Wendell Anderson originally proposed the replacement of the outdated Veterans Affair Medical Center (VAMC) in Minneapolis, MN (built 1926 to 1954). Construction of a new 845-bed facility began in 1983, and concluded in 1988. On June 22, 1988, VAMC administrators successfully moved 218 inpatients from the existing to the replacement facility. The move was particularly notable both in its scope and in the tremendous amount of planning that was executed in preparation for move day.

Assembling the Transition Team and Scheduling the Move

Nearly 5 years prior to the move, in 1983, administrators began forming a Replacement Hospital Committee, whose key responsibilities included the following:

Facility: Minneapolis VAMC

Description: 845-bed, not-for-profit Veterans Affairs Medical Center (VAMC)

Move Distance: Facility adjacent to the hospital

Total Length of Move:

Total Length of Patient Move: 75 minutes

Key Challenges:
- Structuring a move team that is able to easily obtain the input of all clinical departments

Key Recommendations:
- Execute mock moves
- Network with hospitals having recently moved
- Observe an actual facility move

- Coordinating review of preliminary and final project plans and specifications by medical center staff
- Developing and submitting project activation and staffing budgets
- Purchasing and installing equipment, supplies and services required to activate new facility
- Developing and implementing patient move plan
- Disseminating project information to staff, volunteers, and the public
- Identifying and completing all required project changes
- Deactivating vacated buildings and disposing replaced or abandoned equipment prior to demolition

Across the next five years, the committee's composition changed considerably. However, a core group of stakeholders formed the foundation of the committee, which met weekly until the move was executed. These members included:
- ***Committee Chair***—The staff assistant to the director served as Chair of the Committee and represented the primary contact on the project for both the construction and medical center staffs
- ***Resident Engineer (RE)***—The committees key facilities contact, the RE was charged with keeping the committee up-to-date on all project developments, change orders, inspections and acceptance schedules

- *Interior Designer*—the interior designer coordinated the hospital's interior design needs with the Office of Facilities design staff in Washington.
- *Chief and Activation Specialist, Acquisition and Materiel Management Service*—these two administrators coordinated the planning purchase, delivery and installation of the over $60M dollars of equipment and supplies required for activation.
- *Chief, Engineering Service*—The Chief of Engineering was responsible for review of all construction documents to ensure that the programmatic, space and utility requirements of the hospital were met in the project.

During their regular meetings, members of the group continuously amended the projected patient move day until a date for construction completion was known with certainty. Ultimately, administrators opted to move patients within two months of construction completion.

Drafting the Move Plan
Approximately one year prior to the move, the RHC followed a remarkably similar process to other hospitals profiled in this report: clinical departments were solicited (through a dedicated RHC "liaison") by the committee to produce department-specific move plans, categorizing the equipment, supplies, and people they planned to transition to the new facility. Move plans were reviewed in detail by the Committee Chair, and several rounds of edits ensued. By the end of the review process, each department had a finalized move plan which detailed a concept of operations for its new workflows in the new facility, in addition to a checklist of what it planned to move.

Selecting a Mover
After drafting a move plan, administrators released an RFP for a moving company. Having inventoried the full array of services, supplies and equipment that were to be moved, administrators were uniquely situated to discriminate among the move companies responding to the RFP; each move company was assessed on its demonstrated ability (through references and case studies) to move the specific types of equipment and furniture that needed to be moved at Minneapolis VAMC. In addition to being judged on these "heavy lifting" capabilities, moving firms were evaluated on their experience in relocating large numbers of critically ill patients from an existing to a replacement facility.

Executing the "Soft" Move
Two years prior to move day, the RHC composed a Pre-Move Subcommittee, whose role was to coordinate the transition of equipment and furniture from the existing hospital to the new hospital, and to route the delivery of new "big box" supplies to the appropriate location in the new facility upon receipt. As soon as construction of the new facility had been completed (several months before the move) administrators switched the equipment delivery schedule, directing equipment to the new hospital. 30 days prior to the patient move, the move company began the process of shifting all administrative and support services not directly associated with patient care (e.g. Patient Administration,

Accounting, Logistics) to the new facility, with the ultimate goal of making the replacement hospital fully "patient-ready" on move day.

Executing the Patient Move
Outpatient Clinic Move

In the approximately six weeks surrounding the inpatient move, all outpatient clinics were transitioned to the new facility, with the goal of clustering the bulk of clinic moves as close to inpatient move day as possible (to minimize the duplication of services among the facilities). Several months prior to each clinic's move, a checklist was composed detailing the necessary equipment and support services for that clinic to function. A sample checklist is displayed below:

Clinic checklists are a cornerstone of pre-move preparation

Outpatient Clinic Move Checklist

Support Services: Will the following services be readily available by clinic move date:

☑ Lab   ☑ Escort
☑ X-Ray   ☑ Pharmacy
☑ Medical Records   ☑ Emergency Coverage
☑ EKG

Equipment Needs: Will the following systems be set up in new clinic space prior to clinic move date:

☑ Phone
☑ Computer Support
☑ Clinic-specific equipment
☑ Utilities

Space Modifications:

☑ Have all necessary design adjustments been completed?

Supplies:

☑ Are all office supplies needed for clinic operation in place?
☑ Are all pieces of disposable medical equipment purchased and in place?

Several weeks prior to the movement of a particular clinic, administrators sent out clinic cancellation notices to all patients, so that schedules could be adjusted accordingly.

Inpatient Move
While the specific details of the inpatient move can be found in Appendix A of this report (including move team organizational structure, description of move team formation, and process maps for the actual patient move), the RHC identified five key functions that had to be performed during the move:

1) *Prepare existing hospital for patient move*—Coordinate needs of patients and families, and ensure significant staffing and equipment are preserved in old hospital to execute move
2) *Route patients through the existing hospital's hallways*—Station personnel along the ground floor move route to deal with merging lines of patient traffic and to assist with directing patients to emergency stations if need arises
3) *Ensure preparation of the new medical center*—Conduct walkthroughs of new facility, ensure all patient areas are sterilized and equipped with tested machinery and supplies
4) *Assist visitors and families during the move*—Provide families with guidance and entertainment during the move
5) *Maintain a personnel pool of volunteers to assist during the move*—Recruit volunteers to assist move coordinators

Please refer to Appendix A for a detailed description of the Minneapolis VAMC inpatient move

Key Challenges
Among the challenges cited by Minneapolis move administrators was structuring a move team that is able to easily obtain the input of all clinical departments. Ultimately, the quality of the move plan is based on its level of granularity. A sufficiently detailed level of granularity can only be achieved if the input of all clinical departments is incorporated in an organized, detailed fashion. For this to happen, the core move team must incorporate clinical service chiefs and department heads.

Key Recommendations
The recommendations offered by Minneapolis VAMC administrators are focused on ensuring that staff are adequately prepared—both mentally and from a resource perspective—for the facility move. To this end, administrators recommended executing mock moves (simulations in which staff serve as patients and move routes are traced), networking with hospitals having undergone similar facility moves, and visiting hospitals to witness a move in-action. It is only by researching and witnessing the efforts of hospitals conducting facility moves that administrators can truly come to terms with the immensity of the task.

Case Study G: Portsmouth Naval Medical Center

NAVY MEDICINE
World Class Care...Anytime, Anywhere

Background

In April 1999, administrators at Portsmouth Naval Medical Center conducted a large-scale facility move. The move, which involved relocating approximately 250 inpatients from two existing facilities to a replacement hospital located across a parking lot was notable for several reasons. First of all, the move involved relocating patients from the oldest United States military facility (one of the existing hospitals was built in 1827) to a brand-new state-of-the-art facility. Secondly, the move included a robust pre-move communication plan that ensured that streamlined the staff training and orientation process.

Facility: Portsmouth Naval Medical Center
Description: 275-bed Navy hospital
Move Distance: 1 block
Total Length of Move: 6 weeks
Total Length of Patient Move: 4 hours
Key Challenges: ▪ Managing change among hospital staff
Key Recommendations: ▪ Concentrate on creating and maintaining strong avenues of communication during the move planning process

Assembling the Transition Team and Scheduling the Move

To initiate the move planning process, administrators created a Transition Task Force, including (but not limited to), the following administrators:

- Move Director
- Hospital Master Chief
- MSC Officers from different clinical areas
- Facility Planning and Construction Representatives

As a first step in planning the move, the team contacted several other hospitals that had conducted similar facility moves, with a particular effort made to identify health systems that had consolidated two disparate facilities into one replacement hospital. In particular, administrators sought to emulate the model of one system they had identified in Oregon, in which two facilities were moved a distance of approximately 15 miles into a new facility. Having identified the requirements needed to undertake such a move, administrators decided on a move date during the spring of 1999—a date that changed as the building delivery date shifted due to construction complications.

Drafting the Move Plan

Having settled on a move date, administrators began the process of drafting a move plan. As several other hospitals profiled in this report have done, administrators at Portsmouth met individually with all clinical department heads to obtain insight into what each department planned to move and how it planned to operate in the new areas. After several rounds of edits, administrators were able to compile all the department-specific move plans into a document to furnish to the mover.

Selecting a Mover
Administrators made an effort to locate a mover that had experience in relocating large hospitals, both public and private. The firm that was ultimately selected had the precise type of expertise that Portsmouth sought and provided administrators with an estimate that was in-line with cost expectations.

Executing the "Soft" Move
6 weeks prior to inpatient move day, administrators began to transition a number of interdependent clusters of outpatient clinics, as space became available to move them, with the ultimate goal being to minimize the number of materials and supplies needed to be moved on patient move day. Much of the new equipment to be moved was delivered to an off-site warehouse, which was liquidated at the beginning of the soft move. During this time, administrators also relocated all areas not directly related to patient care, such as patient administration, accounting, logistics, and nutritional food services from the existing facilities to the replacement facility.

Training and Orientations
As early as a year prior to the actual move, the move team undertook a variety of innovative training and orientation initiatives to acquaint staff with the new facility and processes. These included:
- *Online way-finding program*—the move team developed an interactive, hyperlink-enabled map of the new facility and posted it on the hospital's intranet. Using this map, users could familiarize themselves with the layout of the new facility (by clicking on each area to see photographs and descriptions).
- *Service-specific training videos*—a variety of training videos were executed for different service areas, which profiled each floor of the new hospital, showing all IT systems, exits, bathrooms, and citing adjacent service areas. A cadre of instructors were trained to host these recorded tours
- *Move Newsletters*—Move newsletters were distributed to all hospital staff explaining construction developments and key move milestones.

Executing the Patient Move
Several days prior to the inpatient move, elective surgeries were cancelled, with the purpose of bringing down the inpatient census to a more manageable level. Additionally, a bridge, which connected the facility furthest from the replacement facility to the replacement facility, was constructed to facilitate the move. Finally, approximately a week prior to the move, boxes and labels were issued to each department to place all supplies and materials needed to be moved on inpatient move day. While the administrator interviewed was unable to speak to the physical intricacies of the inpatient move, he characterized it as a well-choreographed exercise, in which staff assumed roles similar to those assigned at other institutions profiled in this report (such as porter,

ambulance driver, lifter, patient transporter). Ultimately, administrators were able to successfully relocate over 200 patients from 2 separate facilities in 4 hours.

Key Challenges
The foremost challenge cited by administrators at Portsmouth was managing hospital staff during the process of a significant culture change. Administrators noted that several staff were resistant to move from the existing facilities, as they had developed a strong connection to their previous physical surroundings and workflows. To overcome this challenge, administrators recommend reviewing some of the relevant industry literature surrounding change management, such as <u>Managing Transitions</u> by William Bridges.

Key Recommendations
Administrators underscored the importance of devoting a significant level of effort to training and orienting staff to the new facility prior to the physical move. This helps to boost staff satisfaction and breaks down barriers to culture change. Administrators were particularly successful in their "virtual" orientations (detailed above), which provided the opportunity to acquaint a large number of staff to new processes and technologies in a low cost medium.

Facility Move Research Interview Guide

General:
1. General details on the move:
   a. Distance between facilities
   b. Geographic location of hospital(s)
   c. Number of patients moved
   d. Duration and timing of move

Planning:
2. Was there a formal "transition" plan that was drafted for the move?
   a. If so, what did it entail?
   b. Would you be willing to share a copy with us?
3. Who was involved in the move planning process?
4. What types of checklists or other preparatory materials were assembled prior to the move?
5. What was the planned duration of the move?
   a. How was this length of time settled upon?
   b. What time of year was the move scheduled?
6. In planning the move, what measures did you take to minimize the disruption to patient care?
7. Were there any models of other facility moves that you sought to emulate?
   a. If so, which are these facilities?
   b. What made their model promising?

Execution:
8. Were there any unforeseen delays or extensions of the physical move?
9. How is the movement of personal goods—i.e. desk supplies, books, etc—versus the movement of biomedical equipment coordinated?
10. What, if any, was the impact on patient care?
11. What were the impediments or major obstacles to performing the move in the amount of time you agreed upon?
12. What type of inventorying or tracking of goods was needed during the move?

Lessons Learned:

13. What are the advantages of executing a move in a short period of time (a few days) vs. across a several weeks?
14. Given the opportunity to rework the move, what would you have changed?

Networking Permission:

15. If a hospital administrator has interest in following up with you regarding your experience, would it be alright if I passed your name along to them?

Joint Planning Working Groups

The J-1 Manpower & Personnel JPG contains five divisions that deal with Human Resources Concept of Operations, Contract Issues, Walter Reed Joint Historical Artifacts, Guaranteed Placement, and Manpower. Currently, there are no identified WGs in the J-1.

The J-3 Operations JPG contains four divisions that deal with Readiness and Contingency Operations, Force Health Protection, Regional Health Care Delivery (subdivided into Multi-Disciplinary Clinical Operations, Healthcare Business Operations, Dental Advisory Board, and Patient Administration), and Joint Warriors in Transition.

Currently, the J-3 oversees the following WGs:

- Access to Care Working Group – Working to integrate healthcare across the JOA focusing on direct care issues.

- AHLTA Working Group – Working to further the use of AHLTA II throughout the JOA.

- Appointing/Call Center Operations Working Group – Working to Integrate healthcare across the JOA focusing on appointing and call center synchronization.

- Behavioral Health Working Group – Working towards a Standardized Behavioral Healthcare Delivery Model in the JOA, which will support the needs of beneficiaries as they navigate the healthcare system in the NCR.

- Business Plans & Enrollment Working Group - Working to develop business planning guidance for the JTF.

- Case Management Working Group – Working towards a Standardized Case Management Model in the JOA which will support the needs of beneficiaries as they navigate the healthcare system in the NCR.

- Casualty Affairs Working Group - Working on reviewing and standardizing all policies and procedures for casualty affairs.

- Clinician Credentialing & Privileging Working Group – Working to develop an actionable plan to verify the credentials of health care workers and to grant privileges to licensed independent providers consistently across the JOA at all medical/dental treatment facilities (MTFs/DTFs).

  o By-Laws Working Group, Adverse Privileging Working Group, Non-Privileged Providers Working Group – All subgroups of the Credential

and Privilege Process team that completed their work and presented to the J-3 JPG in June 09 (Input pending into MTP)

- Disability Evaluation Working Group - Looking at the Disability Evaluation System across the services in order to integrate best practices for the new joint facilities. This group is also looking at space and locality issues.

- Essentris Working Group - Reviewing all procedures and issues as related to Essentris, an electronic medical records system, and attempting to solve the interface problems between it and AHLTA II.

- GWOT Working Group – Working to develop integrated processes in support of casualty reception, tracking, and reporting throughout the JOA.

- Hazardous Material Working Group – Working to establish processes, procedures, instructions and memorandums of understanding for hazardous biological, chemical, and radiologic agent exposures within DoD laboratories in the JOA.

- Immunization Delivery Optimization Working Group – Working to develop a plan that optimizes immunization care within an integrated regional healthcare delivery system across the JOA.

- Inpatient/Outpatient Medical Records Working Group – Working at review and standardization of all issues and functions dealing with patient records, including space capacity, retirement of records, coding, scanning, etc.

- Joint Pathology Center Working Group – Working to develop a Joint Pathology Center in response to the requirements established in National Defense Authorization Act 2008.

- Key Performance Measures Working Group – Working to identify and track key performance measures across the JOA.

- Level 1 Trauma Working Group - Working towards the objective of achieving American College of Surgeons (ACS) verification as Level I Trauma Center within our world-class medical center.

- Mammography Modernization Working Group – Working to develop an actionable plan that addresses the standardization of Screening Mammography procedures, processes, and equipment in medical treatment facilities throughout the JOA.

- Medical Surveillance Working Group – Working to develop a medical surveillance plan within an integrated regional healthcare delivery system across the JOA.

- Medication Distribution Working Group – Working to develop an actionable plan that addresses the standardization of prescription medication acquisition, processing, and distribution functions in medical treatment facilities throughout the JOA.

- Nuclear Regulatory Commission Licensure Working Group - Working to develop an actionable plan to seamlessly transition from current NRC licenses/permits within the JOA to new ones required by the formation of new joint military treatment facilities.

- Patient Movement Working Group – Working at standardization of all functions related to patient movement including reviewing air evacuation procedures to identify operational differences.

- Pharmacy Working Group – Working to optimize medication delivery systems throughout the JOA to include prescription refill procurement, standardized formularies, and automation technology.

- Productivity Working Group – Working to change the Business Rules that define a Full Time Equivalent to ensure a JTF-centric view of workload accountability.

- Public Health Directorate Working Group – Working to develop an organizational plan that formulates and optimizes public health delivery within an integrated regional healthcare delivery system across the JOA.

- Radiology Working Group – Working to facilitate radiographic image sharing across the JOA.

- Readiness and Contingency Operations Exercise Working Group – Working to provided Health Services Support to Federal, Regional, State, and Local Authorities during Exercise or Contingency Operations within the National Capital Region.

- Referral Management Working Group – Working to integrate healthcare across the JOA focusing on purchased care issues.

- Surgery Optimization Working Group – Working towards an integrated perioperative service that utilizes "best practice" initiatives, scheduling flexibility and resource sharing allowing for the central oversight of surgical services and more efficient allocation of resources (staff and equipment) across the surgical facilities within the JOA.

- Warrior Family Assistance Center Work Group - Identifies the full spectrum of common level services needed to support Wounded Warriors and their Family members, recommending changes and enhancement for the transition of Wounded, Ill and Injured and their families to WRNMMC.

- Warrior Transition Center Working Group – Working to integrate service for wounded, ill, and injured Warriors throughout the JOA who are healing, as they transition back to military duty or civilian life.

- Child Activity Room Working Group - Identifies total requires for providing child care to Wounded Warriors and their Family members focusing on MTF child care during all hospital shift work, hourly child care, and child care for Warriors in the Child Activity Room (CAR) of the Warrior Family Assistance Center (WFAC).

- Regional Specialty Leader Work Group – Working to develop a well-defined selection process and concept of operations for Regional Specialty Leaders who support the CJTF in achieving mission objectives across the JOA.

- Quality Assurance Working Group (Complete)

The J-4 Logistics JPG has one division and no formal Working Groups.

The J-5 Plans and Policy JPG consists of three divisions, Plans, Policy, and Integration. The Integration division oversees three working groups:

- Master Transition Working Group – Working on publication and on-going analysis of the JTF CAPMED Master Transition Plan. The MTP is the capstone document regarding the execution of JTF CAPMED's mission of BRAC oversight.

- Admin/Logistics Working Group – Working on developing integrated administrative and logistic plans that will be incorporated across the JOA.

- Strategic Plan/Futures Working Group – Working on formulating a strategic plan for JTF CAPMED, then identify which areas to focus on within the next couple years that will move the JTF forward in accomplishing its mission and objectives.

The J-6 Comms (IM/IT) JPG consists of one division and no additional Working Groups. The J-6 JPG is developing plans to create a seamless Information Management/ Information Technology system throughout the JOA.

The J-7 Education & Training JPG consists of five Cells, each of which functions as WG:

- GME/GDE/UME Cell – Providing and addressing issues relevant to graduate medical education, dental education and undergraduate medical education. Members of this cell are developing dashboards – a single, easily accessible location where current and relevant data is maintained to provide visibility on the health of training programs.

- Research Working Cell – Providing and addressing issues relevant to research with a goal of establishing a single Department of Research Operations (DRO) to integrate the research oversight, monitoring and education activities that exist in support of DoD Assurances for the Protection of Human Subjects at the individual MTFs.

- Health Professions Education Cell – Providing and addressing issues relevant to the establishment of an integrated Health Professions Education Directorate at WRNMMC and FBCH.

- Enlisted Training Cell - Providing and addressing issues relevant to enlisted training in the JOA. The cell will ensure enlisted medical specialty training requirements are met across the JOA and will keep the Command Senior Enlisted Leaders informed about policies and decisions concerning enlisted specialty training. The J7 Enlisted Training Cell will identify and respond to enlisted training issues and develop COA to present to the J-7 JPG to move initiatives forward to achieve milestones in support of the JTF CapMed mission.

- Simulation Cell - Providing and addressing issues relevant to the use of simulation resources and technology associated with health care education and training in the JOA. The J7 Simulation Cell will identify and respond to simulation issues and develop COA to present to the J-7 JPG to move initiatives forward to achieve milestones in support of the JTF CapMed mission.

The J-8 Resources JPG has one division and no additional Working Groups. It deals with establishing and managing resourcing channels for the JTF.

ID	Task Name	Duration	Start	Finish
0	**JTF CAPMED**	**1015 days**	**Thu 10/11/07**	**Thu 9/1/11**
1	**Fort Belvoir Community Hospital (FBCH)**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
2	**Building A, River**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
3	Design	320 days	Thu 10/11/07	Wed 12/31/08
4	Construction	546 days	Fri 3/14/08	Fri 4/16/10
5	BOD	0 days	Fri 4/16/10	Fri 4/16/10
6	**Building A Outfit & Transition**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
7	**Floor AA-01**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
8	**Directorate - Medical Services**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
9	**Department - Pediatrics**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
10	**Service Unit - Children's Health Services Administr**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
11	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
12	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
13	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
14	**Directorate - Medical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
15	**Department - Primary Care**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
16	**Service Unit - General Internal Medicine**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
17	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
18	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
19	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
20	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
21	**Directorate - Medical Services**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
22	**Department - Pediatrics**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
23	**Service Unit - Pediatric Partial Hospitalization**	**256 days**	**Mon 4/19/10**	**Mon 4/11/11**
24	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
25	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
26	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
27	**Directorate - Medical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
28	**Department - Pediatrics**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
29	**Service Unit - Pediatrics Primary Care (Outpatient)**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
30	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
31	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
32	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
33	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
34	**Directorate - Medical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
35	**Department - Pediatrics**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
36	**Service Unit - Subspecialty**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
37	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
38	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
39	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
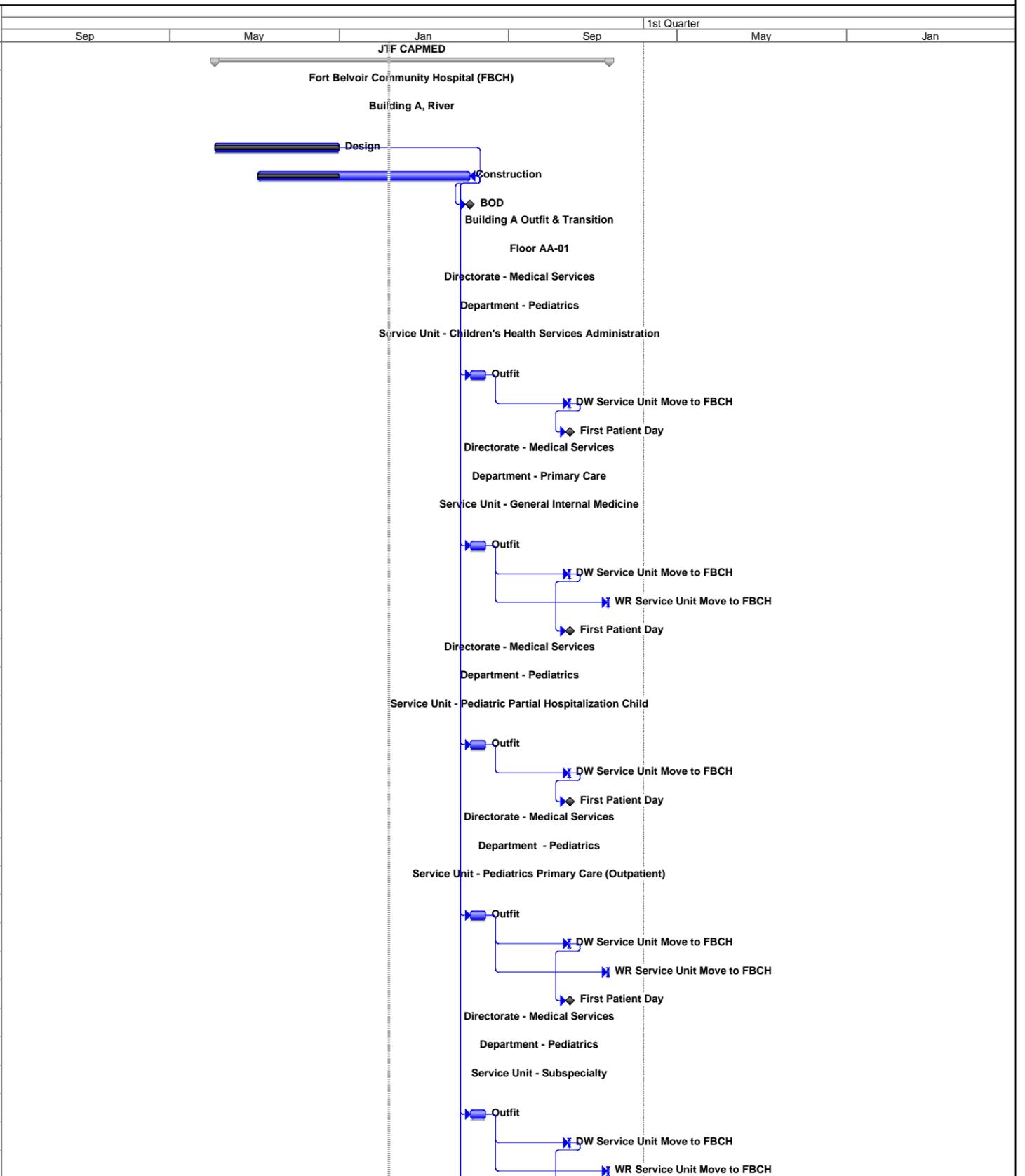
Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

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ID	Task Name	Duration	Start	Finish
40	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
41	**Floor AA-02**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
42	**Directorate - Medical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
43	**Department - Primary Care**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
44	**Service Unit - Internal Medicine Administration**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
45	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
46	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
47	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
48	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
49	**Directorate - Surgical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
50	**Department - Orthopedics Rehabilitation**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
51	**Service Unit - Chiropractics**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
52	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
53	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
54	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
55	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
56	**Directorate - Surgical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
57	**Department - Orthopedics Rehabilitation**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
58	**Service Unit - Orthotic Prosthetics**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
59	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
60	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
61	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
62	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
63	**Directorate - Surgical Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
64	**Department - Orthopedics Rehabilitation**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
65	**Service Unit - Occupational Therapy**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
66	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
67	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
68	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
69	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
70	**Directorate - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
71	**Department - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
72	**Service Unit - Outpatient Substance Abuse**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
73	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
74	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
75	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
76	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
77	**Directorate - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
78	**Department - Children's Health Services**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
79	**Service Unit - Behavioral Health Clinic**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**

Legend:
Task ▬▬ | Milestone ◆ | Rolled Up Task ▬▬ | Rolled Up Progress ▬▬ | External Tasks ▭▭ | Group By Summary ▽▽
Progress ▬▬ | Summary ▭▭ | Rolled Up Milestone ◇ | Split ·········· | Project Summary ▭▭ | Deadline ⇩

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ID	Task Name	Duration	Start	Finish
80	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
81	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
82	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
83	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
84	**Directorate - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
85	**Department - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
86	**Service Unit - Family Advocacy**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
87	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
88	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
89	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
90	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
91	**Directorate - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
92	**Department - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
93	**Service Unit - Outpatient Integrated Adult**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
94	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
95	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
96	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
97	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
98	**Directorate - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
99	**Department - Behavioral Health**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
100	**Service Unit - Behavioral Health Administration**	**356 days**	**Mon 4/19/10**	**Mon 8/29/11**
101	Outfit	40 days	Mon 4/19/10	Fri 6/11/10
102	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
103	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
104	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
105	**Building B, Eagle**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
106	Design	320 days	Thu 10/11/07	Wed 12/31/08
107	Construction	643 days	Wed 3/26/08	Fri 9/10/10
108	BOD	0 days	Fri 9/10/10	Fri 9/10/10
109	**Building B Outfit & Transition**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
110	**Floor BB-01**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
111	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
112	**Department - Specialty Medical Clinics**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
113	**Service Unit - Allergy & Immunology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
114	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
115	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
116	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
117	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
118	**Directorate - Medical Services**	**151 days**	**Mon 9/13/10**	**Mon 4/11/11**
119	**Department - Primary Care**	**151 days**	**Mon 9/13/10**	**Mon 4/11/11**

Task		Milestone ◆	Rolled Up Task	Rolled Up Progress	External Tasks	Group By Summary
Progress		Summary	Rolled Up Milestone ◇	Split	Project Summary	Deadline ⇩
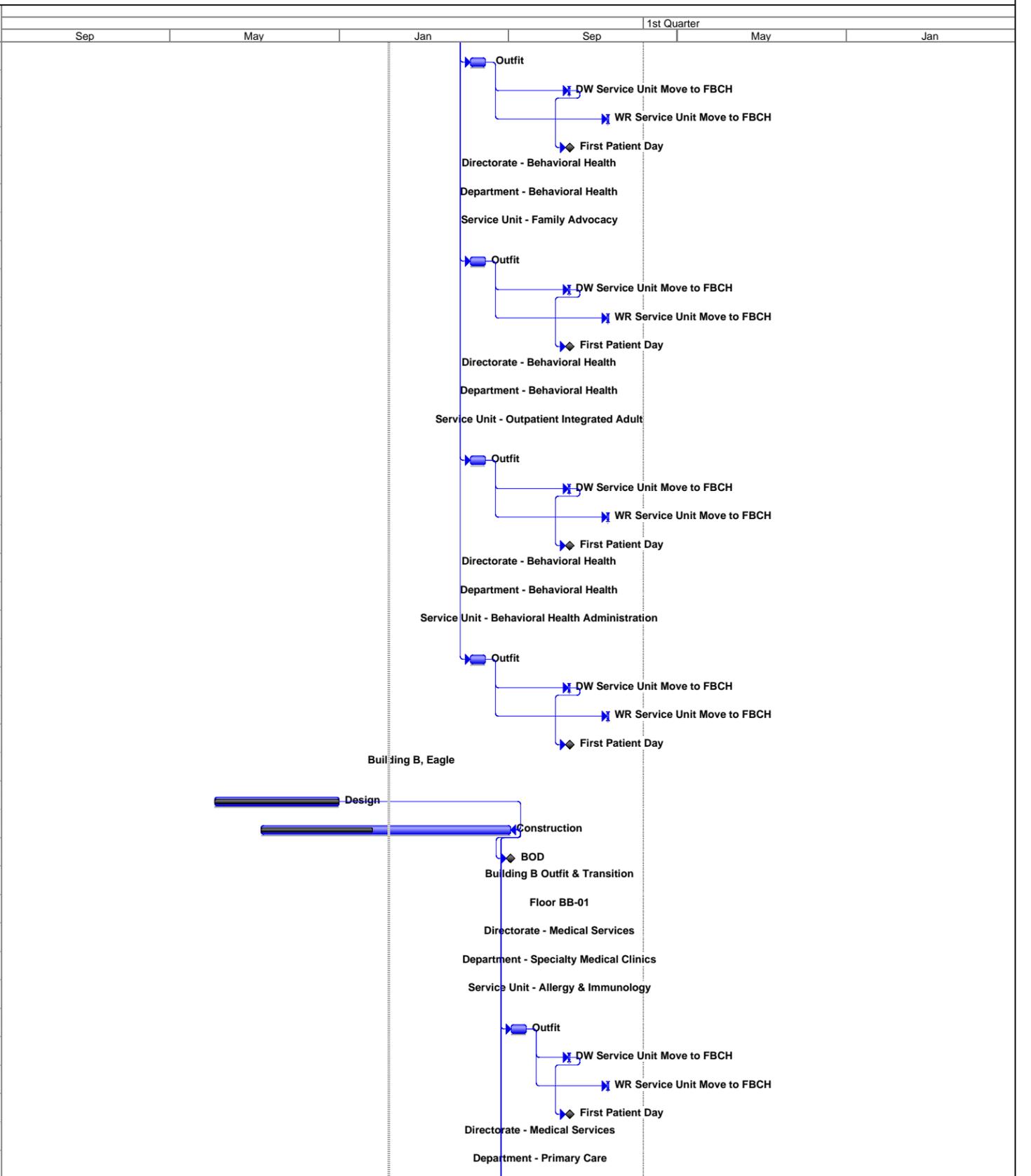
ID	Task Name	Duration	Start	Finish
120	**Service Unit - Family Practice**	**151 days**	**Mon 9/13/10**	**Mon 4/11/11**
121	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
122	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
123	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
124	**Floor BB-02**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
125	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
126	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
127	**Service Unit - Cardiology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
128	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
129	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
130	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
131	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
132	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
133	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
134	**Service Unit - Cardiothoracic Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
135	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
136	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
137	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
138	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
139	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
140	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
141	**Service Unit - Cardiovascular & Pulmonary**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
142	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
143	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
144	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
145	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
146	**Directorate - Public Health (Occupational Medicine)**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
147	**Department - Occupational Health**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
148	**Service Unit - Community Health Nursing**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
149	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
150	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
151	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
152	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
153	**Directorate - Public Health (Occupational Medicine)**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
154	**Department - Occupational Health**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
155	**Service Unit - Occupational Health**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
156	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
157	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
158	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
159	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11

Legend:
Task	Milestone ◆	Rolled Up Task	Rolled Up Progress	External Tasks	Group By Summary
Progress	Summary	Rolled Up Milestone ◇	Split	Project Summary	Deadline ⇩

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ID	Task Name	Duration	Start	Finish
160	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
161	**Department - Medical Specialty**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
162	**Service Unit - GI & Virtual Colonoscopy**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
163	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
164	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
165	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
166	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
167	**Floor BB-03**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
168	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
169	**Department - Orthopedics Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
170	**Service Unit - Sports Medicine**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
171	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
172	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
173	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
174	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
175	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
176	**Department - Orthopedics Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
177	**Service Unit - Physical Therapy**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
178	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
179	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
180	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
181	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
182	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
183	**Department - Orthopedics Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
184	**Service Unit - Physical Medicine & Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
185	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
186	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
187	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
188	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
189	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
190	**Department - Orthopedics Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
191	**Service Unit - Orthopedics**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
192	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
193	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
194	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
195	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
196	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
197	**Department - Orthopedics Rehabilitation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
198	**Service Unit - Podiatry**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
199	Outfit	40 days	Mon 9/13/10	Fri 11/5/10

Task	████	Milestone	◆
Progress	████	Summary	▬▬▬
Rolled Up Task	████	Rolled Up Progress	▬▬▬
Rolled Up Milestone	◇	Split	....
External Tasks	████	Project Summary	▽▽▽
Group By Summary	▽▽▽	Deadline	⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
200	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
201	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
202	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
203	**Building C, Oaks**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
204	Design	427 days	Thu 10/11/07	Fri 5/29/09
205	Construction	722 days	Wed 6/25/08	Thu 3/31/11
206	BOD	0 days	Thu 3/31/11	Thu 3/31/11
207	**Building C Outfit & Transition**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
208	**Floor CC-00**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
209	**Directorate - Public Health (Occupational Medicine)**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
210	**Department - Public Health (Operational Medicine)**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
211	**Service Unit - Environmental Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
212	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
213	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
214	WR Service Unit move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
215	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
216	**Directorate - Public Health (Occupational Medicine)**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
217	**Department - Public Health (Operational Medicine)**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
218	**Service Unit - Industrial Hygiene**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
219	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
220	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
221	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
222	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
223	**Directorate - Logistics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
224	**Department - Facility Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
225	**Service Unit - Facility Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
226	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
227	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
228	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
229	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
230	**Directorate - IM/IT**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
231	**Department - IM/IT**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
232	**Service Unit - Information Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
233	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
234	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
235	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
236	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
237	**Directorate - Logistics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
238	**Department - Logstics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
239	**Service Unit - Housekeeping**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**

Task		Milestone ◆	Rolled Up Task	Rolled Up Progress	External Tasks	Group By Summary
Progress		Summary	Rolled Up Milestone ◇	Split	Project Summary	Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
240	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
241	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
242	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
243	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
244	**Directorate - Logistics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
245	**Department - Logistics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
246	**Service Unit - Logistics Admin. & Logistics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
247	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
248	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
249	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
250	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
251	**Directorate - Safety**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
252	**Department - Public Safety**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
253	**Service Unit - Security & Public Safety**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
254	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
255	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
256	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
257	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
258	**Directorate - Readiness**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
259	**Department - PTOS/PTMS**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
260	**Service Unit - PTMS Safety**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
261	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
262	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
263	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
264	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
265	**Directorate - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
266	**Department - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
267	**Service Unit - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
268	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
269	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
270	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
271	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
272	**Directorate - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
273	**Department - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
274	**Service Unit - Patient Appointing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
275	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
276	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
277	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
278	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
279	**Directorate - Education & Research**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
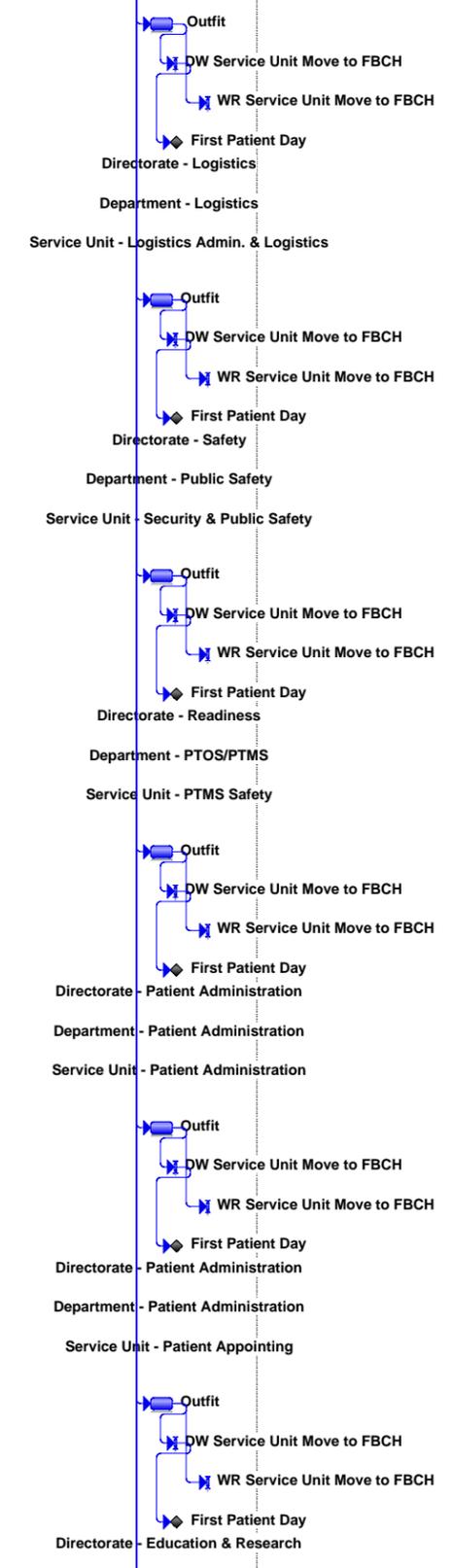
Task ▬▬▬ Milestone ◆ Rolled Up Task ▬▬▬ Rolled Up Progress ▬▬▬ External Tasks ▬▬▬ Group By Summary ▼▼▼

Progress ▬▬▬ Summary ▼▼▼ Rolled Up Milestone ◇ Split ·············· Project Summary ▽▽▽ Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
280	**Department - Research Programs**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
281	**Service Unit - Clinical Investigations**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
282	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
283	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
284	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
285	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
286	**Directorate - Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
287	**Department - Perioperative Nursing Unit**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
288	**Service Unit - CMS**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
289	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
290	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
291	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
292	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
293	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
294	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
295	**Service Unit - Clinical Pathology Core Lab**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
296	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
297	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
298	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
299	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
300	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
301	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
302	**Service Unit - Blood Donor**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
303	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
304	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
305	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
306	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
307	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
308	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
309	**Service Unit - Pathology Admin.**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
310	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
311	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
312	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
313	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
314	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
315	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
316	**Service Unit - Infectious Disease**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
317	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
318	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
319	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11

Legend:
Task ▬▬▬ Milestone ◆ Rolled Up Task ▬▬▬ Rolled Up Progress ▬▬▬ External Tasks ▭▭▭ Group By Summary ▽▽▽
Progress ▬▬ Summary ▭▭▭ Rolled Up Milestone ◇ Split ············ Project Summary ▭▭▭ Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
320	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
321	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
322	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
323	**Service Unit - Anatomic Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
324	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
325	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
326	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
327	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
328	**Directorate - Nutrition Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
329	**Department - Food Services Inpatient & Outpatient**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
330	**Service Unit - Food Service**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
331	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
332	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
333	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
334	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
335	**Floor CC-01**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
336	**Directorate - Commander**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
337	**Department - Command Group**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
338	**Service Unit - Command Group**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
339	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
340	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
341	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
342	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
343	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
344	**Department - Women's Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
345	**Service Unit - General OB/GYN**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
346	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
347	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
348	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
349	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
350	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
351	**Department - Women's Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
352	**Service Unit - Gynecological Oncologic Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
353	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
354	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
355	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
356	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
357	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
358	**Department - Cancer Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
359	**Service Unit - Breast Care Center**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**

Task		Milestone	◆	Rolled Up Task
Progress		Summary		Rolled Up Milestone ◇

Rolled Up Progress | External Tasks | Group By Summary
Split | Project Summary | Deadline ⬇

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
360	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
361	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
362	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
363	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
364	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
365	**Department - Emergency**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
366	**Service Unit - Emergency Ambulance Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
367	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
368	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
369	WR Service Unit to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
370	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
371	**Directorate - Medical Services**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
372	**Department - Primary Care**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
373	**Service Unit - Fast Track Clinic**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
374	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
375	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
376	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
377	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
378	**Department - Cancer Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
379	**Service Unit - Hematology Oncology Pharmacy**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
380	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
381	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
382	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
383	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
384	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
385	**Department - Cancer Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
386	**Service Unit - Medical Oncology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
387	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
388	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
389	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
390	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
391	**Directorate - Chaplain**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
392	**Department - Chapel & Pastoral Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
393	**Service Unit - Chapel & Pastoral Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
394	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
395	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
396	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
397	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
398	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**

Task	▬▬▬	Milestone	◆	Rolled Up Task ▬▬▬
Progress	▬▬▬	Summary		Rolled Up Milestone ◇

Rolled Up Progress ▬▬▬   External Tasks ▬▬▬   Group By Summary ▬▬▬
Split ·········   Project Summary ▭▭▭   Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

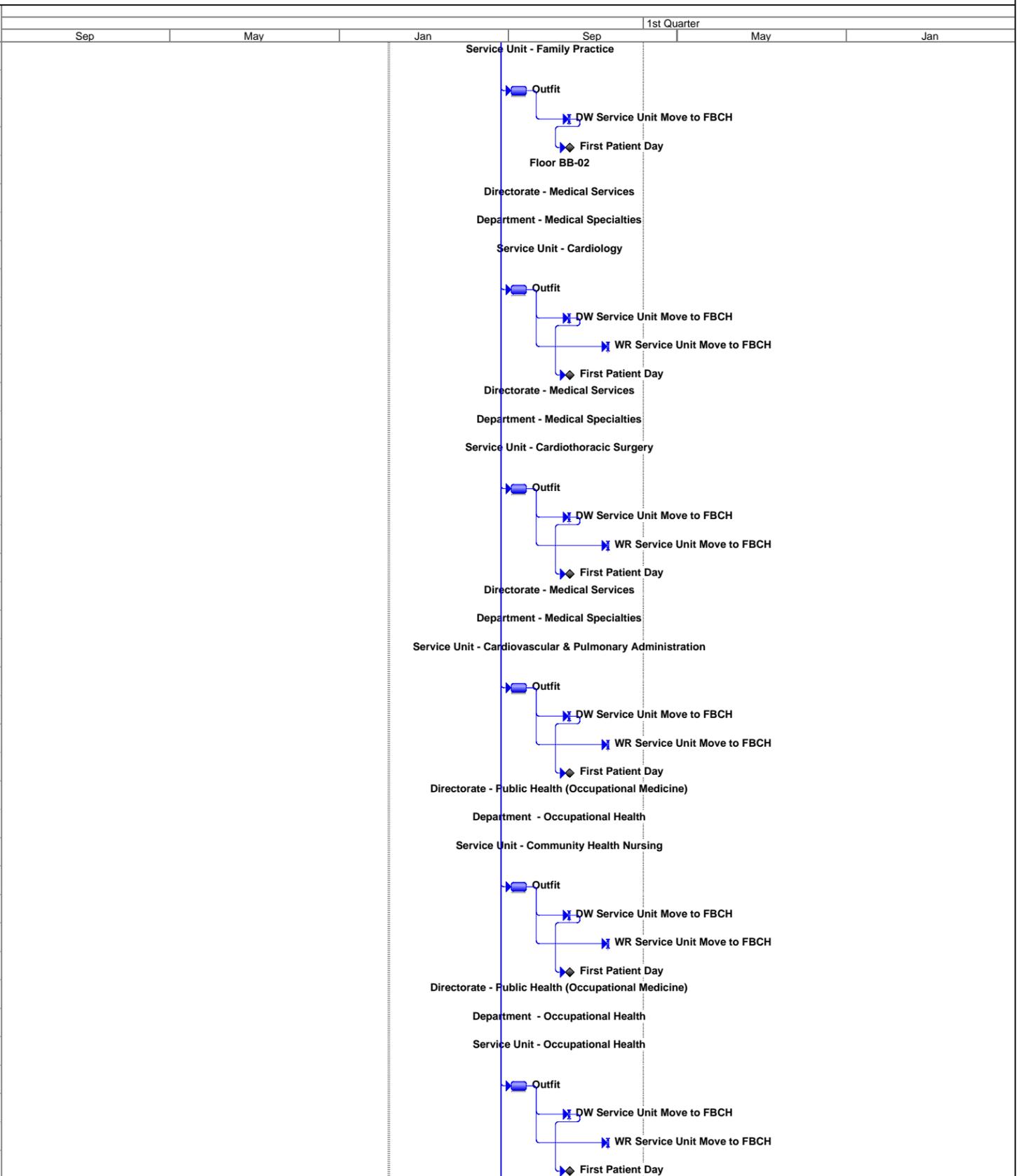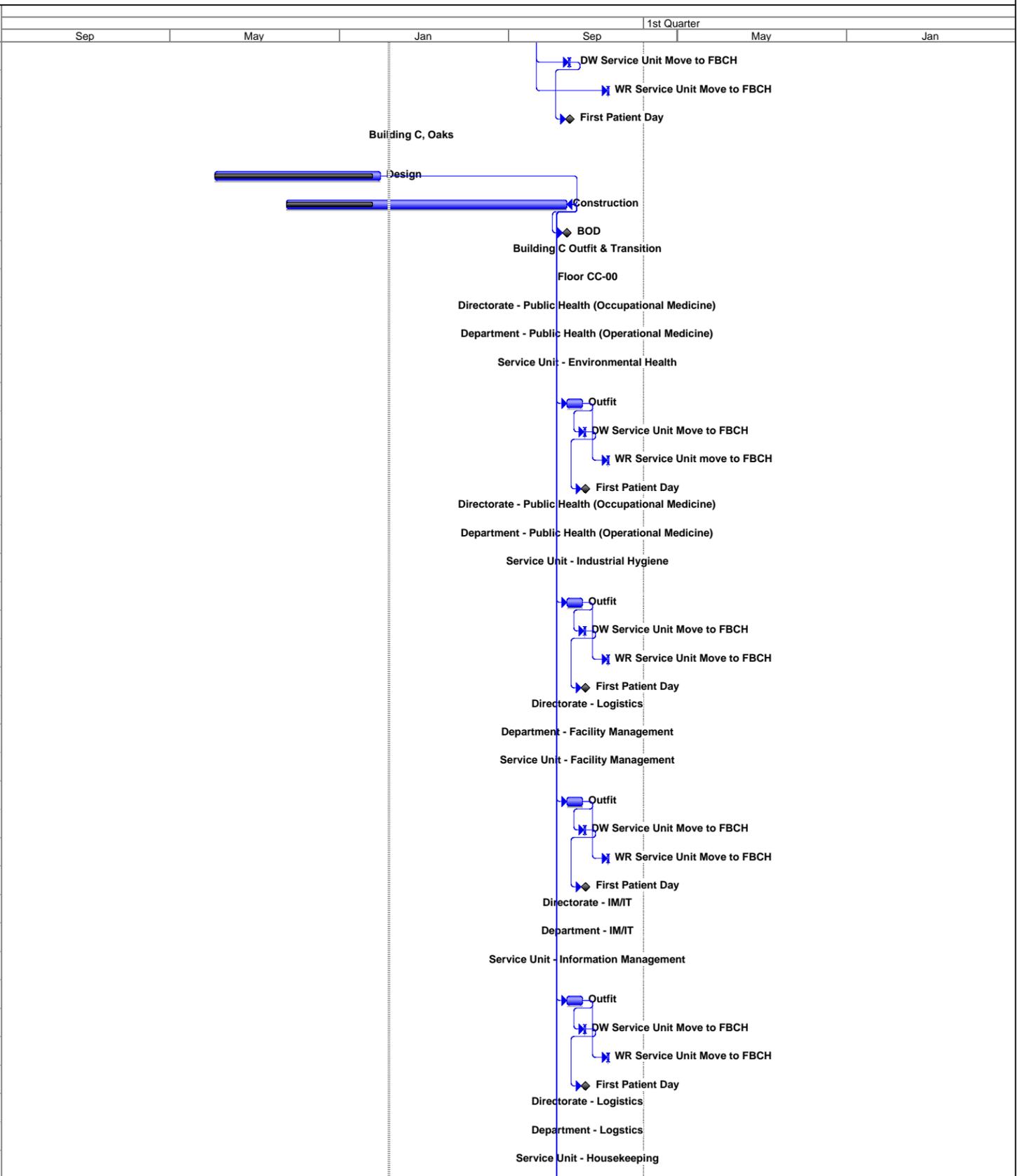| ID	Task Name	Duration	Start	Finish
399	**Department - Pharmacy Department**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
400	**Service Unit - Pharmacy**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
401	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
402	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
403	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
404	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
405	**Directorate - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
406	**Department - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
407	**Service Unit - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
408	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
409	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
410	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
411	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
412	**Directorate - Deputy Commander Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
413	**Department - Nursing Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
414	**Service Unit - Nursing Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
415	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
416	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
417	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
418	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
419	**Directorate - Education & Research**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
420	**Department - Education Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
421	**Service Unit - Education Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
422	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
423	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
424	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
425	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
426	**Directorate - Chief of Staff**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
427	**Department - Public Affairs Officer**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
428	**Service Unit - Communications**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
429	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
430	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
431	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
432	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
433	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
434	**Department - Cancer care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
435	**Service Unit - Cancer Care Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
436	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
437	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
438	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⬇

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
439	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
440	Directorate - Deputy Commander Dental	107 days	Fri 4/1/11	Mon 8/29/11
441	Department - Dentistry	107 days	Fri 4/1/11	Mon 8/29/11
442	Service Unit - Hospital Dentistry	107 days	Fri 4/1/11	Mon 8/29/11
443	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
444	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
445	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
446	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
447	Directorate - Deputy Commander Education &	107 days	Fri 4/1/11	Mon 8/29/11
448	Department - Director GME	107 days	Fri 4/1/11	Mon 8/29/11
449	Service Unit - GME Education	107 days	Fri 4/1/11	Mon 8/29/11
450	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
451	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
452	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
453	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
454	Directorate - Patient Administration	107 days	Fri 4/1/11	Mon 8/29/11
455	Department - CC Administration	107 days	Fri 4/1/11	Mon 8/29/11
456	Service Unit - CC Adimination	107 days	Fri 4/1/11	Mon 8/29/11
457	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
458	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
459	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
460	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
461	Directorate - Deputy Commander Education &	107 days	Fri 4/1/11	Mon 8/29/11
462	Department - Education & Research	107 days	Fri 4/1/11	Mon 8/29/11
463	Service Unit - Medical Library	107 days	Fri 4/1/11	Mon 8/29/11
464	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
465	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
466	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
467	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
468	Directorate - Deputy Commander Stratergy & Future	107 days	Fri 4/1/11	Mon 8/29/11
469	Department - Quality Management	107 days	Fri 4/1/11	Mon 8/29/11
470	Service Unit - Customer Service Patient Advocacy	107 days	Fri 4/1/11	Mon 8/29/11
471	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
472	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
473	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
474	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
475	Directorate - Patient Administration	107 days	Fri 4/1/11	Mon 8/29/11
476	Department - Patient Administration	107 days	Fri 4/1/11	Mon 8/29/11
477	Service Unit - HPMO Managed Care	107 days	Fri 4/1/11	Mon 8/29/11
478	Outfit	40 days	Fri 4/1/11	Thu 5/26/11

Task		Milestone	◆	Rolled Up Task
Progress		Summary		Rolled Up Milestone ◇

Rolled Up Progress
Split
External Tasks
Project Summary
Group By Summary
Deadline

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
479	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
480	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
481	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
482	**Directorate - Quality Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
483	**Department - Quality Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
484	**Service Unit - Quality Management**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
485	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
486	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
487	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
488	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
489	**Directorate - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
490	**Department - Patient Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
491	**Service Unit - Patient Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
492	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
493	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
494	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
495	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
496	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
497	**Department - Blood Donor Center**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
498	**Service Unit - Blood Draw Phlebotomy**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
499	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
500	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
501	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
502	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
503	**Directorate - Hospital Adminsitration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
504	**Department - Hospital Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
505	**Service Unit - Treasurer**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
506	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
507	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
508	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
509	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
510	**Directorate - AFES**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
511	**Department - AFES**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
512	**Service Unit - AFES, PX Flower Gift Shop**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
513	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
514	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
515	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
516	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
517	**Floor CC-02**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
518	**Directorate - Medical Services**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
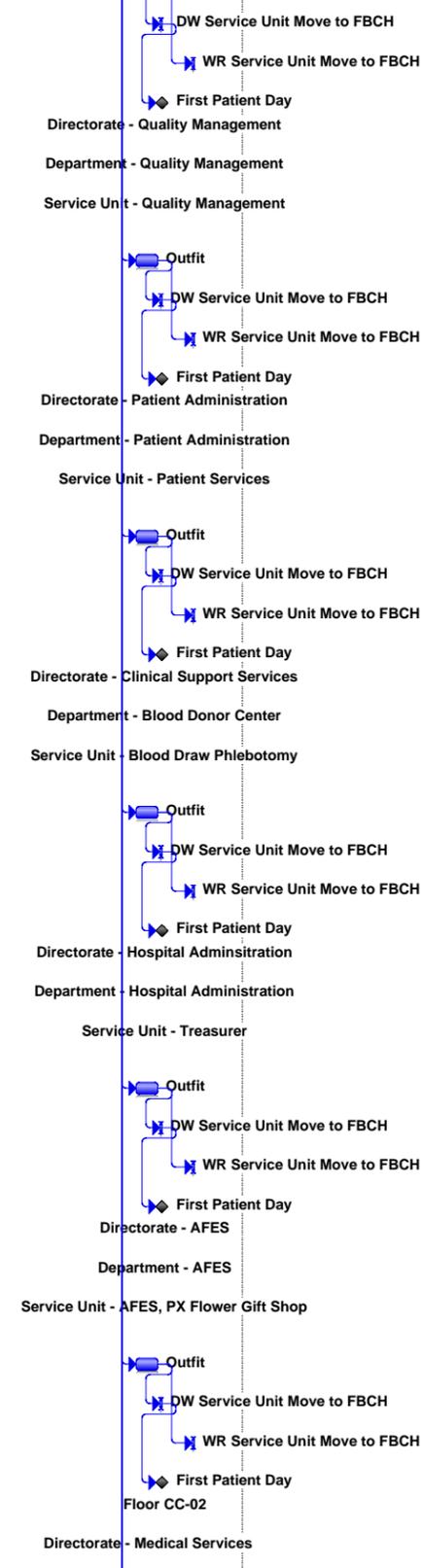
Task		Milestone	◆	Rolled Up Task	Rolled Up Progress	External Tasks
Progress		Summary		Rolled Up Milestone ◇	Split	Project Summary
						Group By Summary
						Deadline ⬇

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
519	**Department - Medical Specialties**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
520	**Service Unit - Multidisciplinary Interventional**	**47 days**	**Fri 4/1/11**	**Mon 6/6/11**
521	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
522	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
523	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
524	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
525	**Department - Surgery**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
526	**Service Unit - Main Operating Room**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
527	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
528	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
529	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
530	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
531	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
532	**Department - Radiology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
533	**Service Unit - Main Radiology Suite**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
534	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
535	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
536	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
537	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
538	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
539	**Department - Radiology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
540	**Service Unit - Nuclear Medicine**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
541	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
542	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
543	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
544	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
545	**Directorate - Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
546	**Department - Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
547	**Service Unit - Critical Care ICU & IMCU**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
548	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
549	DW Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
550	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
551	First Patient Day	0 days	Mon 8/29/11	Mon 8/29/11
552	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
553	**Department - Pathology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
554	**Service Unit - Transfusion & Pheresis Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
555	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
556	DW Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
557	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
558	First Patient Day	0 days	Mon 8/29/11	Mon 8/29/11

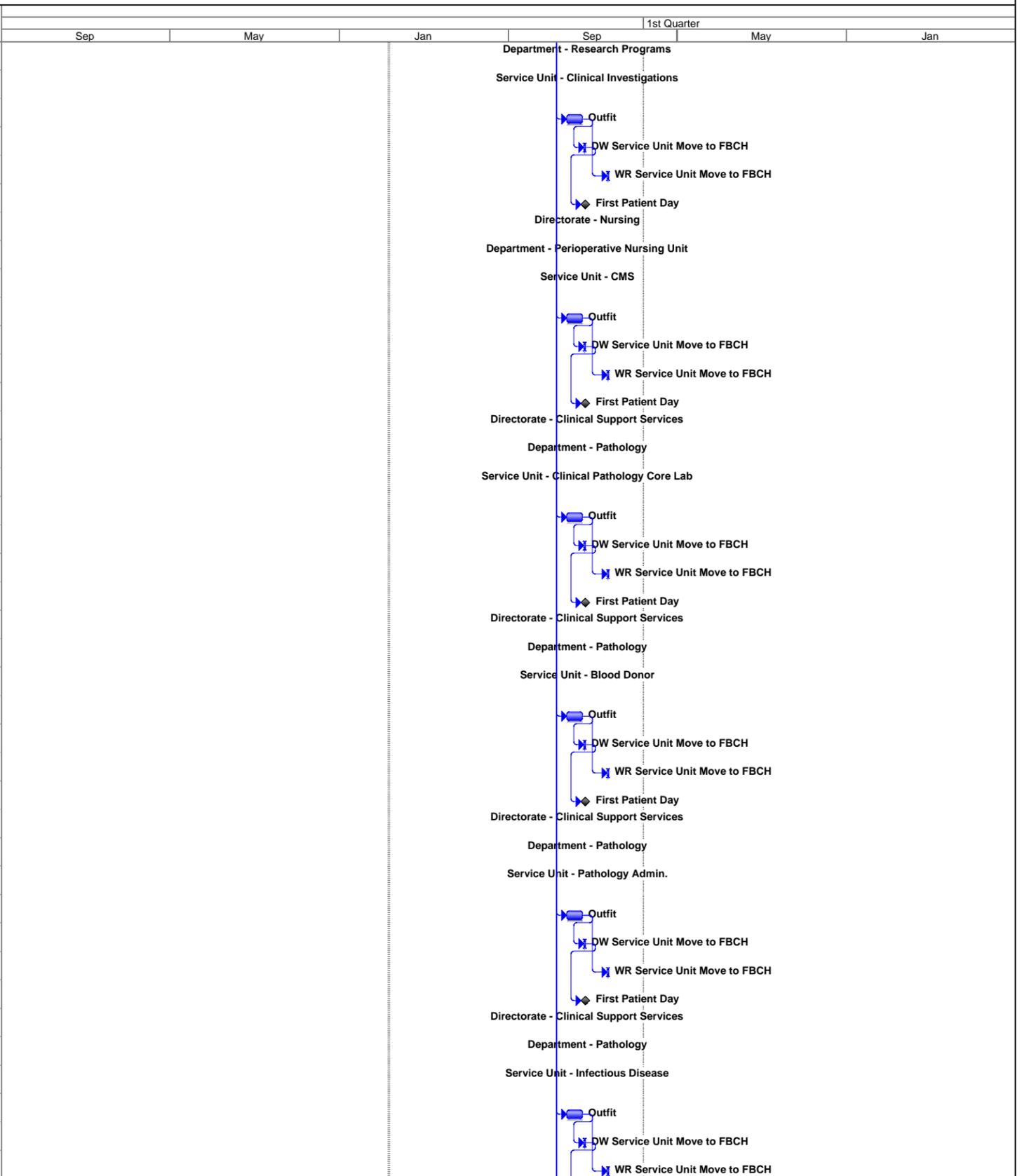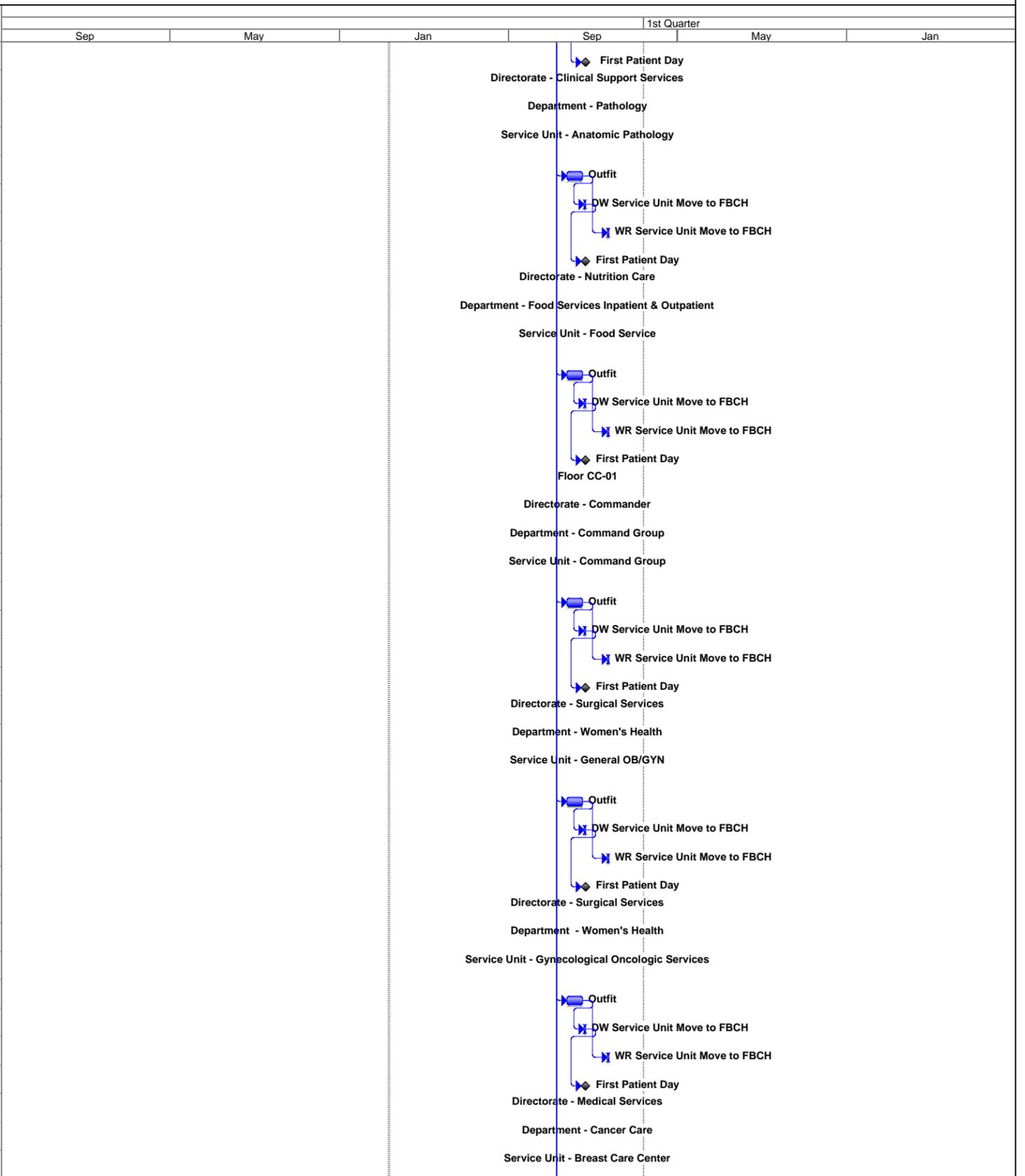| Legend			
Task	Milestone ◆	Rolled Up Task	Rolled Up Progress	External Tasks	Group By Summary
Progress	Summary	Rolled Up Milestone ◇	Split	Project Summary	Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

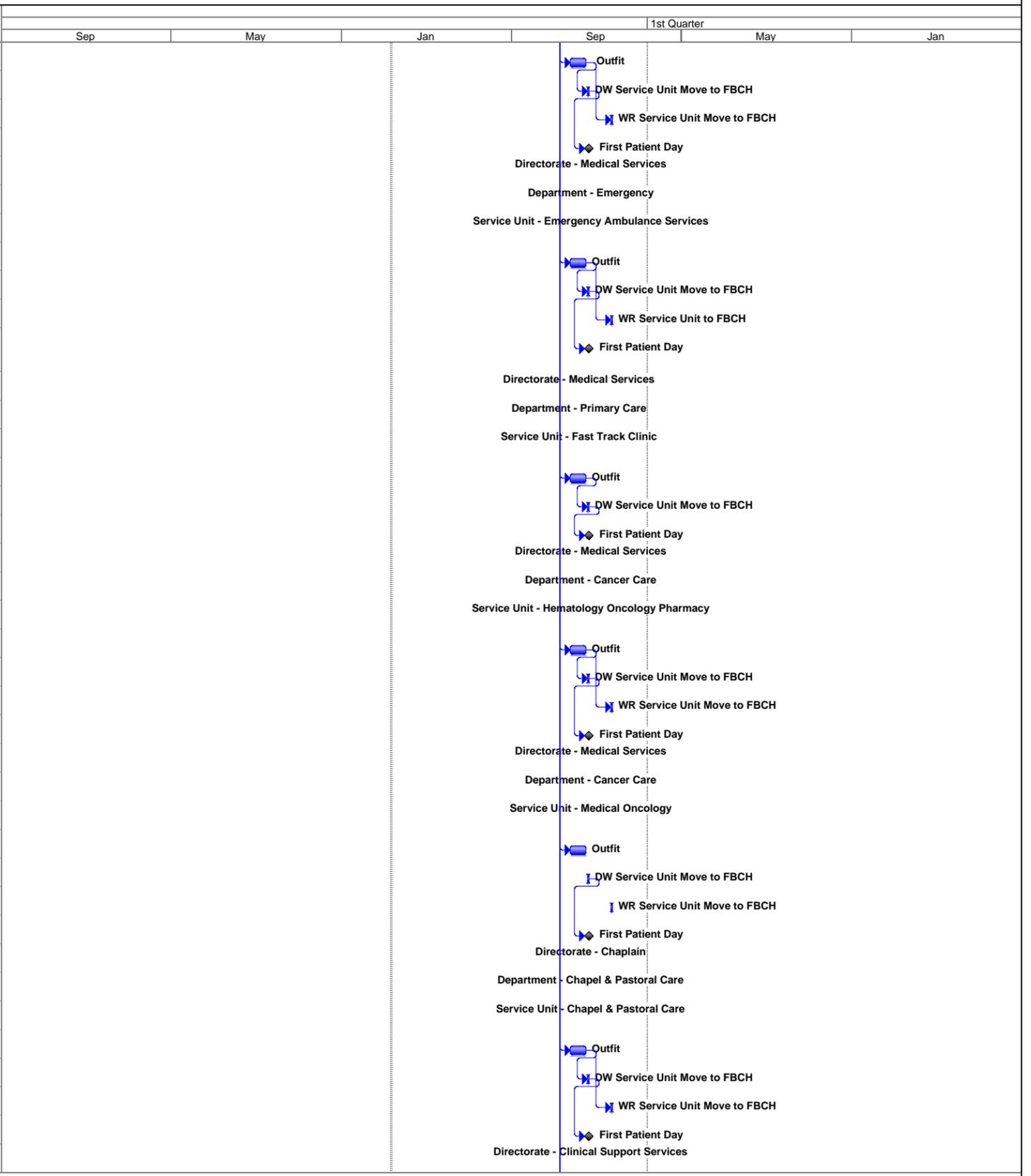| ID	Task Name	Duration	Start	Finish
559	**Directorate - Clinical Support Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
560	**Department - Radiology**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
561	**Service Unit - Radiology Administration**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
562	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
563	DW Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
564	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
565	First Patient Day	0 days	Mon 8/29/11	Mon 8/29/11
566	**Directorate - Surgical Service**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
567	**Department - Surgery**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
568	**Service Unit - Cardiac Cath. Interventional**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
569	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
570	DW Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
571	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
572	First Patient Day	0 days	Mon 8/29/11	Mon 8/29/11
573	**Floor CC-03**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
574	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
575	**Department - Surgery**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
576	**Service Unit - Anesthesia**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
577	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
578	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
579	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
580	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
581	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
582	**Department - Surgery Department**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
583	**Service Unit - GI Endoscopy**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
584	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
585	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
586	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
587	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
588	**Directorate - Nutrition Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
589	**Department - Food Services Inpatient & Outpatient**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
590	**Service Unit - Food Services Nutrition**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
591	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
592	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
593	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
594	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
595	**Directorate - Nutrition Care**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
596	**Department - Food Services Inpatient & Outpatient**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
597	**Service Unit - Food Services Servery/Cafeteria**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
598	Outfit	40 days	Fri 4/1/11	Thu 5/26/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

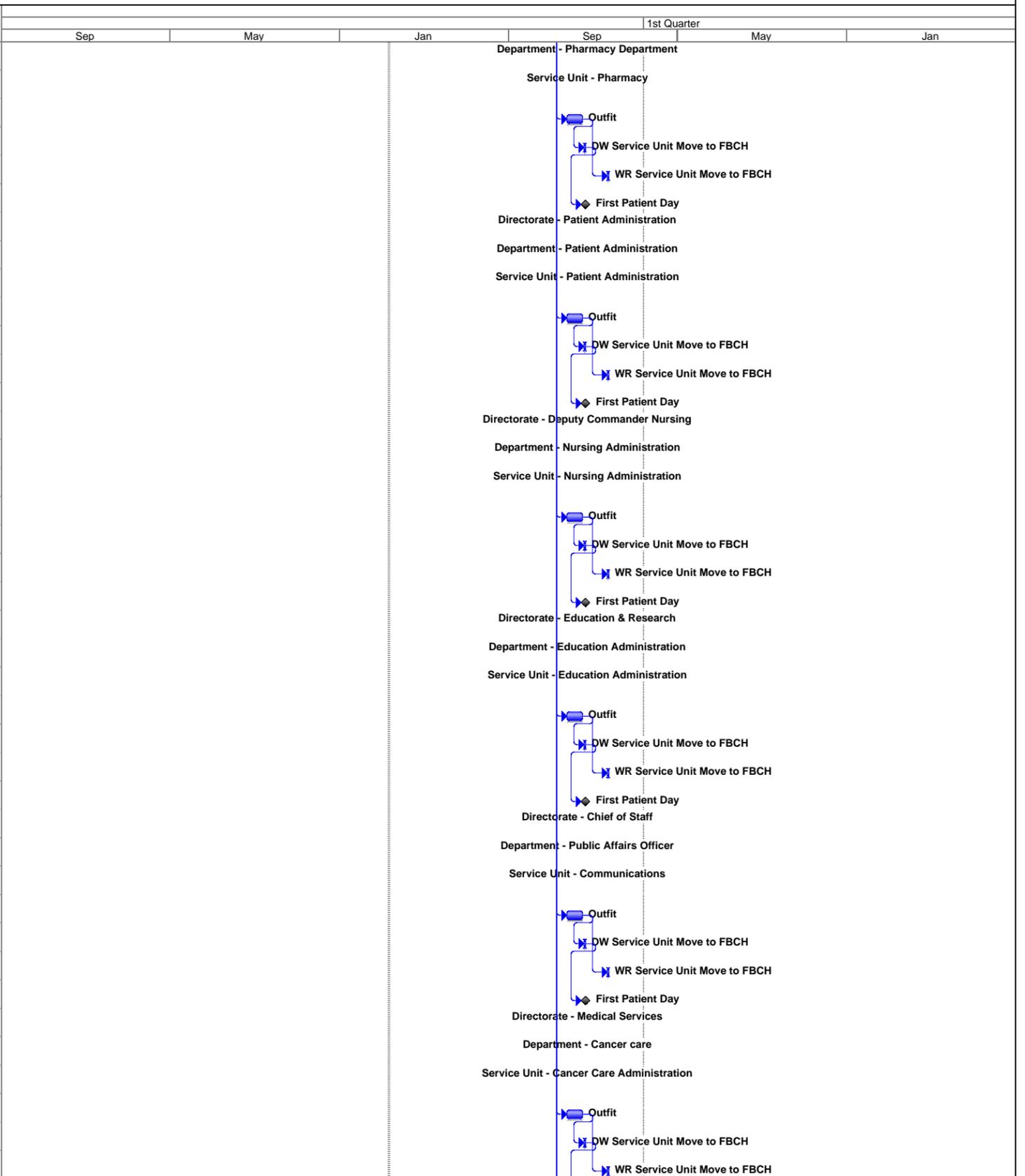| ID	Task Name	Duration	Start	Finish
599	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
600	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
601	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
602	**Floor CC-04**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
603	**Directorate - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
604	**Department - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
605	**Department - Preventive & Consultative Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
606	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
607	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
608	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
609	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
610	**Directorate - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
611	**Department - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
612	**Service Unit - Residential Treatment Facility,**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
613	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
614	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
615	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
616	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
617	**Directorate - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
618	**Department - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
619	**Service Unit - Substance Abuse Partial**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
620	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
621	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
622	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
623	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
624	**Directorate - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
625	**Department - Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
626	**Service Unit - Inpatient Behavioral Health**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
627	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
628	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
629	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
630	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
631	**Floor CC-05**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
632	**Directorate - Deputy Cmdr. Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
633	**Department - Womens Health Nursing Unit**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
634	**Service Unit - Post & Ante Partum**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
635	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
636	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
637	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
638	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
639	**Directorate - Deputy Cmdr. Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
640	**Department - Womens Health Nursing Unit**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
641	**Service Unit - Nursery**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
642	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
643	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
644	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
645	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
646	**Directorate - Deputy Cmdr. Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
647	**Department - Womens Health Nursing Unit**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
648	**Service Unit - Labor & Delivery**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
649	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
650	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
651	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
652	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
653	**Floor CC-06**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
654	**Directorate - Medical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
655	**Department - Pediatrics**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
656	**Service Unit - Pediatrics Inpatient**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
657	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
658	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
659	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
660	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
661	**Directorate - Deputy Cmdr. Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
662	**Department - Adult Medical Surgical**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
663	**Service Unit - Medical Surgical**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
664	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
665	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
666	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
667	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
668	**Floor CC-07**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
669	**Directorate - Deputy Cmdr. Nursing**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
670	**Department - Adult Medical Surgical**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
671	**Service Unit - Medical Surgical**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
672	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
673	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
674	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
675	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
676	**Directorate - Surgical Services**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
677	**Department - Orthopedics Rehabilitation**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**
678	**Service Unit - Inpatient Physical Therapy**	**107 days**	**Fri 4/1/11**	**Mon 8/29/11**

Legend:
Task — Milestone ◆ — Rolled Up Task — Rolled Up Progress — External Tasks — Group By Summary
Progress — Summary — Rolled Up Milestone ◇ — Split .... — Project Summary — Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
679	Outfit	40 days	Fri 4/1/11	Thu 5/26/11
680	DW Service Unit Move to FBCH	3 days	Thu 6/2/11	Mon 6/6/11
681	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
682	First Patient Day	0 days	Mon 6/6/11	Mon 6/6/11
683	**Building D, Sunrise**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
684	Design	320 days	Thu 10/11/07	Wed 12/31/08
685	Construction	623 days	Wed 4/23/08	Fri 9/10/10
686	BOD	0 days	Fri 9/10/10	Fri 9/10/10
687	**Building D Outfit & Transition**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
688	**Floor DD-01**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
689	**Directorate - Clinical Support Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
690	**Department Radiology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
691	**Service Unit - Radiation Oncology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
692	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
693	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
694	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
695	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
696	**Directorate**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
697	**Department Vetrans Administration**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
698	**Service Unit - VA Clinic**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
699	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
700	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
701	DW Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
702	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
703	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
704	**Department - Cancer Care**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
705	**Service Unit - Breast Care Center**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
706	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
707	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
708	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
709	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
710	**Directorate - Clinical Support Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
711	**Department Radiology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
712	**Service Unit - Breast Care Center**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
713	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
714	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
715	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
716	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
717	**Floor DD-02**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
718	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇

Rolled Up Progress	▬▬▬	External Tasks	▬▬▬	Group By Summary	▬▬▬
Split	·········	Project Summary	▬▬▬	Deadline	⇩

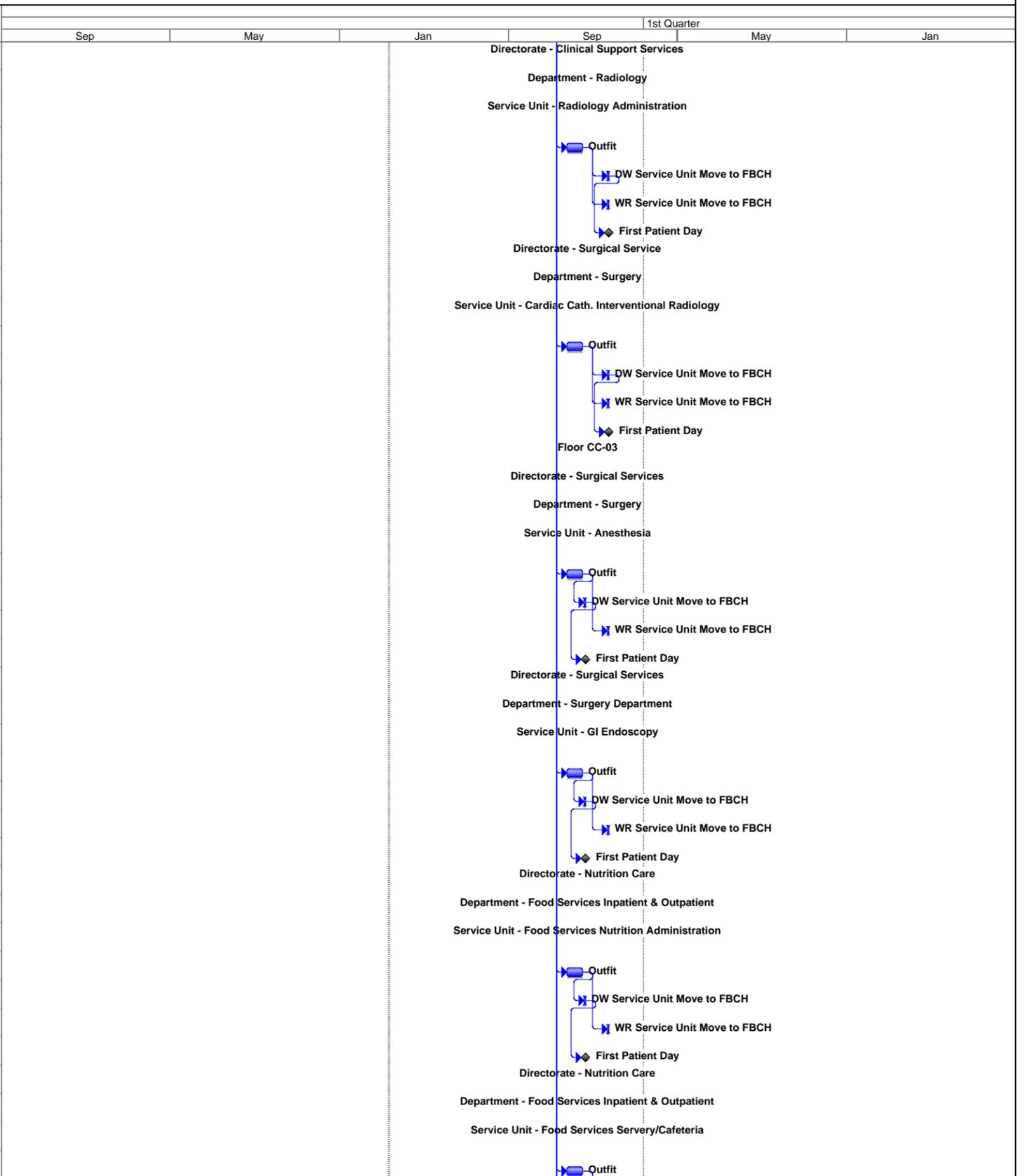| ID	Task Name	Duration	Start	Finish
719	**Department Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
720	**Service Unit - ENT Otolaryngology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
721	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
722	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
723	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
724	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
725	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
726	**Department Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
727	**Service Unit - Audiology Speech**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
728	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
729	Service Unit Move	3 days	Thu 4/7/11	Mon 4/11/11
730	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
731	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
732	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
733	**Department Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
734	**Service Unit - Urology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
735	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
736	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
737	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
738	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
739	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
740	**Department Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
741	**Service Unit - General Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
742	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
743	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
744	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
745	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
746	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
747	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
748	**Service Unit - Nephrology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
749	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
750	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
751	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
752	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
753	**Directorate - Surgical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
754	**Department Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
755	**Service Unit - Plastic Surgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
756	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
757	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
758	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

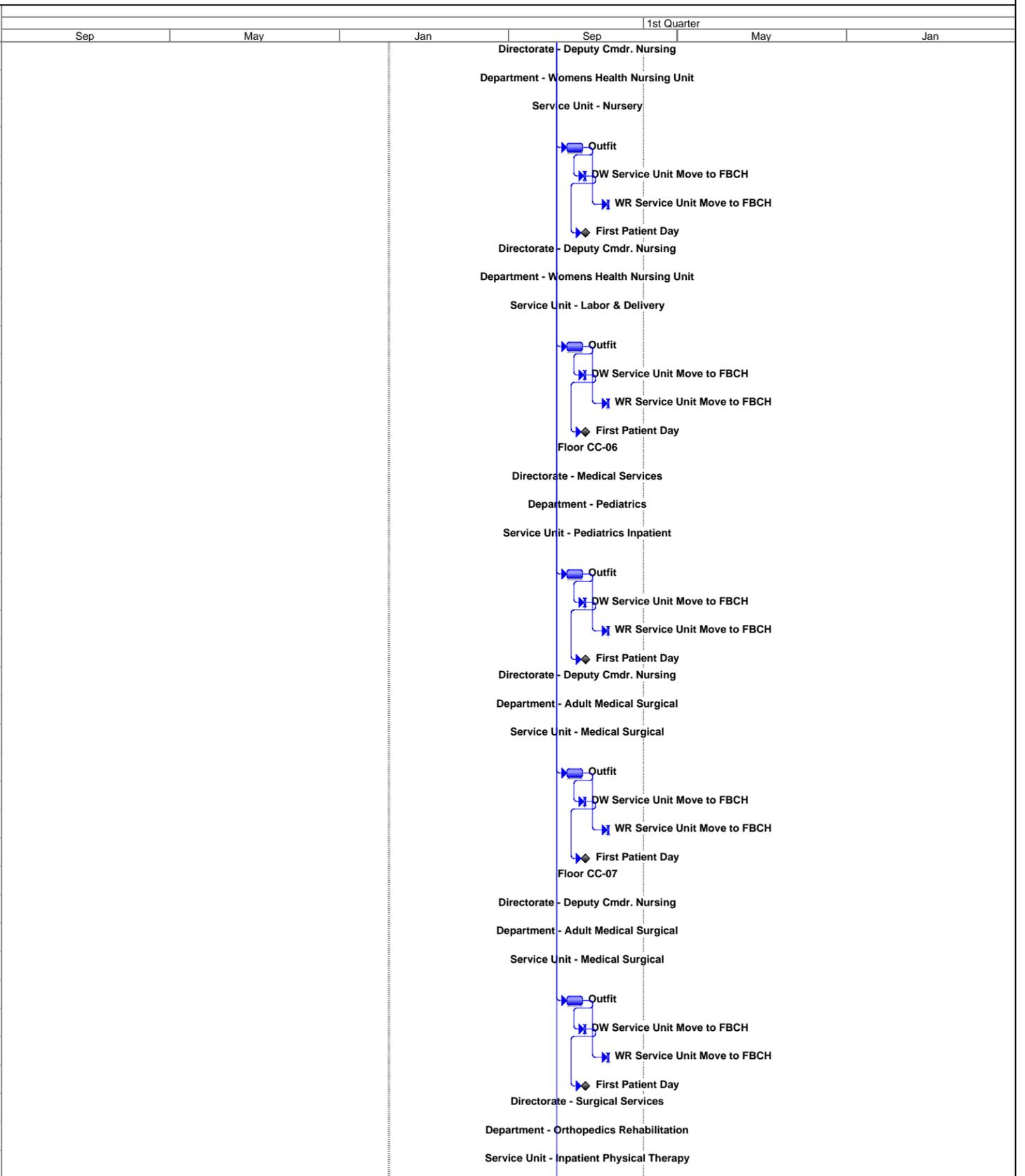| ID	Task Name	Duration	Start	Finish
759	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
760	**Floor DD-03**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
761	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
762	**Department Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
763	**Service Unit - Neurology**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
764	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
765	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
766	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
767	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
768	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
769	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
770	**Service Unit - DVBIC**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
771	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
772	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
773	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
774	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
775	**Directorate - Medical Services**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
776	**Department - Medical Specialties**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
777	**Service Unit - Neurosurgery**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
778	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
779	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
780	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
781	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
782	**Directorate - Healthcare Operations**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
783	**Department - Healthcare Operations**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
784	**Service Unit - Referral Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
785	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
786	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
787	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
788	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
789	**Directorate - Resource Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
790	**Department - Resource Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
791	**Service Unit - Resource Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
792	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
793	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
794	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
795	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
796	**Directorate - Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
797	**Department - Civilian Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
798	**Service Unit - Civilian HR**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
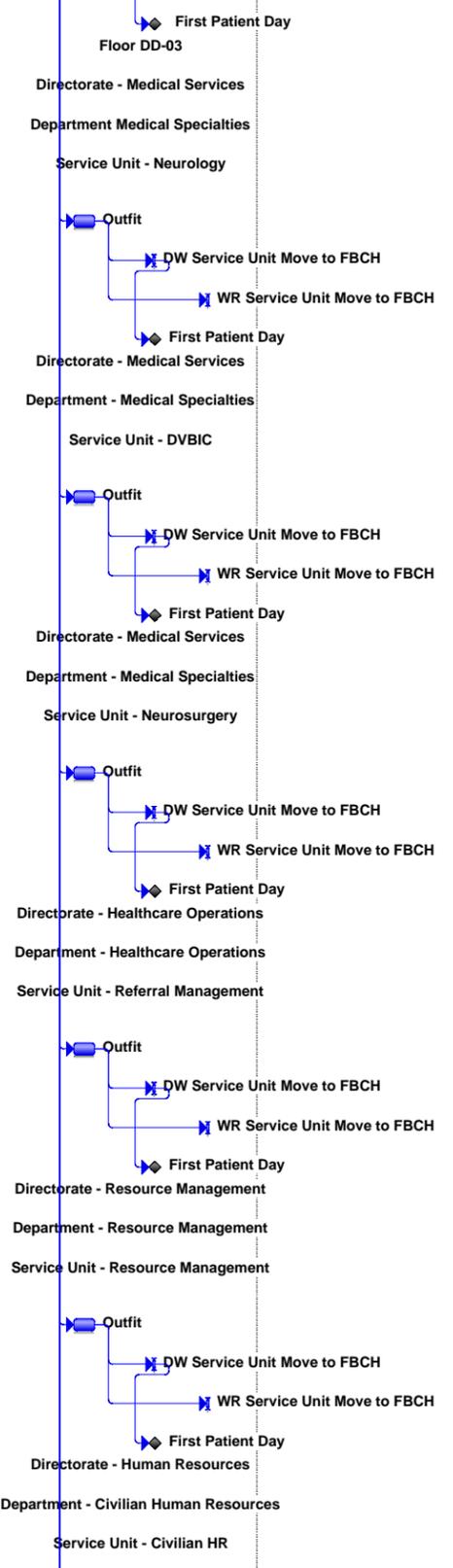
Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
799	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
800	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
801	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
802	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
803	**Directorate - Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
804	**Department - Contracting Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
805	**Service Unit - Contracting HR**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
806	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
807	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
808	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
809	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
810	**Directorate - Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
811	**Department - Milirtary Human Resources**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
812	**Service Unit - Military HR**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
813	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
814	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
815	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
816	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
817	**Directorate - Healthcare Operations**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
818	**Department - HPMO Managed Care**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
819	**Service Unit - HPMO Managed Care**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
820	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
821	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
822	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
823	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
824	**Directorate - Chief of Staff**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
825	**Department - JAG**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
826	**Service Unit - JAG**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
827	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
828	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
829	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
830	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
831	**Directorate - Chief of Staff**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
832	**Department - Internal Review & Evaluation**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
833	**Service Unit - Internal Review**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
834	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
835	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
836	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
837	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
838	**Directorate - Inspector General**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**

Task	▬▬▬	Milestone ◆	Rolled Up Task ▬▬▬	Rolled Up Progress ▬▬▬	External Tasks ▬▬▬	Group By Summary ▼▼
Progress		Summary ▼▼	Rolled Up Milestone ◇	Split ··········	Project Summary ▼▼	Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
839	**Department - Inspector General**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
840	**Service Unit - Inspector General**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
841	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
842	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
843	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
844	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
845	**Directorate - Healthcare Operations**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
846	**Department - Clinical Case Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
847	**Service Unit - Clinical Case Management**	**251 days**	**Mon 9/13/10**	**Mon 8/29/11**
848	Outfit	40 days	Mon 9/13/10	Fri 11/5/10
849	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
850	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
851	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
852	**Building E, Meadows**	**1013 days**	**Thu 10/11/07**	**Mon 8/29/11**
853	Design	320 days	Thu 10/11/07	Wed 12/31/08
854	Construction	565 days	Wed 3/26/08	Tue 5/25/10
855	BOD	0 days	Tue 5/25/10	Tue 5/25/10
856	**Building E Outfit & Transition**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
857	**Floor EE-01**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
858	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
859	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
860	**Service Unit - Dermatology**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
861	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
862	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
863	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
864	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
865	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
866	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
867	**Service Unit - Endocrinology Service**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
868	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
869	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
870	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
871	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
872	**Directorate**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
873	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
874	**Service Unit - Optometry**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
875	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
876	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
877	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
878	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
879	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
880	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
881	**Service Unit - Infectious Disease**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
882	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
883	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
884	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
885	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
886	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
887	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
888	**Service Unit - Rheumatology**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
889	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
890	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
891	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
892	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
893	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
894	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
895	**Service Unit - Vaccine Healthcare Centers**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
896	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
897	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
898	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
899	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
900	**Directorate - Deputy Commander Nursing**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
901	**Department - Deputy Commander Nursing**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
902	**Service Unit - Infection Control**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
903	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
904	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
905	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
906	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
907	**Floor EE-02**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
908	**Directorate - Surgical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
909	**Department Surgery**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
910	**Service Unit - Opthamology**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
911	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
912	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
913	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
914	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
915	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
916	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
917	**Service Unit - Pulmonary**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
918	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
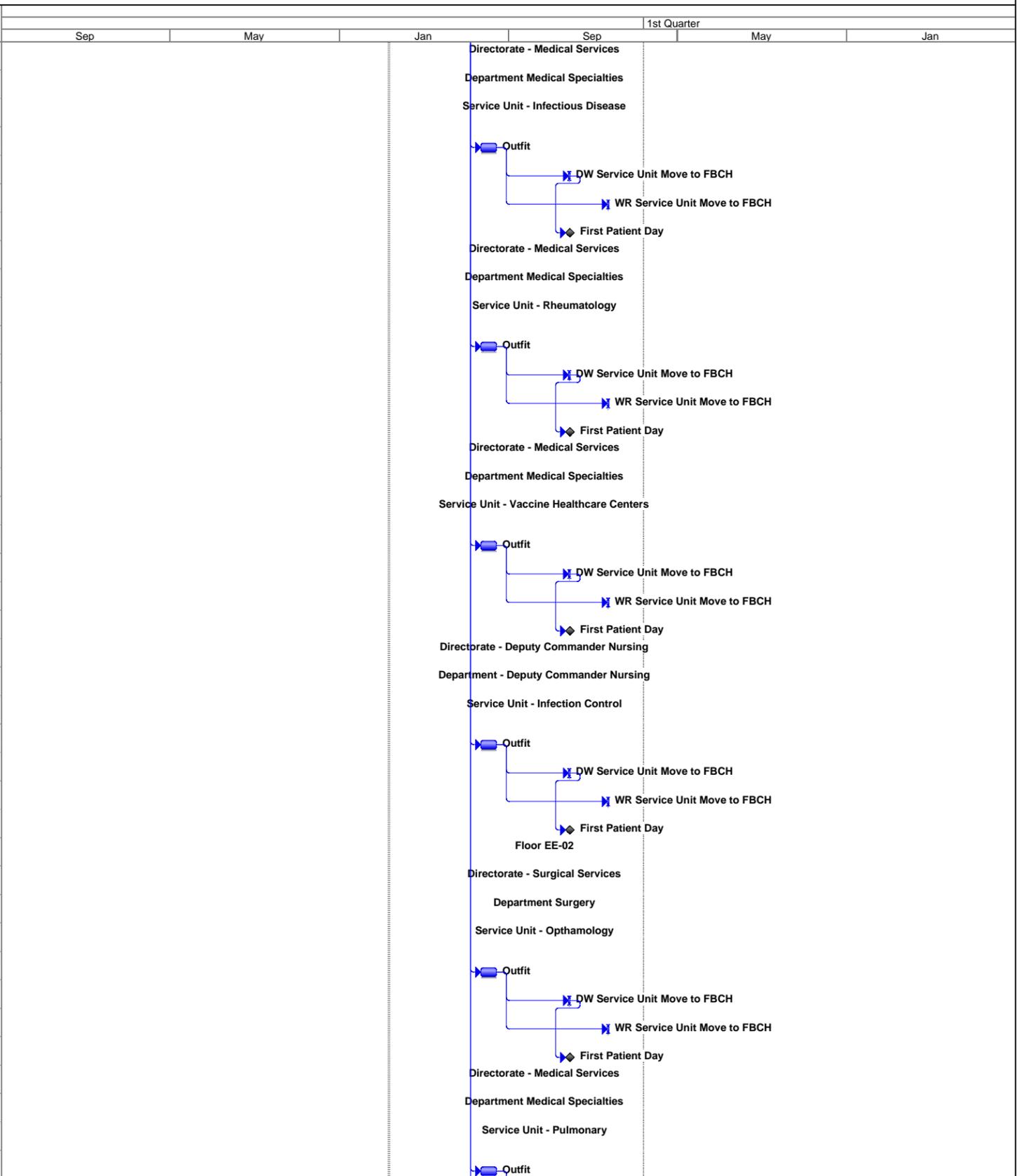
Task	████	Milestone	◆	Rolled Up Task ████
Progress	████	Summary	▬▬▬	Rolled Up Milestone ◇

Rolled Up Progress ▬▬▬ · External Tasks ▬▬▬ · Group By Summary ▼▼
Split ·········· · Project Summary ▽▽ · Deadline ⇩

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ID	Task Name	Duration	Start	Finish
919	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
920	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
921	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
922	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
923	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
924	**Service Unit - Respiratory Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
925	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
926	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
927	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
928	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
929	**Directorate - Medical Services**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
930	**Department Medical Specialties**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
931	**Service Unit - Vascular Surgery**	**329 days**	**Wed 5/26/10**	**Mon 8/29/11**
932	Outfit	40 days	Wed 5/26/10	Tue 7/20/10
933	DW Service Unit Move to FBCH	3 days	Thu 4/7/11	Mon 4/11/11
934	WR Service Unit Move to FBCH	3 days	Thu 8/25/11	Mon 8/29/11
935	First Patient Day	0 days	Mon 4/11/11	Mon 4/11/11
936	**Central Utility Plant (CUP)**	**737 days**	**Thu 10/11/07**	**Fri 8/6/10**
937	Design	296 days	Thu 10/11/07	Wed 12/31/08
938	Construction	532 days	Thu 7/24/08	Fri 8/6/10
939	**Garage South**	**737 days**	**Thu 10/11/07**	**Fri 8/6/10**
940	Design	210 days	Thu 10/11/07	Wed 7/30/08
941	Construction	527 days	Thu 7/31/08	Fri 8/6/10
942	**Garage North**	**764 days**	**Thu 10/11/07**	**Tue 9/14/10**
943	Design	221 days	Thu 10/11/07	Thu 8/14/08
944	Construction	543 days	Fri 8/15/08	Tue 9/14/10
945	**Walter Reed National Military Medical Center (WRNMMC)**	**909 days**	**Fri 3/7/08**	**Thu 9/1/11**
946	**Building A (Medical Office Building)**	**909 days**	**Fri 3/7/08**	**Thu 9/1/11**
947	Design	387 days	Fri 3/7/08	Mon 8/31/09
948	Constuction	578 days	Tue 7/15/08	Thu 9/30/10
949	BOD	0 days	Thu 9/30/10	Thu 9/30/10
950	Overall Outfitting	80 days	Fri 8/6/10	Thu 11/25/10
951	Overall Bethesda Transition to Building A	65 days	Fri 10/1/10	Thu 12/30/10
952	Overall WARMC to Transition to Building A	3 days	Thu 8/25/11	Mon 8/29/11
953	**Building A**	**722 days**	**Tue 11/25/08**	**Thu 9/1/11**
954	**Floor AA-00**	**719 days**	**Fri 11/28/08**	**Thu 9/1/11**
955	**Directorate: Surgical Services**	**719 days**	**Fri 11/28/08**	**Thu 9/1/11**
956	**Dept: Orthopedics Rehabilitation Medicine**	**719 days**	**Fri 11/28/08**	**Thu 9/1/11**
957	**Service Unit: Physical Therapy Out Patient**	**718 days**	**Fri 11/28/08**	**Tue 8/30/11**
958	BT Temp Service Unit Move to BT	4 days	Fri 11/28/08	Wed 12/3/08
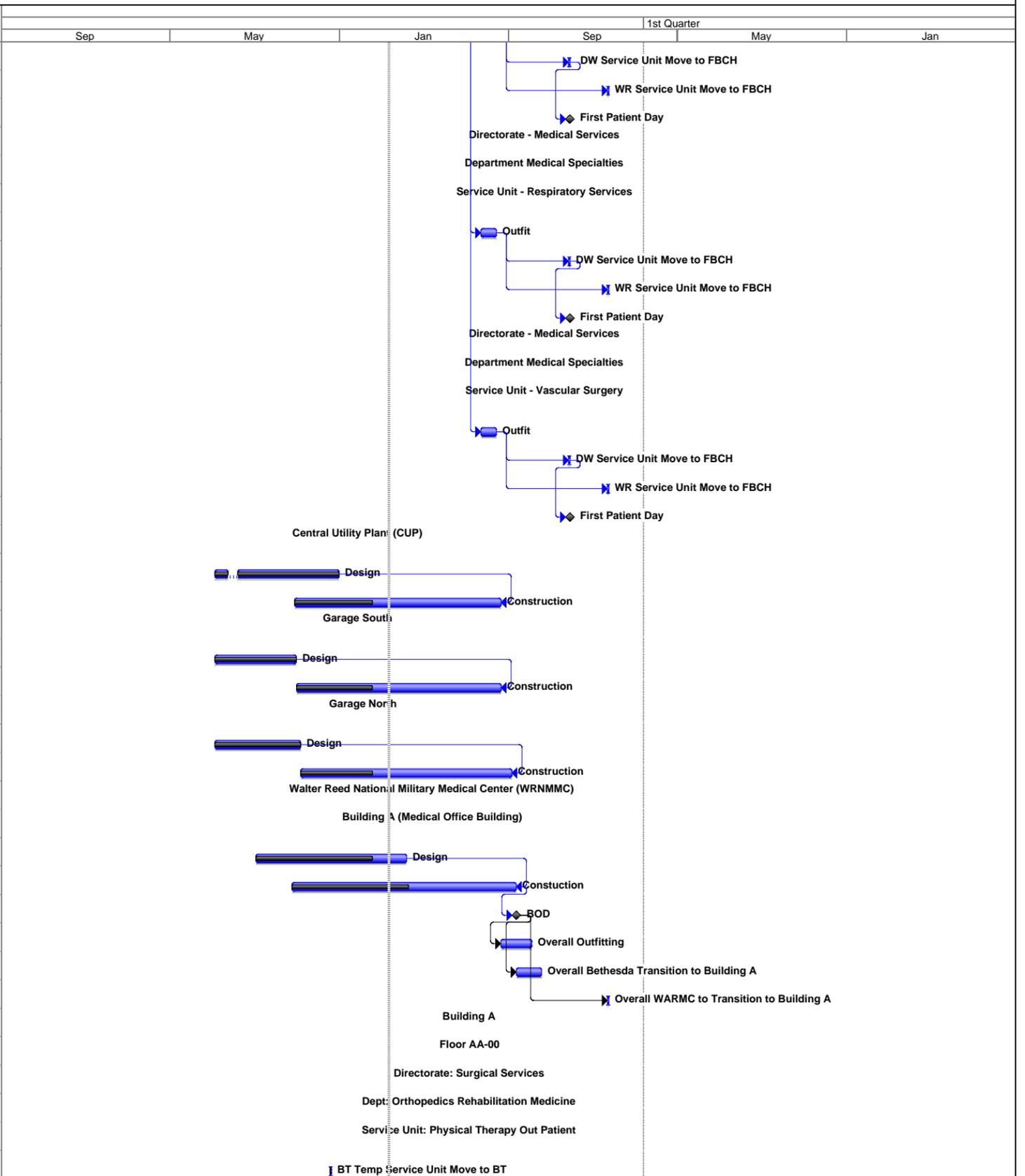
Legend:
Task ▬▬ Milestone ◆ Rolled Up Task ▬▬ Rolled Up Progress ▬▬ External Tasks ▭ Group By Summary ▽
Progress ▬▬ Summary ▬▬ Rolled Up Milestone ◇ Split ··········· Project Summary ▽ Deadline ⇩

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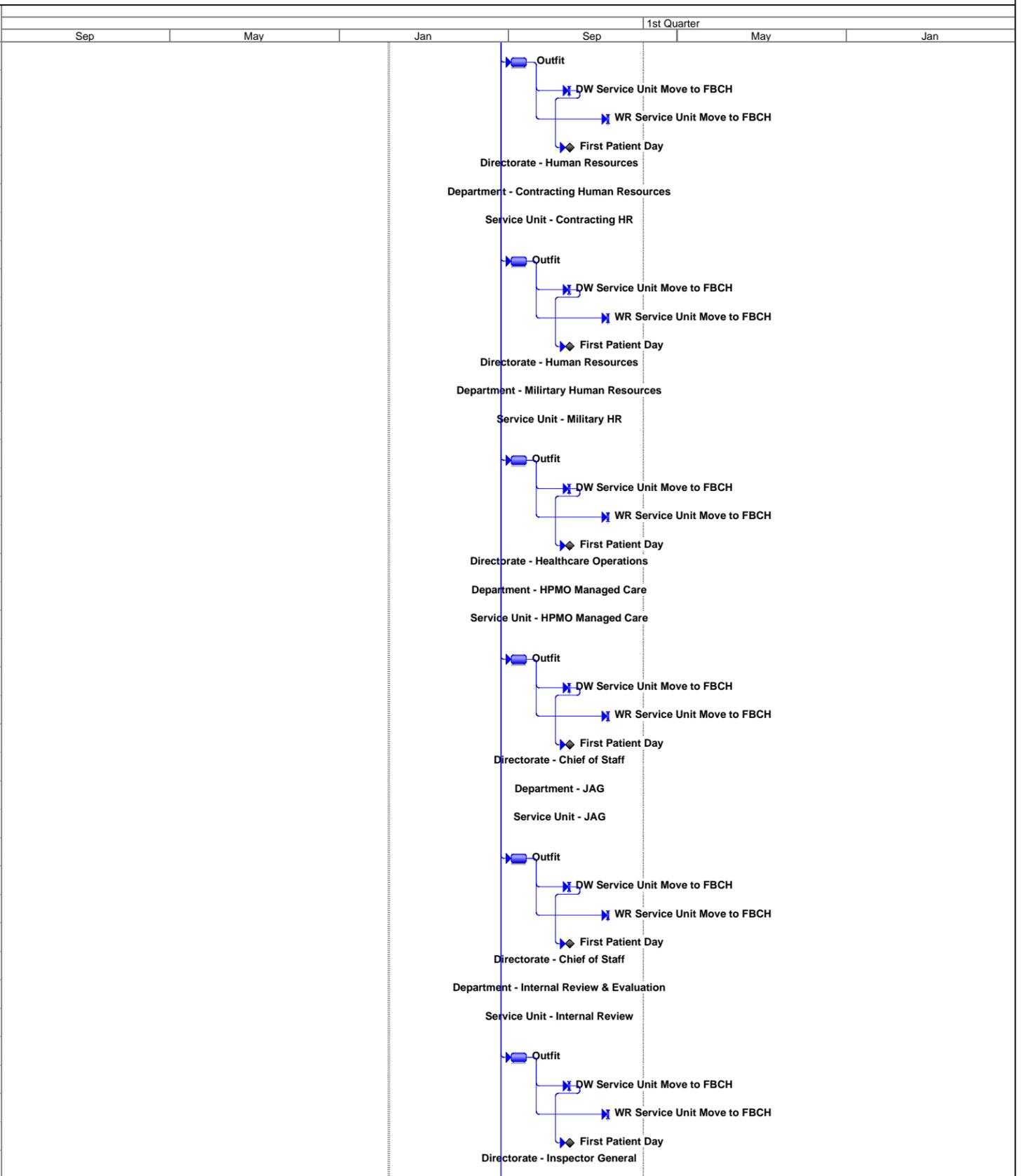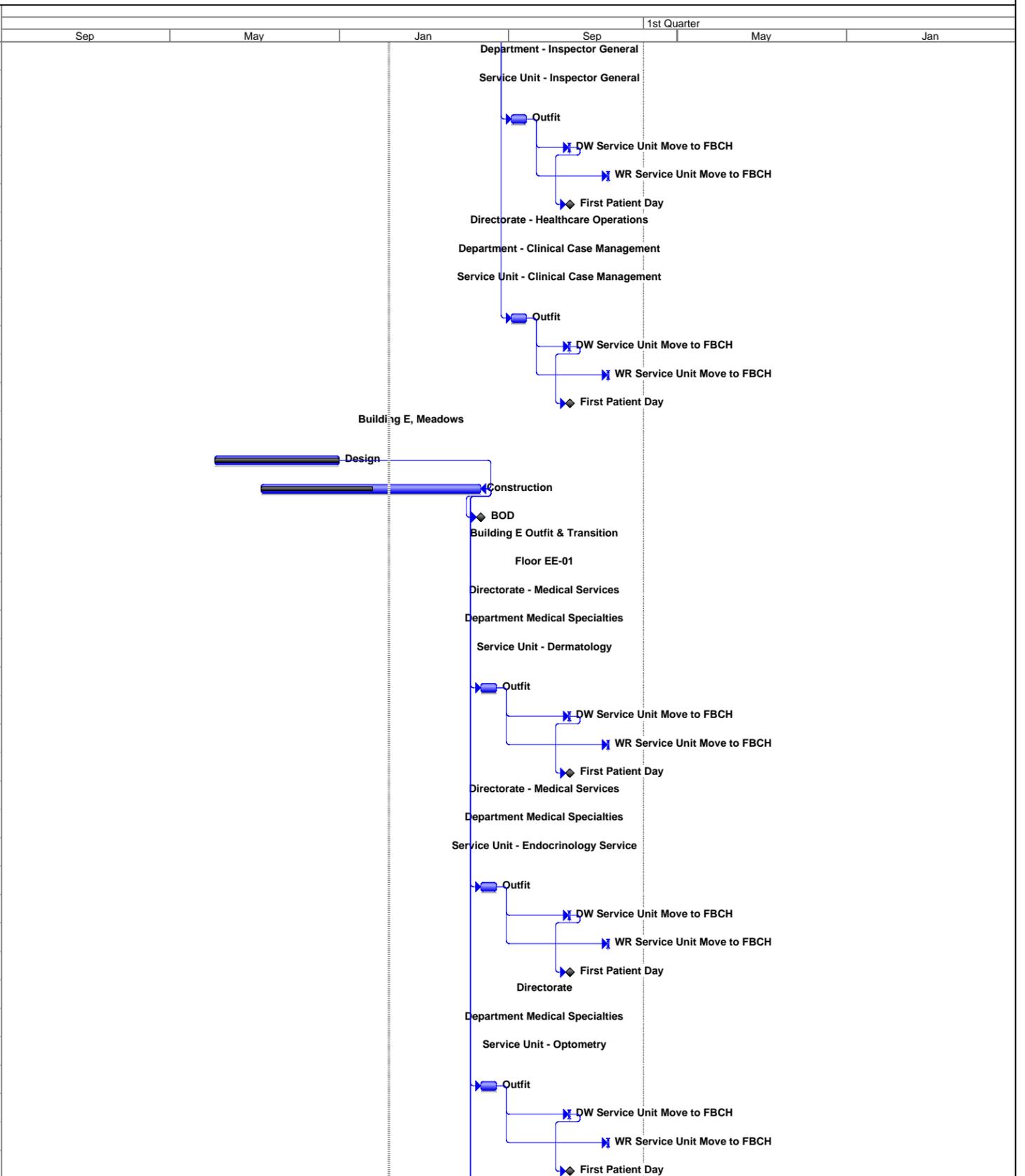| ID	Task Name	Duration	Start	Finish
959	BOD	0 days	Fri 10/1/10	Fri 10/1/10
960	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
961	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
962	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
963	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
964	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
965	**Service Unit: Occupational Therapy**	**718 days**	**Fri 11/28/08**	**Tue 8/30/11**
966	BOD	0 days	Fri 10/1/10	Fri 10/1/10
967	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
968	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
969	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
970	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
971	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
972	BT Temp Service Unit Move to BT	4 days	Fri 11/28/08	Wed 12/3/08
973	**Service Unit: Amputee Care**	**279 days**	**Fri 8/6/10**	**Thu 9/1/11**
974	BOD	0 days	Fri 10/1/10	Fri 10/1/10
975	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
976	Outfit	275 days	Fri 8/6/10	Thu 8/25/11
977	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
978	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
979	**Directorate: Clinical Support Services**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
980	**Dept: Radiology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
981	**Service Unit: Radiation Oncology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
982	BOD	0 days	Fri 10/1/10	Fri 10/1/10
983	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
984	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
985	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
986	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
987	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
988	**Floor AA-01**	**718 days**	**Fri 11/28/08**	**Tue 8/30/11**
989	**Directorate: Surgical Services**	**718 days**	**Fri 11/28/08**	**Tue 8/30/11**
990	**Dept: Orthopedics Rehabilitation Medicine**	**718 days**	**Fri 11/28/08**	**Tue 8/30/11**
991	**Service Unit: Orthotics Prosthetics**	**101 days**	**Fri 8/6/10**	**Mon 12/27/10**
992	BOD	0 days	Fri 10/1/10	Fri 10/1/10
993	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
994	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
995	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
996	First Patient Day	0 days	Mon 12/27/10	Mon 12/27/10
997	**Service Unit: Physical Medicine and Rehabilitation**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
998	BOD	0 days	Fri 10/1/10	Fri 10/1/10

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
999	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1000	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1001	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1002	First Patient Day	0 days	Mon 12/27/10	Mon 12/27/10
1003	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1004	**Service Unit: Chiropractics**	**542 days**	**Fri 11/28/08**	**Tue 12/28/10**
1005	BT Temp Service Unit Move to BT	4 days	Fri 11/28/08	Wed 12/3/08
1006	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1007	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1008	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1009	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1010	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1011	**Directorate: Clinical Support Services**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1012	**Dept: Pathology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1013	**Service Unit: Satellite Lab**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1014	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1015	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1016	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1017	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1018	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1019	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1020	**Dept: Pharmacy**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1021	**Service Unit: Clinical (Satellite) Pharmacy**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1022	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1023	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1024	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1025	BT Final Service Unit Move to BT	3 days	Fri 10/22/10	Tue 10/26/10
1026	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1027	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1028	**Floor AA-02**	**721 days**	**Tue 11/25/08**	**Tue 8/30/11**
1029	**Directorate: Surgical Services**	**721 days**	**Tue 11/25/08**	**Tue 8/30/11**
1030	**Dept: Orthopedics Rehabilitation Medicine**	**721 days**	**Tue 11/25/08**	**Tue 8/30/11**
1031	**Service Unit: Orthopedics**	**717 days**	**Sun 11/30/08**	**Tue 8/30/11**
1032	BT-BT Temp Move	0 days	Sun 11/30/08	Sun 11/30/08
1033	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1034	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1035	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1036	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1037	First Patient Day	0 days	Mon 12/27/10	Mon 12/27/10
1038	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
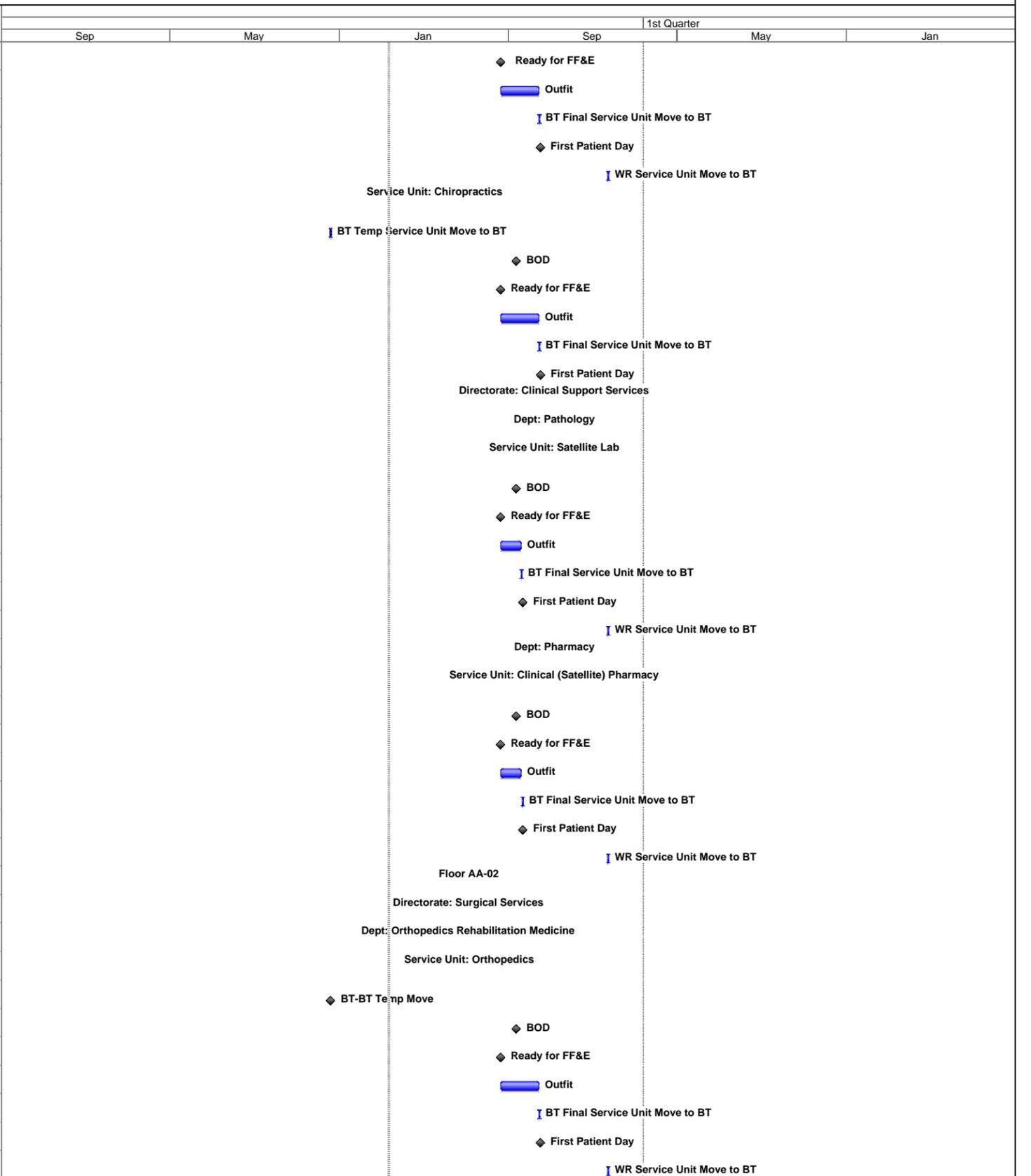
Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇

Rolled Up Progress	▬▬▬	External Tasks	▬▬▬	Group By Summary	▬▬▬
Split	....	Project Summary	▽▽▽	Deadline	⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
1039	Service Unit: Podiatry	721 days	Tue 11/25/08	Tue 8/30/11
1040	BT-BT Temp Move	4 days	Tue 11/25/08	Sun 11/30/08
1041	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1042	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1043	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1044	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1045	First Patient Day	0 days	Mon 12/27/10	Mon 12/27/10
1046	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1047	Directorate: Medical	278 days	Fri 8/6/10	Tue 8/30/11
1048	Dept: Medicine	278 days	Fri 8/6/10	Tue 8/30/11
1049	Service Unit: Internal Medicine	278 days	Fri 8/6/10	Tue 8/30/11
1050	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1051	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1052	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1053	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1054	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1055	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1056	Dept: Primary Care	56 days	Fri 8/6/10	Mon 10/25/10
1057	Service Unit: Internal Medicine	56 days	Fri 8/6/10	Mon 10/25/10
1058	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1059	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1060	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1061	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1062	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1063	Floor AA-03	497 days	Mon 10/5/09	Tue 8/30/11
1064	Directorate: Surgical Services	278 days	Fri 8/6/10	Tue 8/30/11
1065	Dept: OBGYN	278 days	Fri 8/6/10	Tue 8/30/11
1066	Service Unit: GYN Oncology	278 days	Fri 8/6/10	Tue 8/30/11
1067	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1068	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1069	Outfit	275 days	Fri 8/6/10	Thu 8/25/11
1070	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1071	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11
1072	Dept: Surgery	278 days	Fri 8/6/10	Tue 8/30/11
1073	Service Unit: Breast Care	278 days	Fri 8/6/10	Tue 8/30/11
1074	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1075	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1076	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1077	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1078	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10

Legend:
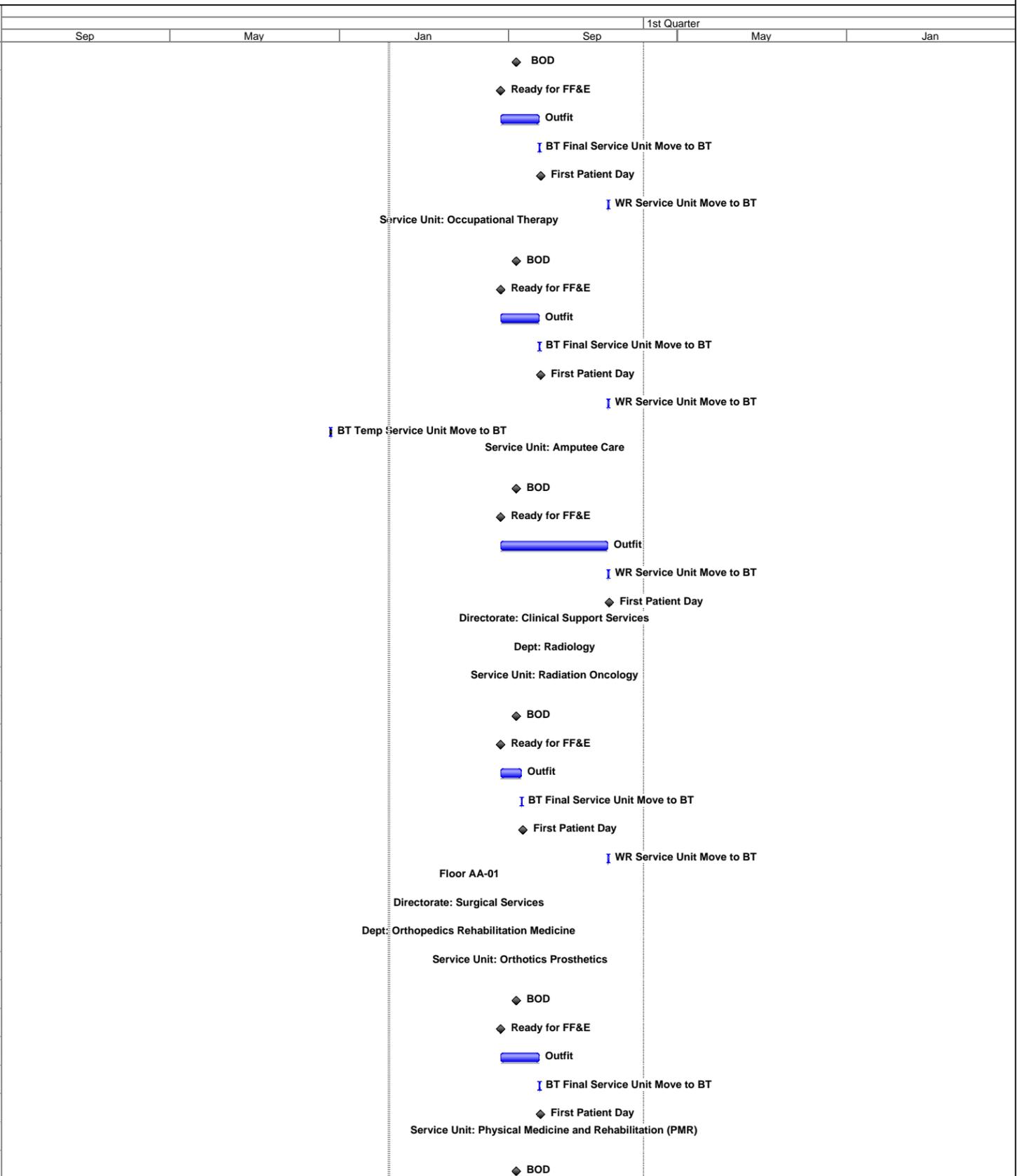Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

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ID	Task Name	Duration	Start	Finish
1079	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1080	**Directorate: Medical**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1081	**Dept: Medicine**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1082	**Service Unit: Rheumatology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1083	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1084	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1085	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1086	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1087	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1088	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1089	**Service Unit: Hematology Oncology/ Cancer**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1090	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1091	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1092	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1093	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1094	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1095	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1096	**Service Unit: Cancer Center Admin**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1097	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1098	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1099	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1100	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1101	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1102	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1103	**Service Unit: Dermatology**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1104	BT Temp Service Unit Move to BT	3 days	Mon 10/5/09	Wed 10/7/09
1105	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1106	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1107	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1108	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1109	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1110	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1111	**Directorate: Center of Excellence**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1112	**Dept: Prostate Center**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1113	**Service Unit: Prostate Cancer Center**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1114	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1115	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1116	Outfit	275 days	Fri 8/6/10	Thu 8/25/11
1117	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1118	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬
Progress		Summary		Rolled Up Milestone	◇

Rolled Up Progress	▬▬▬	External Tasks	▬▬▬	Group By Summary	▬▬▬
Split	·············	Project Summary		Deadline	⇩

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ID	Task Name	Duration	Start	Finish
1119	**Floor AA-04**	**603 days**	**Fri 5/8/09**	**Tue 8/30/11**
1120	**Directorate: Medical**	**603 days**	**Fri 5/8/09**	**Tue 8/30/11**
1121	**Dept: Pediatrics**	**603 days**	**Fri 5/8/09**	**Tue 8/30/11**
1122	**Service Unit: Pediatrics Primary Care**	**603 days**	**Fri 5/8/09**	**Tue 8/30/11**
1123	BT Temp Service Unit Move to BT	1 day	Fri 5/8/09	Fri 5/8/09
1124	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1125	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1126	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1127	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1128	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1129	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1130	**Service Unit: Adolescent Medicine**	**427 days**	**Fri 5/8/09**	**Tue 12/28/10**
1131	BT Temp Service Unit Move to BT	1 day	Fri 5/8/09	Fri 5/8/09
1132	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1133	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1134	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1135	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1136	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1137	**Service Unit: Pediatric Hematology Oncology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1138	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1139	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1140	Outfit	275 days	Fri 8/6/10	Thu 8/25/11
1141	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1142	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11
1143	**Service Unit: Pediatric Subspecialties**	**603 days**	**Fri 5/8/09**	**Tue 8/30/11**
1144	BT Temp Service Unit Move to BT	1 day	Fri 5/8/09	Fri 5/8/09
1145	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1146	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1147	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1148	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1149	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1150	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1151	**Service Unit: Exceptional Family Program**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1152	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1153	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1154	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1155	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1156	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1157	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1158	**Service Unit: Early Intervention**	**56 days**	**Fri 8/6/10**	**Mon 10/25/10**

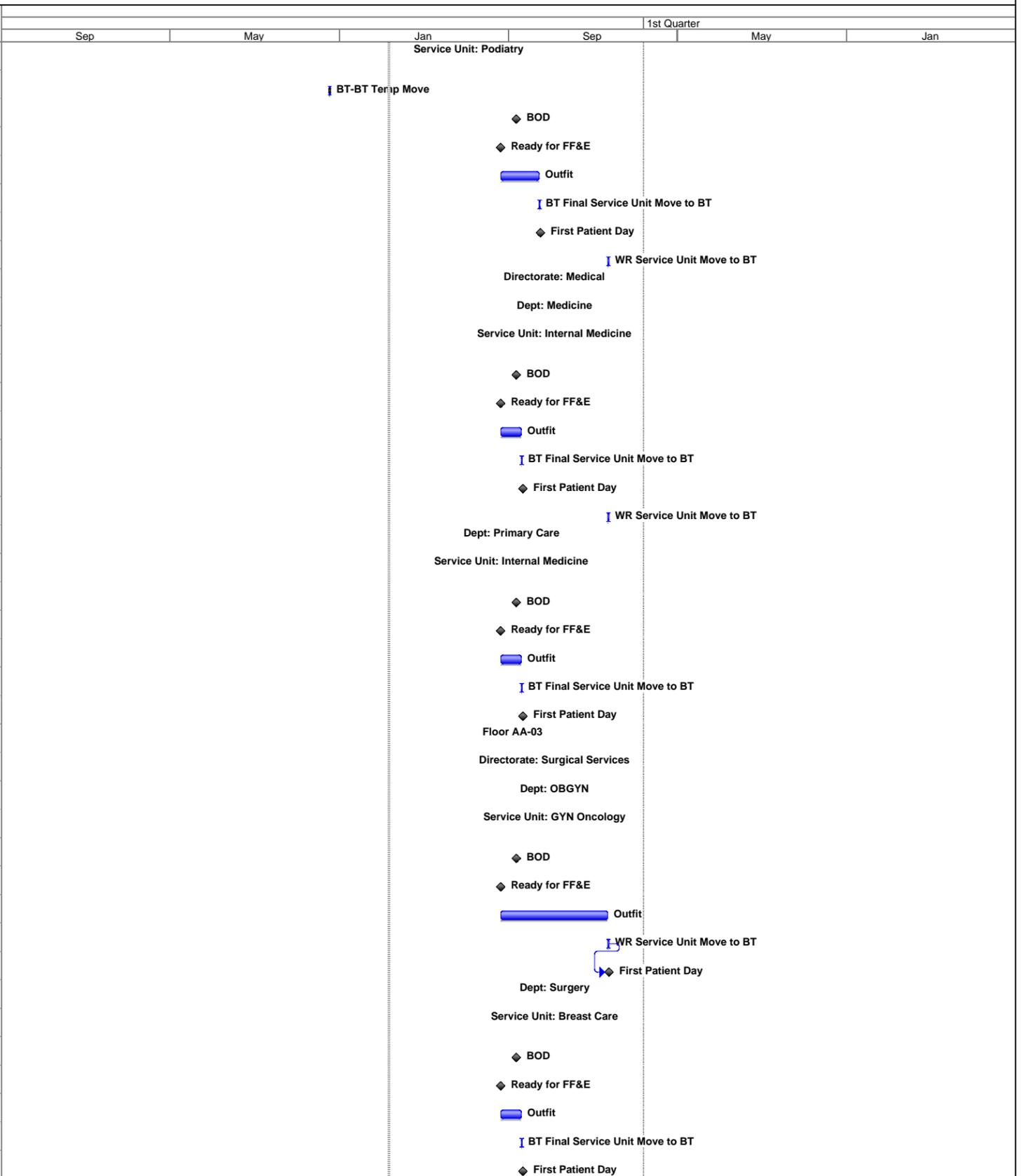| ID	Task Name	Duration	Start	Finish
1159	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1160	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1161	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1162	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1163	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1164	**Dept: Medicine**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1165	**Service Unit: Allergy**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1166	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1167	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1168	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1169	BT Final Service Unit Move to BT	3 days	Fri 10/22/10	Tue 10/26/10
1170	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1171	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1172	**Service Unit: Immunization/ Vaccine Healthcare**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1173	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1174	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1175	Outfit	52 days	Fri 8/6/10	Mon 10/18/10
1176	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1177	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1178	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1179	**Directorate: Behavioral Health**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1180	**Dept: Behavioral Health**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1181	**Service Unit: Adolescent Psychology/ Children's**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1182	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1183	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1184	Outfit	31 days	Mon 9/6/10	Mon 10/18/10
1185	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1186	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10
1187	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1188	**Floor AA-05**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1189	**Directorate: Surgical Services**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1190	**Dept: Surgery**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1191	**Service Unit: ENT: Ear Nose & Throat/**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1192	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1193	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1194	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1195	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10
1196	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10
1197	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1198	**Service Unit: Audiology/ Speech Pathology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**

Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
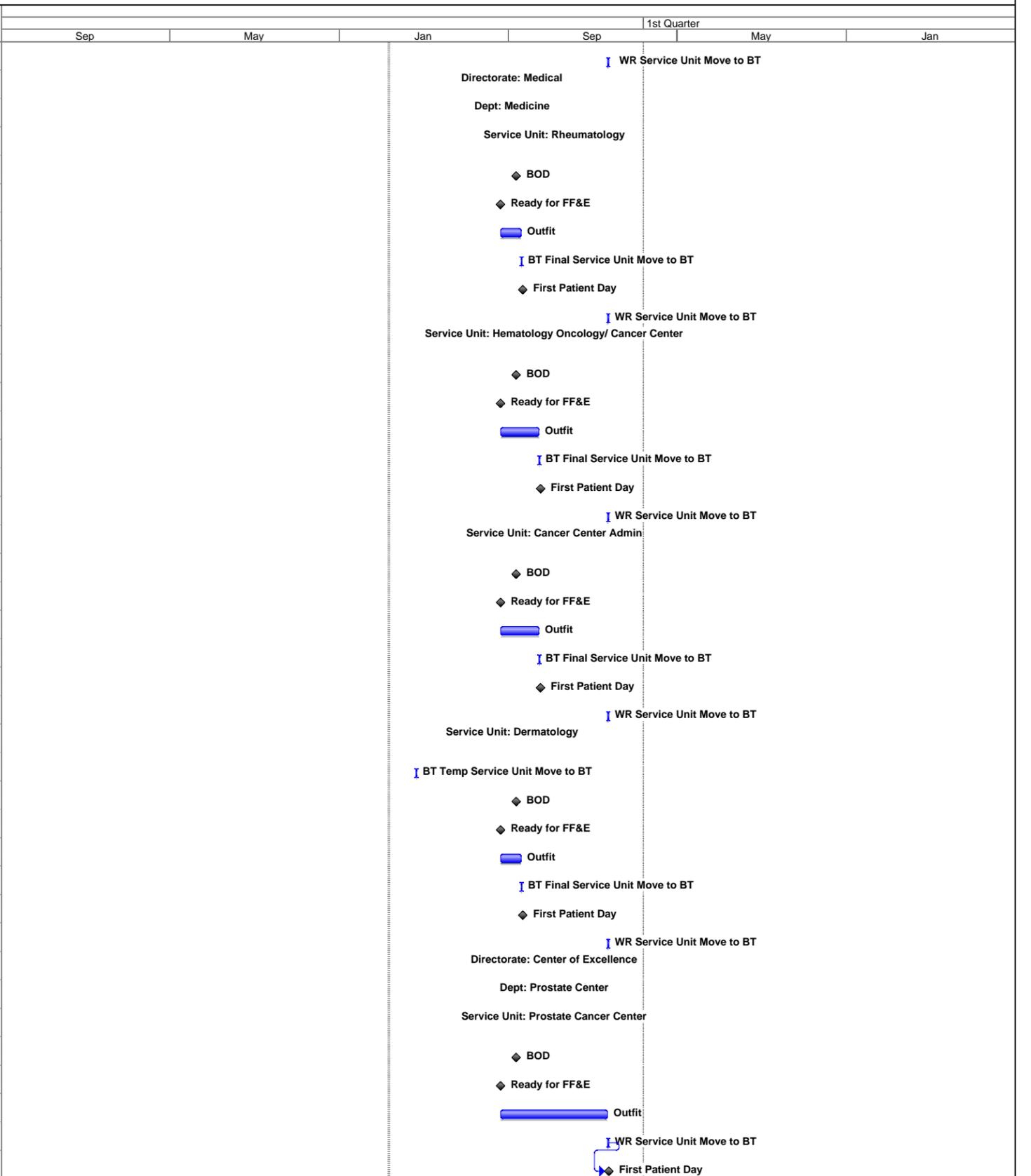Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⬇

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ID	Task Name	Duration	Start	Finish								
										1st Quarter		
					Sep	May	Jan		Sep	May	Jan	
1199	BOD	0 days	Fri 10/1/10	Fri 10/1/10					◆ BOD			
1200	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10					◆ Ready for FF&E			
1201	Outfit	98 days	Fri 8/6/10	Tue 12/21/10					Outfit			
1202	BT Final Service Unit Move to BT	0 days	Mon 12/27/10	Mon 12/27/10					◆ BT Final Service Unit Move to BT			
1203	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10					◆ First Patient Day			
1204	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11						I WR Service Unit Move to BT		
1205	**Directorate: Medical**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Directorate: Medical			
1206	**Dept: Medicine**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Dept: Medicine			
1207	**Service Unit: Endocrinology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Service Unit: Endocrinology			
1208	BOD	0 days	Fri 10/1/10	Fri 10/1/10					◆ BOD			
1209	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10					◆ Ready for FF&E			
1210	Outfit	52 days	Fri 8/6/10	Mon 10/18/10					Outfit			
1211	BT Final Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10					I BT Final Service Unit Move to BT			
1212	First Patient Day	0 days	Mon 10/25/10	Mon 10/25/10					◆ First Patient Day			
1213	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11						I WR Service Unit Move to BT		
1214	**Floor AA-06**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Floor AA-06			
1215	**Directorate: Medical**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Directorate: Medical			
1216	**Dept: Neurology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Dept: Neurology			
1217	**Service Unit: Neurology**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Service Unit: Neurology			
1218	BOD	0 days	Fri 10/1/10	Fri 10/1/10					◆ BOD			
1219	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10					◆ Ready for FF&E			
1220	Outfit	98 days	Fri 8/6/10	Tue 12/21/10					Outfit			
1221	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10					I BT Final Service Unit Move to BT			
1222	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10					◆ First Patient Day			
1223	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11						I WR Service Unit Move to BT		
1224	**Service Unit: Traumatic Brain Injury (DVBIC)**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Service Unit: Traumatic Brain Injury (DVBIC)			
1225	BOD	0 days	Fri 10/1/10	Fri 10/1/10					◆ BOD			
1226	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10					◆ Ready for FF&E			
1227	Outfit	275 days	Fri 8/6/10	Thu 8/25/11					Outfit			
1228	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11						I WR Service Unit Move to BT		
1229	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11						◆ First Patient Day		
1230	**Directorate: Behavioral Health**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Directorate: Behavioral Health			
1231	**Dept: Behavioral Health**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Dept: Behavioral Health			
1232	**Service Unit: Adult Outpatient Behavioral Health/**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**					Service Unit: Adult Outpatient Behavioral Health/ BH Clinic			
1233	BOD	0 days	Fri 10/1/10	Fri 10/1/10					◆ BOD			
1234	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10					◆ Ready for FF&E			
1235	Outfit	98 days	Fri 8/6/10	Tue 12/21/10					Outfit			
1236	BT Final Service Unit Move to BT	3 days	Wed 12/22/10	Fri 12/24/10					I BT Final Service Unit Move to BT			
1237	First Patient Day	0 days	Tue 12/28/10	Tue 12/28/10					◆ First Patient Day			
1238	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11						I WR Service Unit Move to BT		

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬	Rolled Up Progress ▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇	Split ....

External Tasks	▬▬▬	Group By Summary	▼▼▼
Project Summary	▽▽▽	Deadline	⇩

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ID	Task Name	Duration	Start	Finish
1239	**Service Unit: BH Partial Hospitalization**	**278 days**	**Fri 8/6/10**	**Tue 8/30/11**
1240	BOD	0 days	Fri 10/1/10	Fri 10/1/10
1241	Ready for FF&E	0 days	Fri 8/6/10	Fri 8/6/10
1242	Outfit	98 days	Fri 8/6/10	Tue 12/21/10
1243	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1244	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11
1245	**Building B (Hospital Annex)**	**908 days**	**Fri 3/7/08**	**Tue 8/30/11**
1246	Design	312 days	Fri 3/7/08	Mon 5/18/09
1247	Construction	691 days	Fri 3/7/08	Fri 10/29/10
1248	BOD	0 days	Fri 10/29/10	Fri 10/29/10
1249	Overall Outfitting	80 days	Mon 9/6/10	Fri 12/24/10
1250	Overall Bethesda Transition to Building B	40 days	Mon 11/1/10	Fri 12/24/10
1251	Overall WARMC to Transition to Building B	3 days	Thu 8/25/11	Mon 8/29/11
1252	**Building B**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1253	**Building B**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1254	**Floor BB-01**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1255	**Directorate: Clinical Support Services**	**493 days**	**Fri 10/9/09**	**Tue 8/30/11**
1256	**Dept: Radiology**	**493 days**	**Fri 10/9/09**	**Tue 8/30/11**
1257	**Service Unit: Diagnostic Radiology (Imaging)**	**493 days**	**Fri 10/9/09**	**Tue 8/30/11**
1258	Renovate - Phased	331 days	Fri 10/9/09	Fri 1/14/11
1259	BOD - Final Phase	0 days	Mon 1/17/11	Mon 1/17/11
1260	Ready for FF&E - First Phase	0 days	Fri 6/4/10	Fri 6/4/10
1261	Outfit - Phased	174 days	Fri 6/4/10	Wed 2/2/11
1262	BT Final Service Unit Move to BT into New	3 days	Tue 7/6/10	Thu 7/8/10
1263	BT Final Service Unit Move to BT into B	3 days	Wed 11/17/10	Fri 11/19/10
1264	BT Final Service Unit Move to BT into	3 days	Thu 2/3/11	Mon 2/7/11
1265	First Patient Day - Final Phase	0 days	Wed 2/9/11	Wed 2/9/11
1266	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1267	**Directorate: Medical**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1268	**Dept: Emergency**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1269	**Service Unit: Emergency Dept/ Room (ED/ER)**	**630 days**	**Wed 4/1/09**	**Tue 8/30/11**
1270	BT Temp Service Unit Move to BT	18 days	Wed 4/1/09	Fri 4/24/09
1271	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1272	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1273	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1274	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1275	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1276	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1277	**Floor BB-02**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1278	**Directorate: Surgical Services**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬	Rolled Up Progress	▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇	Split	··········

External Tasks	▬▬▬	Group By Summary	▬▬▬
Project Summary	▬▬▬	Deadline	⇩

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ID	Task Name	Duration	Start	Finish
1279	**Dept: Surgery**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1280	**Service Unit: Cardio Thoracic (CT) Surgery**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1281	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1282	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1283	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1284	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1285	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1286	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1287	**Directorate: Medical**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1288	**Dept: Medicine**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1289	**Service Unit: Cardiology**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1290	Renovate	180 days	Fri 10/16/09	Thu 6/24/10
1291	BOD - Final Phase (Bldg B)	0 days	Mon 11/1/10	Mon 11/1/10
1292	Ready for FF&E	0 days	Fri 6/11/10	Fri 6/11/10
1293	Outfit	22 days	Fri 6/11/10	Mon 7/12/10
1294	BT Final Service Unit Move to BT	3 days	Tue 7/13/10	Thu 7/15/10
1295	First Patient Day	0 days	Mon 7/19/10	Mon 7/19/10
1296	BT Final Service Unit Move to BT (Expand into	3 days	Wed 11/17/10	Fri 11/19/10
1297	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1298	**Service Unit: Cardiac Cath**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1299	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1300	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1301	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1302	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1303	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1304	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1305	**Directorate: Clinical Support Services**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1306	**Dept: Radiology**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1307	**Service Unit: Radiographic Procedures / Multi**	**257 days**	**Mon 9/6/10**	**Tue 8/30/11**
1308	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1309	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1310	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1311	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1312	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1313	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1314	**Floor BB-03**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1315	**Directorate: Surgical Services**	**340 days**	**Wed 5/12/10**	**Tue 8/30/11**
1316	**Dept: Surgery**	**340 days**	**Wed 5/12/10**	**Tue 8/30/11**
1317	**Service Unit: Anesthesia - Surgical (In Patient)**	**340 days**	**Wed 5/12/10**	**Tue 8/30/11**
1318	BT Temp Service Unit Move to BT	3 days	Wed 5/12/10	Fri 5/14/10

ID	Task Name	Duration	Start	Finish
1319	Renovate	105 days	Mon 5/24/10	Fri 10/15/10
1320	BOD - Final (Bldg B)	0 days	Mon 10/18/10	Mon 10/18/10
1321	Ready for FF&E	0 days	Mon 10/4/10	Mon 10/4/10
1322	Outfit	32 days	Mon 10/4/10	Tue 11/16/10
1323	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1324	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1325	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1326	**Directorate: Critical Care**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1327	**Dept: Critical Care / I.C.U**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1328	**Service Unit: BB-03 Critical Care/ Intensive**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1329	BT Temp Service Unit Move to BT	3 days	Wed 12/30/09	Fri 1/1/10
1330	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1331	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1332	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1333	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1334	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1335	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1336	**Floor BB-04**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1337	**Directorate: Critical Care**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1338	**Dept: Critical Care / I.C.U**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1339	**Service Unit: BB-04 Critical Care/ Intensive**	**435 days**	**Wed 12/30/09**	**Tue 8/30/11**
1340	BT Temp Service Unit Move to BT	3 days	Wed 12/30/09	Fri 1/1/10
1341	BOD	0 days	Mon 11/1/10	Mon 11/1/10
1342	Ready for FF&E	0 days	Mon 9/6/10	Mon 9/6/10
1343	Outfit	52 days	Mon 9/6/10	Tue 11/16/10
1344	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1345	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1346	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1347	**Renovations**	**909 days**	**Fri 3/7/08**	**Thu 9/1/11**
1348	Overal Renovations Design	537 days	Fri 3/7/08	Mon 3/29/10
1349	Overall Renovations Construction	794 days	Tue 7/15/08	Fri 7/29/11
1350	Swing Space Construction & Temporary Department Moves for	811 days	Fri 7/18/08	Fri 8/26/11
1351	Overall Final Outfitting of Renovated Space	520 days	Tue 9/1/09	Mon 8/29/11
1352	Overall Bethesda Final Transition to Renovated Space	500 days	Thu 10/1/09	Wed 8/31/11
1353	Overall WARMC Final Transition to Renovated Space	3 days	Thu 8/25/11	Mon 8/29/11
1354	**Building 01**	**423 days**	**Mon 1/18/10**	**Thu 9/1/11**
1355	**Floor 01-04**	**423 days**	**Mon 1/18/10**	**Thu 9/1/11**
1356	**Directorate: Clinical Support Services**	**423 days**	**Mon 1/18/10**	**Thu 9/1/11**
1357	**Dept: Radiology**	**423 days**	**Mon 1/18/10**	**Thu 9/1/11**
1358	**Service Unit: 3-D Medical Applications**	**423 days**	**Mon 1/18/10**	**Thu 9/1/11**

Task	▬▬▬	Milestone	◆
Progress	▬▬▬	Summary	▼▬▬▼
Rolled Up Task	▬▬▬	Rolled Up Progress	▬▬▬
Rolled Up Milestone	◇	Split	....
External Tasks	▬▬▬	Group By Summary	▼▬▬▼
Project Summary	▽▬▬▽	Deadline	⬇

MTP v. 1.0 Appendix G: Integrated Master Schedule

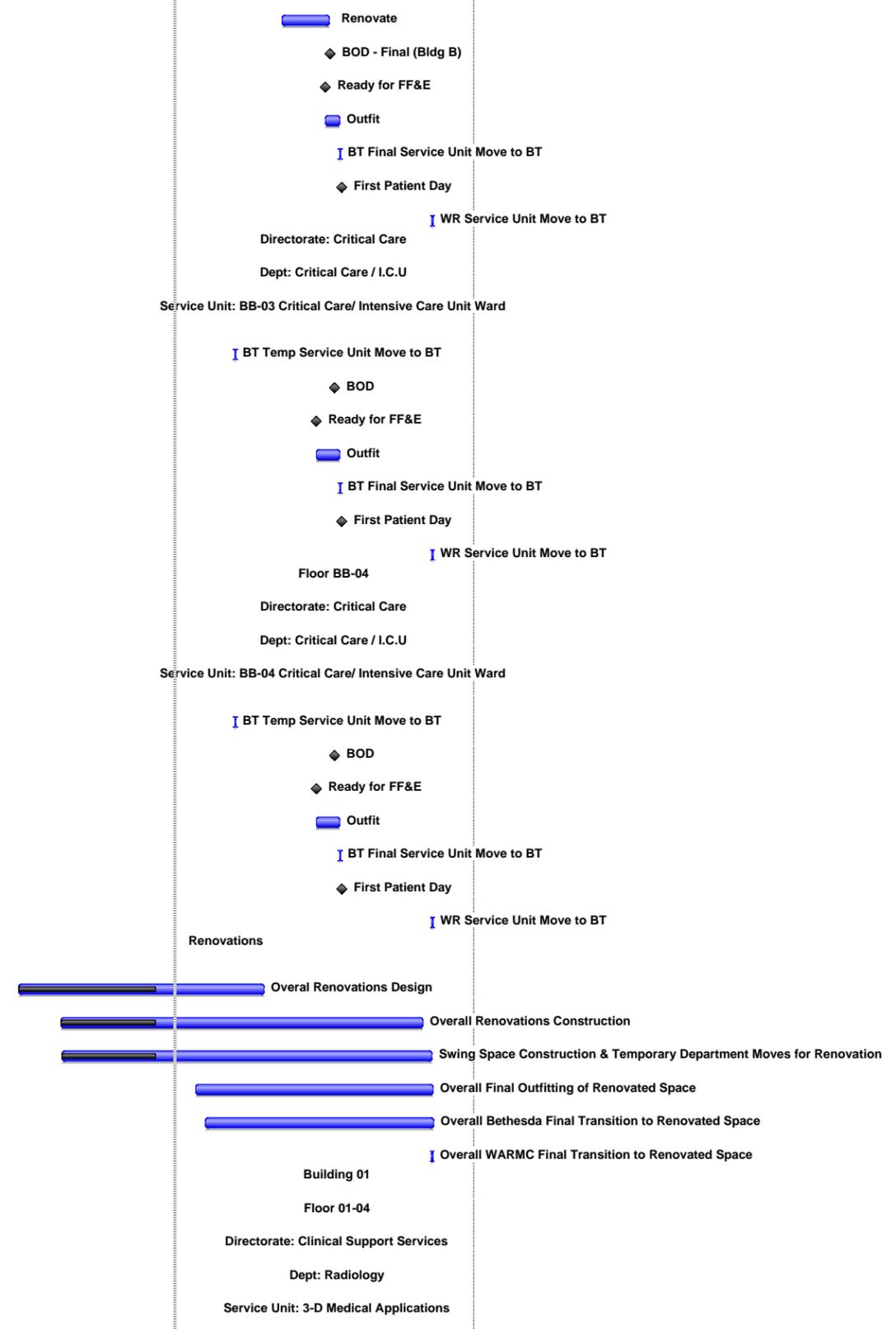| ID	Task Name	Duration	Start	Finish
1359	Renovate	101 days	Mon 1/18/10	Mon 6/7/10
1360	BOD	0 days	Tue 6/8/10	Tue 6/8/10
1361	Ready for FF&E	0 days	Tue 5/25/10	Tue 5/25/10
1362	Outfit	328 days	Tue 5/25/10	Thu 8/25/11
1363	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1364	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1365	**Floor 01-11**	**36 days**	**Wed 7/13/11**	**Thu 9/1/11**
1366	**Directorate: Behavioral Health**	**36 days**	**Wed 7/13/11**	**Thu 9/1/11**
1367	**Dept: Behavioral Health**	**36 days**	**Wed 7/13/11**	**Thu 9/1/11**
1368	**Service Unit: Family Advocacy Program**	**36 days**	**Wed 7/13/11**	**Thu 9/1/11**
1369	Renovate	20 days	Wed 7/13/11	Tue 8/9/11
1370	BOD	0 days	Tue 8/9/11	Tue 8/9/11
1371	Ready for FF&E	0 days	Thu 8/11/11	Thu 8/11/11
1372	Outfit	10 days	Thu 8/11/11	Wed 8/24/11
1373	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1374	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1375	**Building 02**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1376	**Floor 02-02**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1377	**Directorate: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1378	**Dept: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1379	**Service Unit: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1380	Renovate - Phased	240 days	Tue 6/30/09	Mon 5/31/10
1381	BOD - Final Phase	0 days	Tue 5/31/11	Tue 5/31/11
1382	Ready for FF&E - First Phase	0 days	Fri 12/11/09	Fri 12/11/09
1383	Outfit - Phased	134 days	Fri 12/11/09	Wed 6/16/10
1384	BT Final Service Unit Move to BT Phase 1 of 2	3 days	Tue 1/12/10	Thu 1/14/10
1385	BT Final Service Unit Move to BT Phase 2 of 2	3 days	Fri 6/18/10	Tue 6/22/10
1386	First Patient Day - Final Phase	0 days	Tue 6/22/10	Tue 6/22/10
1387	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1388	**Building 07**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1389	**Floor 07-01**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1390	**Directorate: Medical**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1391	**Dept: Medicine**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1392	**Service Unit: Infectious Disease Clinic**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1393	BT Temp Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1394	Renovate	90 days	Mon 11/1/10	Fri 3/4/11
1395	BOD	0 days	Mon 3/7/11	Mon 3/7/11
1396	Ready for FF&E	0 days	Mon 2/21/11	Mon 2/21/11
1397	Outfit	22 days	Mon 2/21/11	Tue 3/22/11
1398	BT Final Service Unit Move to BT	3 days	Wed 3/23/11	Fri 3/25/11
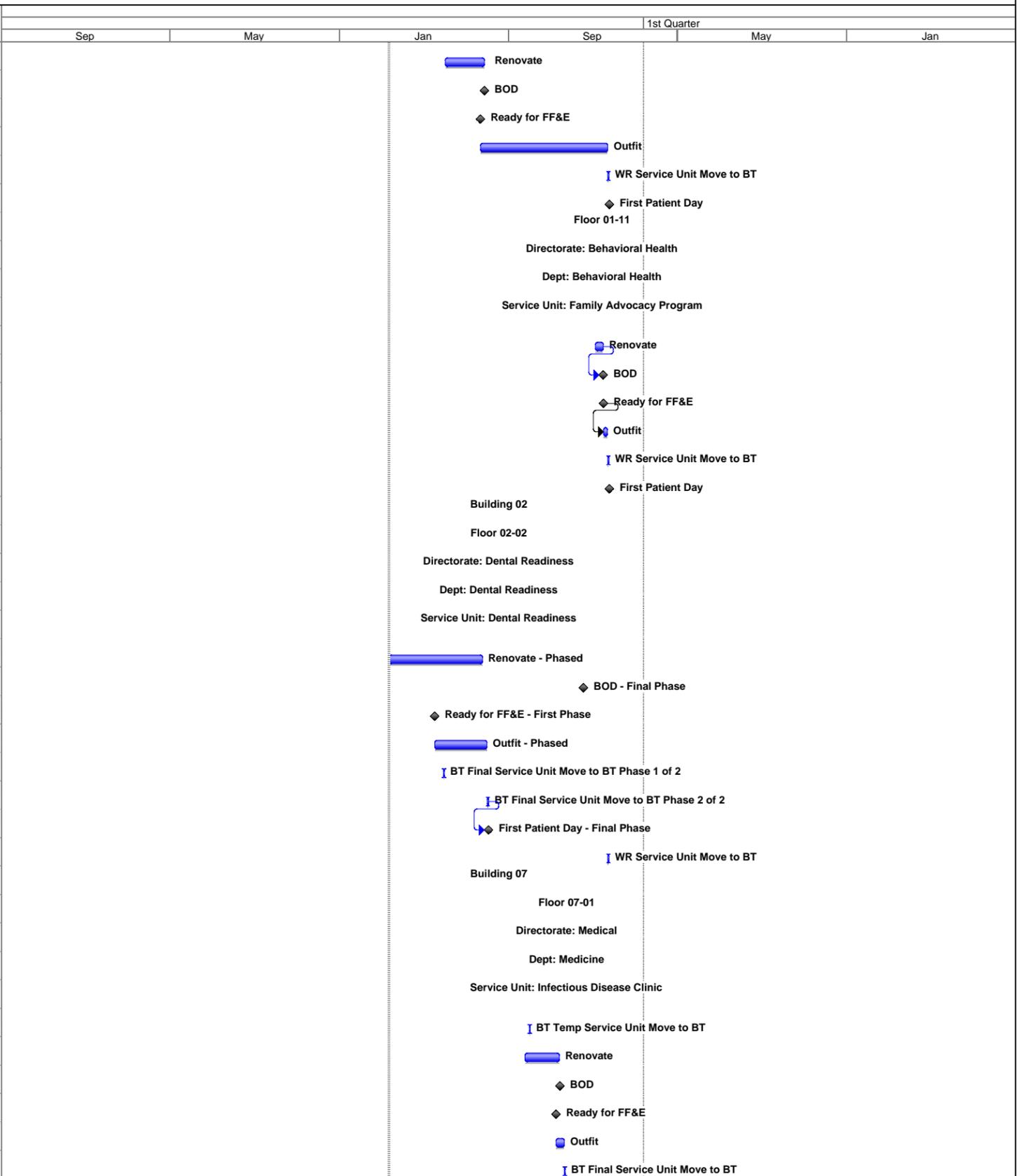
Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
1399	First Patient Day	0 days	Tue 3/29/11	Tue 3/29/11
1400	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1401	**Service Unit: Infectious Disease Admin**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1402	Renovate	90 days	Mon 11/1/10	Fri 3/4/11
1403	BOD	0 days	Mon 3/7/11	Mon 3/7/11
1404	Ready for FF&E	0 days	Mon 2/21/11	Mon 2/21/11
1405	Outfit	22 days	Mon 2/21/11	Tue 3/22/11
1406	BT Final Service Unit Move to BT	3 days	Wed 3/23/11	Fri 3/25/11
1407	First Patient Day	0 days	Tue 3/29/11	Tue 3/29/11
1408	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1409	**Floor 07-02**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1410	**Directorate: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1411	**Dept: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1412	**Service Unit: Dental Readiness**	**566 days**	**Tue 6/30/09**	**Tue 8/30/11**
1413	Renovate - Phased	240 days	Tue 6/30/09	Mon 5/31/10
1414	BOD - Final Phase	0 days	Tue 5/31/11	Tue 5/31/11
1415	Ready for FF&E - First Phase	0 days	Fri 12/11/09	Fri 12/11/09
1416	Outfit - Phased	134 days	Fri 12/11/09	Wed 6/16/10
1417	BT Final Service Unit Move to BT Phase 1 of 2	3 days	Tue 1/12/10	Thu 1/14/10
1418	BT Final Service Unit Move to BT Phase 2 of 2	3 days	Fri 6/18/10	Tue 6/22/10
1419	First Patient Day - Final Phase	0 days	Tue 6/22/10	Tue 6/22/10
1420	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1421	Renovate - Phased	249 days	Tue 6/30/09	Fri 6/11/10
1422	BOD - Final Phase	0 days	Mon 6/14/10	Mon 6/14/10
1423	Ready for FF&E - First Phase	0 days	Fri 12/11/09	Fri 12/11/09
1424	Outfit - Phased	143 days	Fri 12/11/09	Tue 6/29/10
1425	BT Final Service Unit Move to BT Phase 1 of 2	3 days	Tue 1/12/10	Thu 1/14/10
1426	BT Final Service Unit Move to BT Phase 2 of 2	3 days	Wed 6/30/10	Fri 7/2/10
1427	First Patient Day - Final Phase	0 days	Tue 7/6/10	Tue 7/6/10
1428	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1429	**Building 08**	**707 days**	**Fri 12/12/08**	**Tue 8/30/11**
1430	**Floor 08-01**	**562 days**	**Mon 7/6/09**	**Tue 8/30/11**
1431	**Directorate: Surgical Services**	**562 days**	**Mon 7/6/09**	**Tue 8/30/11**
1432	**Dept: Surgery**	**562 days**	**Mon 7/6/09**	**Tue 8/30/11**
1433	**Service Unit: Ophthalmology (Laser Vision**	**562 days**	**Mon 7/6/09**	**Tue 8/30/11**
1434	Renovate	174 days	Mon 7/6/09	Thu 3/4/10
1435	BOD	0 days	Fri 3/5/10	Fri 3/5/10
1436	Ready for FF&E	0 days	Fri 2/19/10	Fri 2/19/10
1437	Outfit	22 days	Fri 2/19/10	Mon 3/22/10
1438	BT Final Service Unit Move to BT	0 days	Fri 3/26/10	Fri 3/26/10
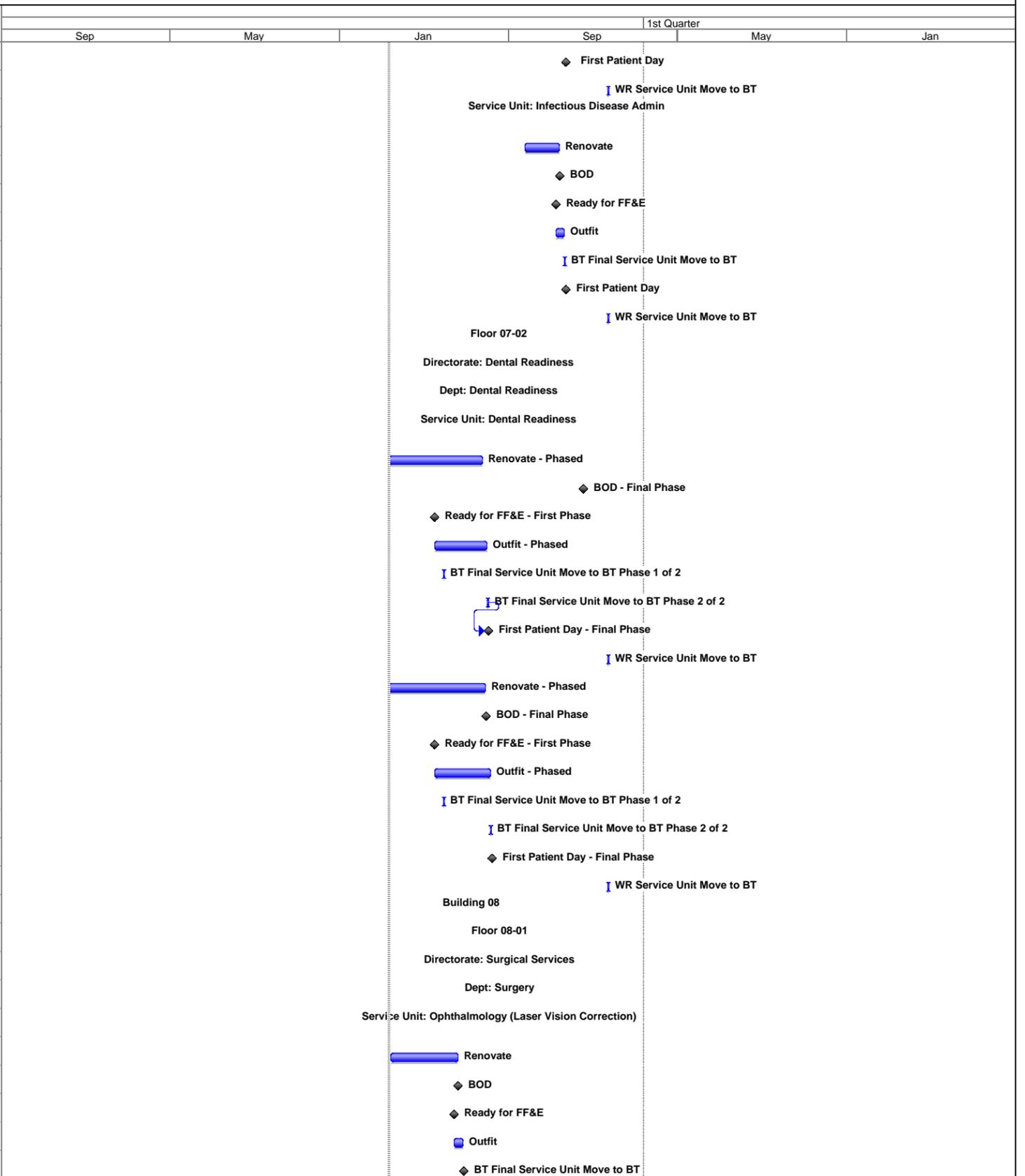
Task		Milestone ◆	Rolled Up Task	Rolled Up Progress	External Tasks	Group By Summary
Progress		Summary	Rolled Up Milestone ◇	Split	Project Summary	Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
1439	First Patient Day	0 days	Mon 3/29/10	Mon 3/29/10
1440	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1441	**Floor 08-03**	**707 days**	**Fri 12/12/08**	**Tue 8/30/11**
1442	**Directorate: Public Health**	**707 days**	**Fri 12/12/08**	**Tue 8/30/11**
1443	**Dept: Preventive Medicine**	**707 days**	**Fri 12/12/08**	**Tue 8/30/11**
1444	**Service Unit: Health Physics**	**707 days**	**Fri 12/12/08**	**Tue 8/30/11**
1445	BT Temp Service Unit Move to BT	0 days	Fri 12/12/08	Fri 12/12/08
1446	Renovate	60 days	Wed 1/5/11	Tue 3/29/11
1447	BOD	0 days	Tue 3/29/11	Tue 3/29/11
1448	Ready for FF&E	0 days	Wed 3/16/11	Wed 3/16/11
1449	Outfit	22 days	Wed 3/16/11	Thu 4/14/11
1450	BT Final Service Unit Move to BT	3 days	Fri 4/15/11	Tue 4/19/11
1451	First Patient Day	0 days	Tue 4/19/11	Tue 4/19/11
1452	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1453	**Building 09**	**592 days**	**Tue 5/26/09**	**Thu 9/1/11**
1454	**Floor 09-00**	**527 days**	**Mon 8/24/09**	**Tue 8/30/11**
1455	**Directorate: Medical**	**205 days**	**Wed 11/17/10**	**Tue 8/30/11**
1456	**Dept: Medicine**	**205 days**	**Wed 11/17/10**	**Tue 8/30/11**
1457	**Service Unit: Infectious Disease Lab**	**205 days**	**Wed 11/17/10**	**Tue 8/30/11**
1458	BT Temp Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1459	Renovate	107 days	Thu 2/17/11	Fri 7/15/11
1460	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1461	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1462	Outfit	33 days	Fri 7/1/11	Tue 8/16/11
1463	BT Final Service Unit Move to BT	3 days	Wed 8/17/11	Fri 8/19/11
1464	First Patient Day	0 days	Tue 8/23/11	Tue 8/23/11
1465	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1466	**Directorate: Clinical Support Services**	**527 days**	**Mon 8/24/09**	**Tue 8/30/11**
1467	**Dept: Pathology**	**527 days**	**Mon 8/24/09**	**Tue 8/30/11**
1468	**Service Unit: Anatomical Pathology**	**527 days**	**Mon 8/24/09**	**Tue 8/30/11**
1469	Renovate	175 days	Mon 8/24/09	Fri 4/23/10
1470	BOD	0 days	Mon 4/26/10	Mon 4/26/10
1471	Ready for FF&E	0 days	Mon 4/12/10	Mon 4/12/10
1472	Outfit	22 days	Mon 4/12/10	Tue 5/11/10
1473	BT Final Service Unit Move to BT	3 days	Wed 5/12/10	Fri 5/14/10
1474	First Patient Day	0 days	Tue 5/18/10	Tue 5/18/10
1475	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1476	**Service Unit: Clinical Pathology**	**527 days**	**Mon 8/24/09**	**Tue 8/30/11**
1477	Renovate - Phased	495 days	Mon 8/24/09	Fri 7/15/11
1478	BOD - Final Phase	0 days	Mon 7/18/11	Mon 7/18/11
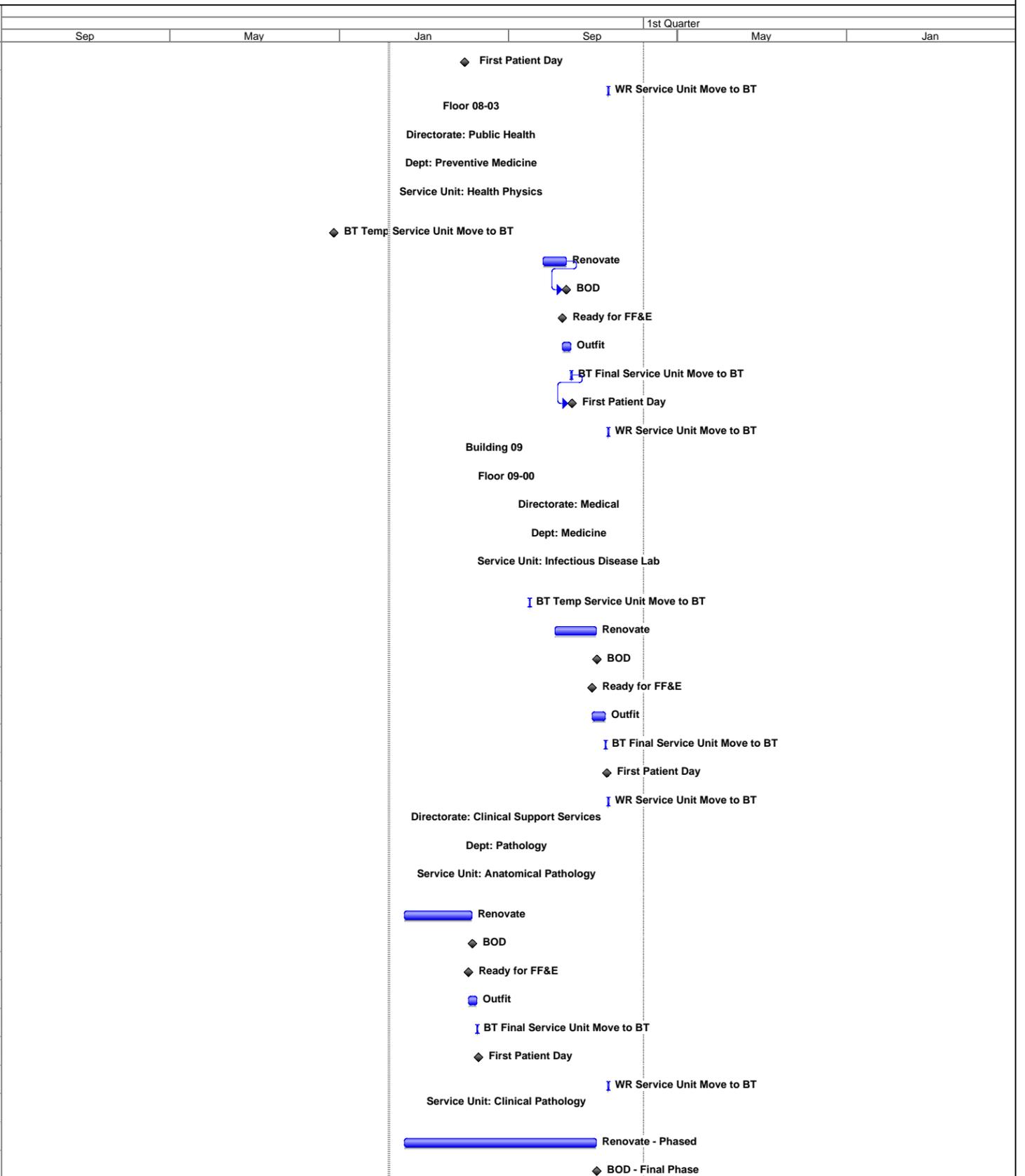
	Task	▭	Milestone	◆	Rolled Up Task	▭	Rolled Up Progress	━━	External Tasks	▭	Group By Summary	▽
	Progress	━	Summary	▬	Rolled Up Milestone	◇	Split	┈┈┈	Project Summary	▽	Deadline	⇩

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ID	Task Name	Duration	Start	Finish
1479	Ready for FF&E - First Phase	0 days	Mon 4/12/10	Mon 4/12/10
1480	Outfit - Phased	342 days	Mon 4/12/10	Tue 8/2/11
1481	BT Final Service Unit Move to BT Into Phase 1 of 3	3 days	Wed 5/12/10	Fri 5/14/10
1482	BT Final Service Unit Move to BT Into Phase 2 of 3	3 days	Wed 11/3/10	Fri 11/5/10
1483	BT Final Service Unit Move to BT into Phase 3 of 3	3 days	Wed 8/3/11	Fri 8/5/11
1484	First Patient Day - Final	0 days	Tue 8/9/11	Tue 8/9/11
1485	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1486	**Floor 09-01**	**592 days**	**Tue 5/26/09**	**Thu 9/1/11**
1487	**Directorate: Surgical Services**	**592 days**	**Tue 5/26/09**	**Thu 9/1/11**
1488	**Dept: Surgery**	**592 days**	**Tue 5/26/09**	**Thu 9/1/11**
1489	**Service Unit: Organ Transplant**	**218 days**	**Mon 11/1/10**	**Thu 9/1/11**
1490	Renovate	185 days	Mon 11/1/10	Fri 7/15/11
1491	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1492	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1493	Outfit	40 days	Fri 7/1/11	Thu 8/25/11
1494	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1495	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1496	**Service Unit: Neurosurgery**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1497	BT Temp Service Unit Move to BT	3 days	Mon 10/5/09	Wed 10/7/09
1498	Renovate	163 days	Tue 11/30/10	Thu 7/14/11
1499	BOD	0 days	Fri 7/15/11	Fri 7/15/11
1500	Ready for FF&E	0 days	Thu 6/30/11	Thu 6/30/11
1501	Outfit	18 days	Thu 6/30/11	Mon 7/25/11
1502	BT Final Service Unit Move to BT	3 days	Tue 7/26/11	Thu 7/28/11
1503	First Patient Day	0 days	Mon 8/1/11	Mon 8/1/11
1504	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1505	**Service Unit: General Surgery**	**591 days**	**Tue 5/26/09**	**Tue 8/30/11**
1506	Renovate	82 days	Tue 5/26/09	Wed 9/16/09
1507	BOD	0 days	Thu 9/17/09	Thu 9/17/09
1508	Ready for FF&E	0 days	Thu 9/3/09	Thu 9/3/09
1509	Outfit	22 days	Thu 9/3/09	Fri 10/2/09
1510	BT Final Service Unit Move to BT	3 days	Mon 10/5/09	Wed 10/7/09
1511	First Patient Day	0 days	Fri 10/9/09	Fri 10/9/09
1512	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1513	**Directorate: Medical**	**564 days**	**Thu 7/2/09**	**Tue 8/30/11**
1514	**Dept: Medicine**	**564 days**	**Thu 7/2/09**	**Tue 8/30/11**
1515	**Service Unit: Nephrology**	**555 days**	**Wed 7/15/09**	**Tue 8/30/11**
1516	Renovate - Phased	523 days	Wed 7/15/09	Fri 7/15/11
1517	BOD - Final Phase	0 days	Mon 7/18/11	Mon 7/18/11
1518	Ready for FF&E - First Phase	0 days	Wed 11/25/09	Wed 11/25/09

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇

| Rolled Up Progress | ▬▬▬ | External Tasks | ▬▬▬ | Group By Summary | ▽▬▬▽ |
| Split | ·········· | Project Summary | ▽▬▬▽ | Deadline | ⇩ |

ID	Task Name	Duration	Start	Finish
1519	Outfit - Phased	450 days	Wed 11/25/09	Tue 8/16/11
1520	BT Final Service Unit Move to BT into Phase 1 of 2	3 days	Fri 12/25/09	Tue 12/29/09
1521	BT Final Service Unit Move to BT into Phase 2 of 2	3 days	Wed 8/17/11	Fri 8/19/11
1522	First Patient Day - Final Phase	0 days	Tue 8/23/11	Tue 8/23/11
1523	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1524	**Service Unit: Pulmonary**	**564 days**	**Thu 7/2/09**	**Tue 8/30/11**
1525	BT Temp Service Unit Move to BT	3 days	Thu 7/2/09	Mon 7/6/09
1526	Renovate	85 days	Mon 11/1/10	Fri 2/25/11
1527	BOD	0 days	Mon 2/28/11	Mon 2/28/11
1528	Ready for FF&E	0 days	Mon 2/14/11	Mon 2/14/11
1529	Outfit	22 days	Mon 2/14/11	Tue 3/15/11
1530	BT Final Service Unit Move to BT	3 days	Wed 3/16/11	Fri 3/18/11
1531	First Patient Day	0 days	Tue 3/22/11	Tue 3/22/11
1532	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1533	**Floor 09-02**	**498 days**	**Mon 10/5/09**	**Thu 9/1/11**
1534	**Directorate: Surgical Services**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1535	**Dept: OBGYN**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1536	**Service Unit: OB/GYN Admin**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1537	Renovate	130 days	Fri 6/25/10	Thu 12/23/10
1538	BOD	0 days	Fri 12/24/10	Fri 12/24/10
1539	Ready for FF&E	0 days	Fri 12/10/10	Fri 12/10/10
1540	Outfit	22 days	Fri 12/10/10	Mon 1/10/11
1541	BT Final Service Unit Move to BT	3 days	Tue 1/11/11	Thu 1/13/11
1542	First Patient Day	0 days	Mon 1/17/11	Mon 1/17/11
1543	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1544	**Service Unit: General OB/GYN**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1545	Renovate	130 days	Fri 6/25/10	Thu 12/23/10
1546	BOD	0 days	Fri 12/24/10	Fri 12/24/10
1547	Ready for FF&E	0 days	Fri 12/10/10	Fri 12/10/10
1548	Outfit	22 days	Fri 12/10/10	Mon 1/10/11
1549	BT Final Service Unit Move to BT	3 days	Tue 1/11/11	Thu 1/13/11
1550	First Patient Day	0 days	Mon 1/17/11	Mon 1/17/11
1551	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1552	**Service Unit: Repro. Endo and Infertility**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1553	Renovate	130 days	Fri 6/25/10	Thu 12/23/10
1554	BOD	0 days	Fri 12/24/10	Fri 12/24/10
1555	Ready for FF&E	0 days	Fri 12/10/10	Fri 12/10/10
1556	Outfit	22 days	Fri 12/10/10	Mon 1/10/11
1557	BT Final Service Unit Move to BT	3 days	Tue 1/11/11	Thu 1/13/11
1558	First Patient Day	0 days	Mon 1/17/11	Mon 1/17/11

Task		Milestone	◆	Rolled Up Task	
Progress		Summary		Rolled Up Progress	

Rolled Up Milestone	◇	External Tasks	
Split		Project Summary	

Group By Summary		
Deadline	⇩	

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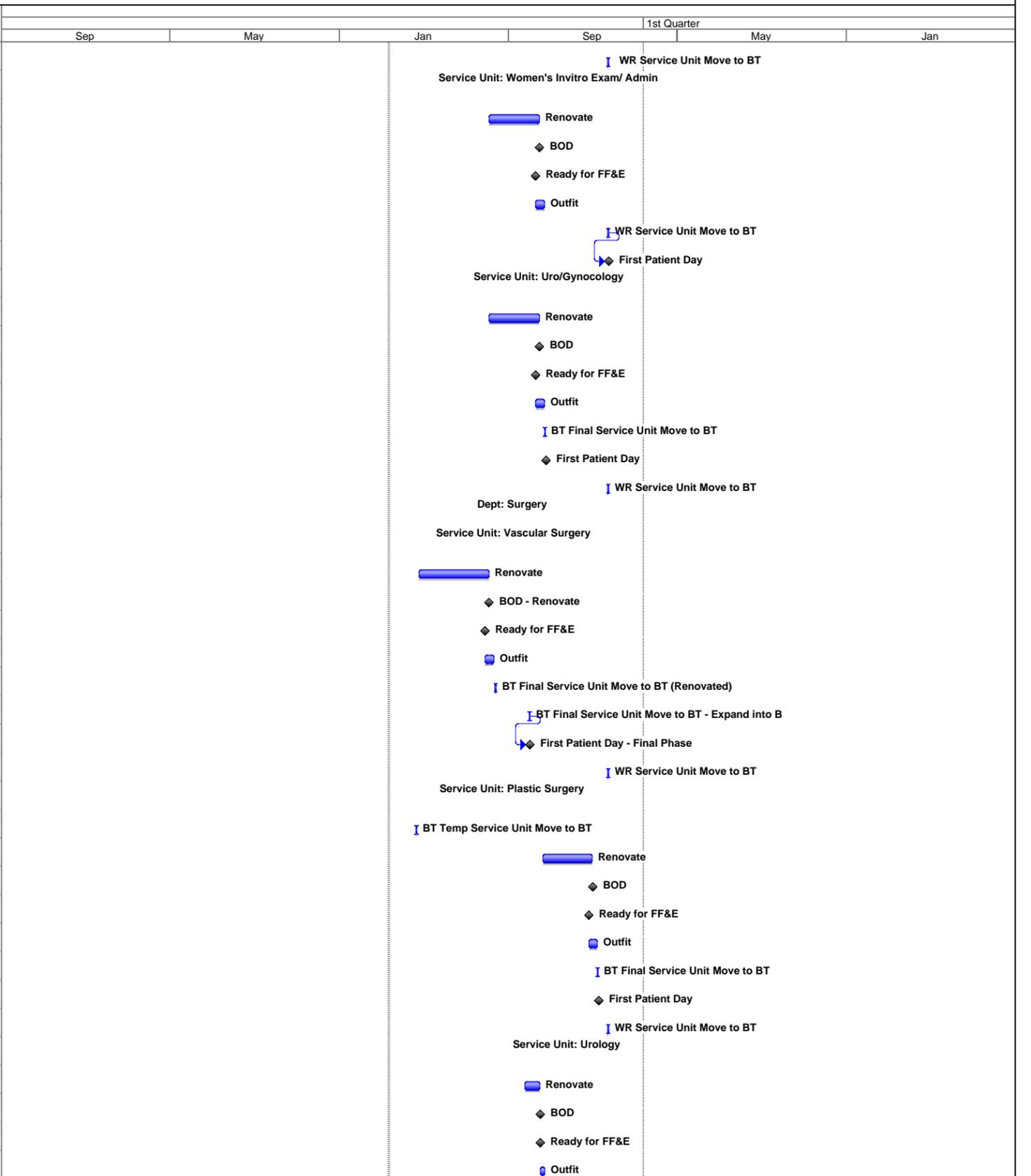| ID	Task Name	Duration	Start	Finish
1559	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1560	**Service Unit: Women's Invitro Exam/ Admin**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1561	Renovate	130 days	Fri 6/25/10	Thu 12/23/10
1562	BOD	0 days	Fri 12/24/10	Fri 12/24/10
1563	Ready for FF&E	0 days	Fri 12/10/10	Fri 12/10/10
1564	Outfit	22 days	Fri 12/10/10	Mon 1/10/11
1565	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1566	First Patient Day	0 days	Tue 8/30/11	Tue 8/30/11
1567	**Service Unit: Uro/Gynocology**	**308 days**	**Fri 6/25/10**	**Tue 8/30/11**
1568	Renovate	130 days	Fri 6/25/10	Thu 12/23/10
1569	BOD	0 days	Fri 12/24/10	Fri 12/24/10
1570	Ready for FF&E	0 days	Fri 12/10/10	Fri 12/10/10
1571	Outfit	22 days	Fri 12/10/10	Mon 1/10/11
1572	BT Final Service Unit Move to BT	3 days	Tue 1/11/11	Thu 1/13/11
1573	First Patient Day	0 days	Mon 1/17/11	Mon 1/17/11
1574	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1575	**Dept: Surgery**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1576	**Service Unit: Vascular Surgery**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1577	Renovate	180 days	Fri 10/16/09	Thu 6/24/10
1578	BOD - Renovate	0 days	Fri 6/25/10	Fri 6/25/10
1579	Ready for FF&E	0 days	Fri 6/11/10	Fri 6/11/10
1580	Outfit	22 days	Fri 6/11/10	Mon 7/12/10
1581	BT Final Service Unit Move to BT (Renovated)	3 days	Fri 7/16/10	Tue 7/20/10
1582	BT Final Service Unit Move to BT - Expand into B	3 days	Wed 11/17/10	Fri 11/19/10
1583	First Patient Day - Final Phase	0 days	Fri 11/19/10	Fri 11/19/10
1584	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1585	**Service Unit: Plastic Surgery**	**497 days**	**Mon 10/5/09**	**Tue 8/30/11**
1586	BT Temp Service Unit Move to BT	3 days	Mon 10/5/09	Wed 10/7/09
1587	Renovate	128 days	Wed 1/5/11	Fri 7/1/11
1588	BOD	0 days	Mon 7/4/11	Mon 7/4/11
1589	Ready for FF&E	0 days	Mon 6/20/11	Mon 6/20/11
1590	Outfit	22 days	Mon 6/20/11	Tue 7/19/11
1591	BT Final Service Unit Move to BT	3 days	Wed 7/20/11	Fri 7/22/11
1592	First Patient Day	0 days	Tue 7/26/11	Tue 7/26/11
1593	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1594	**Service Unit: Urology**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1595	Renovate	40 days	Mon 11/1/10	Fri 12/24/10
1596	BOD	0 days	Mon 12/27/10	Mon 12/27/10
1597	Ready for FF&E	0 days	Mon 12/27/10	Mon 12/27/10
1598	Outfit	12 days	Mon 12/27/10	Tue 1/11/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
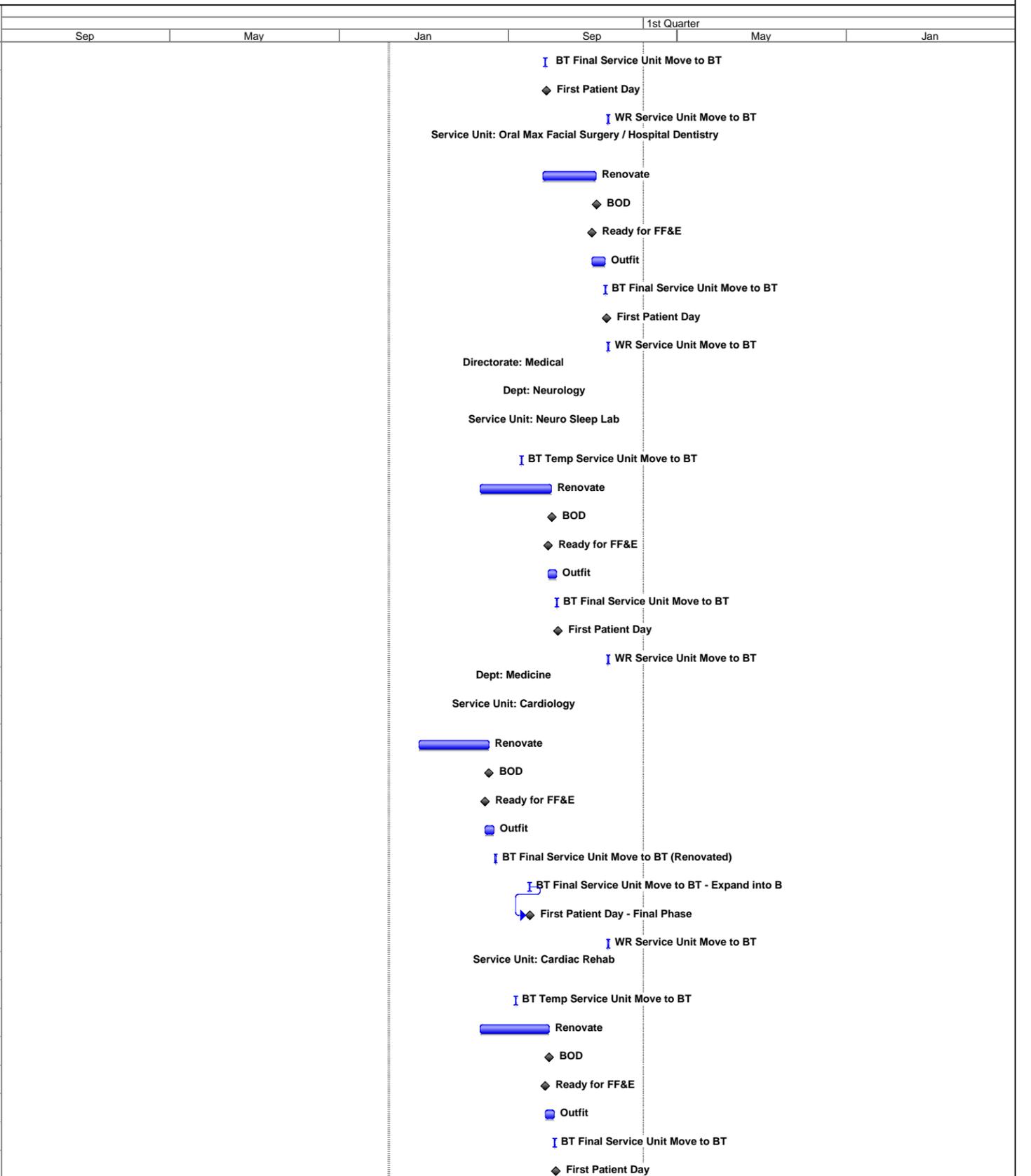Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
1599	BT Final Service Unit Move to BT	3 days	Wed 1/12/11	Fri 1/14/11
1600	First Patient Day	0 days	Tue 1/18/11	Tue 1/18/11
1601	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1602	**Service Unit: Oral Max Facial Surgery / Hospital**	**170 days**	**Wed 1/5/11**	**Tue 8/30/11**
1603	Renovate	138 days	Wed 1/5/11	Fri 7/15/11
1604	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1605	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1606	Outfit	33 days	Fri 7/1/11	Tue 8/16/11
1607	BT Final Service Unit Move to BT	3 days	Wed 8/17/11	Fri 8/19/11
1608	First Patient Day	0 days	Tue 8/23/11	Tue 8/23/11
1609	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1610	**Directorate: Medical**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1611	**Dept: Neurology**	**332 days**	**Mon 5/24/10**	**Tue 8/30/11**
1612	**Service Unit: Neuro Sleep Lab**	**332 days**	**Mon 5/24/10**	**Tue 8/30/11**
1613	BT Temp Service Unit Move to BT	3 days	Tue 10/19/10	Thu 10/21/10
1614	Renovate	185 days	Mon 5/24/10	Fri 2/4/11
1615	BOD	0 days	Mon 2/7/11	Mon 2/7/11
1616	Ready for FF&E	0 days	Mon 1/24/11	Mon 1/24/11
1617	Outfit	22 days	Mon 1/24/11	Tue 2/22/11
1618	BT Final Service Unit Move to BT	3 days	Wed 2/23/11	Fri 2/25/11
1619	First Patient Day	0 days	Tue 3/1/11	Tue 3/1/11
1620	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1621	**Dept: Medicine**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1622	**Service Unit: Cardiology**	**488 days**	**Fri 10/16/09**	**Tue 8/30/11**
1623	Renovate	180 days	Fri 10/16/09	Thu 6/24/10
1624	BOD	0 days	Fri 6/25/10	Fri 6/25/10
1625	Ready for FF&E	0 days	Fri 6/11/10	Fri 6/11/10
1626	Outfit	22 days	Fri 6/11/10	Mon 7/12/10
1627	BT Final Service Unit Move to BT (Renovated)	3 days	Fri 7/16/10	Tue 7/20/10
1628	BT Final Service Unit Move to BT - Expand into B	3 days	Wed 11/17/10	Fri 11/19/10
1629	First Patient Day - Final Phase	0 days	Fri 11/19/10	Fri 11/19/10
1630	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1631	**Service Unit: Cardiac Rehab**	**332 days**	**Mon 5/24/10**	**Tue 8/30/11**
1632	BT Temp Service Unit Move to BT	3 days	Tue 9/28/10	Thu 9/30/10
1633	Renovate	179 days	Mon 5/24/10	Thu 1/27/11
1634	BOD	0 days	Fri 1/28/11	Fri 1/28/11
1635	Ready for FF&E	0 days	Fri 1/14/11	Fri 1/14/11
1636	Outfit	22 days	Fri 1/14/11	Mon 2/14/11
1637	BT Final Service Unit Move to BT	3 days	Tue 2/15/11	Thu 2/17/11
1638	First Patient Day	0 days	Mon 2/21/11	Mon 2/21/11

Task	▭	Milestone	◆	Rolled Up Task	▭
Progress	▬	Summary	◆▬◆	Rolled Up Milestone	◇

Rolled Up Progress	▬	External Tasks	▭	Group By Summary	▽▬▽
Split	....	Project Summary	▽▬▽	Deadline	⇩

MTP v. 1.0 Appendix G: Integrated Master Schedule

ID	Task Name	Duration	Start	Finish
1639	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1640	**Directorate: GME/GDE**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1641	**Dept: GME**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1642	**Service Unit: GME (On Call Rooms)**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1643	Renovate	165 days	Mon 11/1/10	Fri 6/17/11
1644	BOD	0 days	Mon 6/20/11	Mon 6/20/11
1645	Ready for FF&E	0 days	Mon 6/6/11	Mon 6/6/11
1646	Outfit	52 days	Mon 6/6/11	Tue 8/16/11
1647	BT Final Service Unit Move to BT	3 days	Wed 8/17/11	Fri 8/19/11
1648	First Patient Day	0 days	Tue 8/23/11	Tue 8/23/11
1649	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1650	**Directorate: Research Programs**	**288 days**	**Mon 7/26/10**	**Thu 9/1/11**
1651	**Dept: Clinical Investigations (Pharmacy)**	**288 days**	**Mon 7/26/10**	**Thu 9/1/11**
1652	**Service Unit: Clinical Investigations (Pharmacy)**	**288 days**	**Mon 7/26/10**	**Thu 9/1/11**
1653	Renovate	185 days	Mon 7/26/10	Fri 4/8/11
1654	BOD	0 days	Mon 4/11/11	Mon 4/11/11
1655	Ready for FF&E	0 days	Mon 3/28/11	Mon 3/28/11
1656	Outfit	109 days	Mon 3/28/11	Thu 8/25/11
1657	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1658	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1659	**Floor 09-03**	**426 days**	**Wed 1/13/10**	**Thu 9/1/11**
1660	**Directorate: Surgical Services**	**341 days**	**Wed 5/12/10**	**Thu 9/1/11**
1661	**Dept: OBGYN**	**171 days**	**Wed 1/5/11**	**Thu 9/1/11**
1662	**Service Unit: Women's Invitro Procedures**	**171 days**	**Wed 1/5/11**	**Thu 9/1/11**
1663	Renovate	138 days	Wed 1/5/11	Fri 7/15/11
1664	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1665	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1666	Outfit	40 days	Fri 7/1/11	Thu 8/25/11
1667	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1668	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1669	**Dept: Surgery**	**341 days**	**Wed 5/12/10**	**Thu 9/1/11**
1670	**Service Unit: Anesthesia - Surgical (In Patient)**	**340 days**	**Wed 5/12/10**	**Tue 8/30/11**
1671	BT Temp Service Unit Move to BT	3 days	Wed 5/12/10	Fri 5/14/10
1672	Renovate	105 days	Mon 5/24/10	Fri 10/15/10
1673	BOD	0 days	Mon 10/18/10	Mon 10/18/10
1674	Ready for FF&E	0 days	Mon 10/4/10	Mon 10/4/10
1675	Outfit	32 days	Mon 10/4/10	Tue 11/16/10
1676	BT Final Service Unit Move to BT	3 days	Wed 11/17/10	Fri 11/19/10
1677	First Patient Day	0 days	Tue 11/23/10	Tue 11/23/10
1678	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11

Task	▬▬▬	Milestone	◆	Rolled Up Task	▬▬▬
Progress	▬▬▬	Summary	▬▬▬	Rolled Up Milestone	◇

Rolled Up Progress ▬▬▬ External Tasks ▬▬▬ Group By Summary ▬▬▬
Split ··········· Project Summary ▬▬▬ Deadline ⇩

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ID	Task Name	Duration	Start	Finish
1679	**Service Unit: Anesthesia Pain Clinic (Out Patient)**	**215 days**	**Wed 11/3/10**	**Tue 8/30/11**
1680	BT Temp Service Unit Move to BT	3 days	Wed 11/3/10	Fri 11/5/10
1681	Renovate	163 days	Wed 12/1/10	Fri 7/15/11
1682	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1683	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1684	Outfit	33 days	Fri 7/1/11	Tue 8/16/11
1685	BT Final Service Unit Move to BT	3 days	Wed 8/17/11	Fri 8/19/11
1686	First Patient Day	0 days	Tue 8/23/11	Tue 8/23/11
1687	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1688	**Service Unit: Stone Center**	**196 days**	**Wed 12/1/10**	**Thu 9/1/11**
1689	Renovate	86 days	Wed 12/1/10	Wed 3/30/11
1690	BOD	0 days	Thu 3/31/11	Thu 3/31/11
1691	Ready for FF&E	0 days	Thu 3/17/11	Thu 3/17/11
1692	Outfit	116 days	Thu 3/17/11	Thu 8/25/11
1693	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1694	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1695	**Directorate: Medical**	**44 days**	**Fri 7/1/11**	**Thu 9/1/11**
1696	**Dept: Pediatrics**	**44 days**	**Fri 7/1/11**	**Thu 9/1/11**
1697	**Service Unit: Pediatric Sedation & Procedures**	**44 days**	**Fri 7/1/11**	**Thu 9/1/11**
1698	Renovate	0 days	Mon 7/18/11	Mon 7/18/11
1699	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1700	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1701	Outfit	40 days	Fri 7/1/11	Thu 8/25/11
1702	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1703	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1704	**Directorate: Perioperative Nursing**	**425 days**	**Wed 1/13/10**	**Tue 8/30/11**
1705	**Dept: Perioperative Nursing**	**425 days**	**Wed 1/13/10**	**Tue 8/30/11**
1706	**Service Unit: Ambulatory Procedure Unit (APU)**	**425 days**	**Wed 1/13/10**	**Tue 8/30/11**
1707	Renovate	177 days	Wed 1/13/10	Thu 9/16/10
1708	BOD	0 days	Fri 9/17/10	Fri 9/17/10
1709	Ready for FF&E	0 days	Thu 9/2/10	Thu 9/2/10
1710	Outfit	23 days	Thu 9/2/10	Mon 10/4/10
1711	BT Final Service Unit Move to BT	3 days	Tue 10/5/10	Thu 10/7/10
1712	First Patient Day	0 days	Mon 10/11/10	Mon 10/11/10
1713	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1714	**Service Unit: Main Operating Room (MOR)**	**206 days**	**Tue 11/16/10**	**Tue 8/30/11**
1715	Renovate	174 days	Tue 11/16/10	Fri 7/15/11
1716	BOD	0 days	Mon 7/18/11	Mon 7/18/11
1717	Ready for FF&E	0 days	Fri 7/1/11	Fri 7/1/11
1718	Outfit	23 days	Fri 7/1/11	Tue 8/2/11

Task	�	Milestone	◆	Rolled Up Task ▬▬	Rolled Up Progress ▬▬	External Tasks ▬▬	Group By Summary ▽▽
Progress	▬▬	Summary	▼▼	Rolled Up Milestone ◇	Split ··········	Project Summary ▽▽	Deadline ⇩

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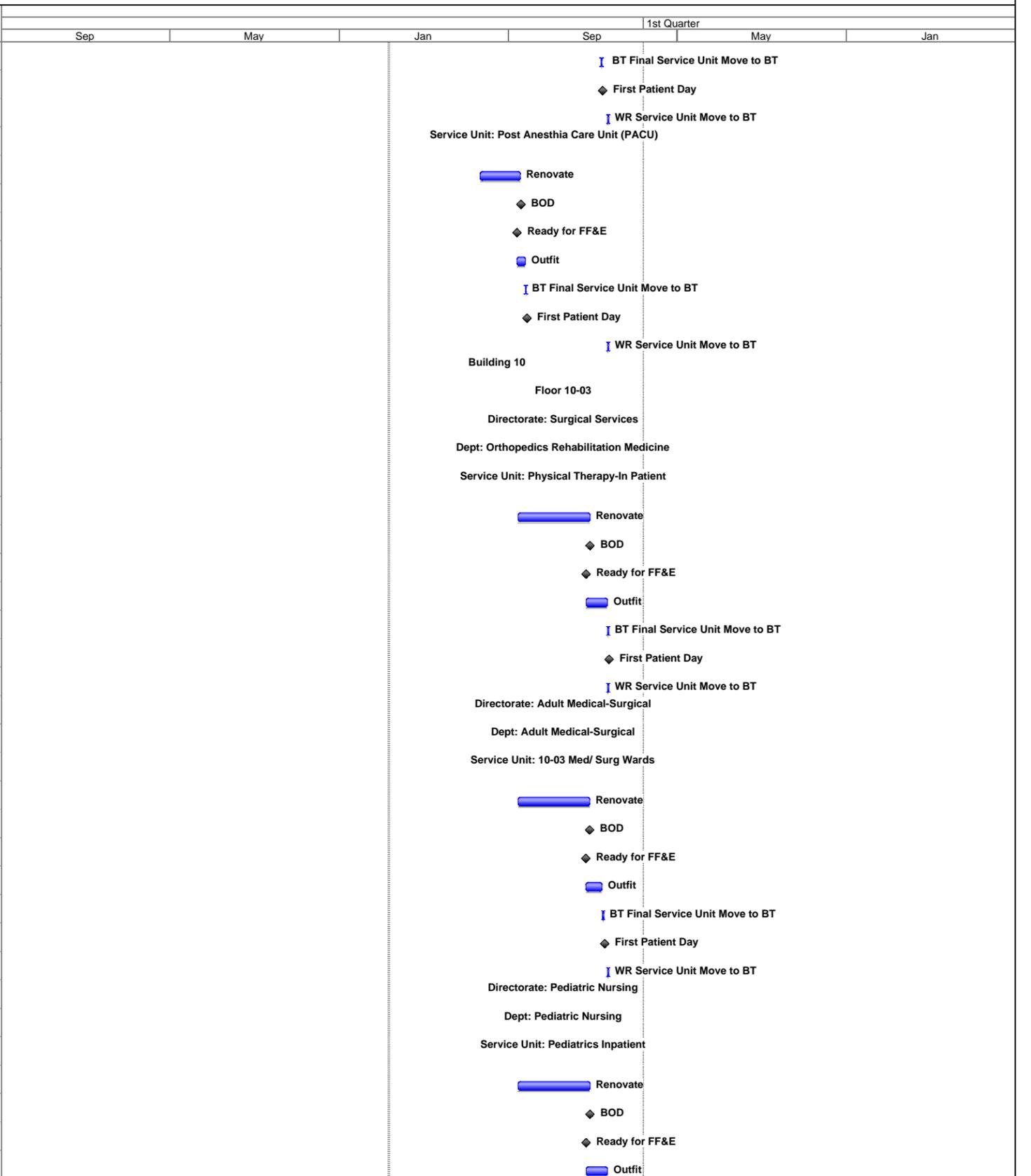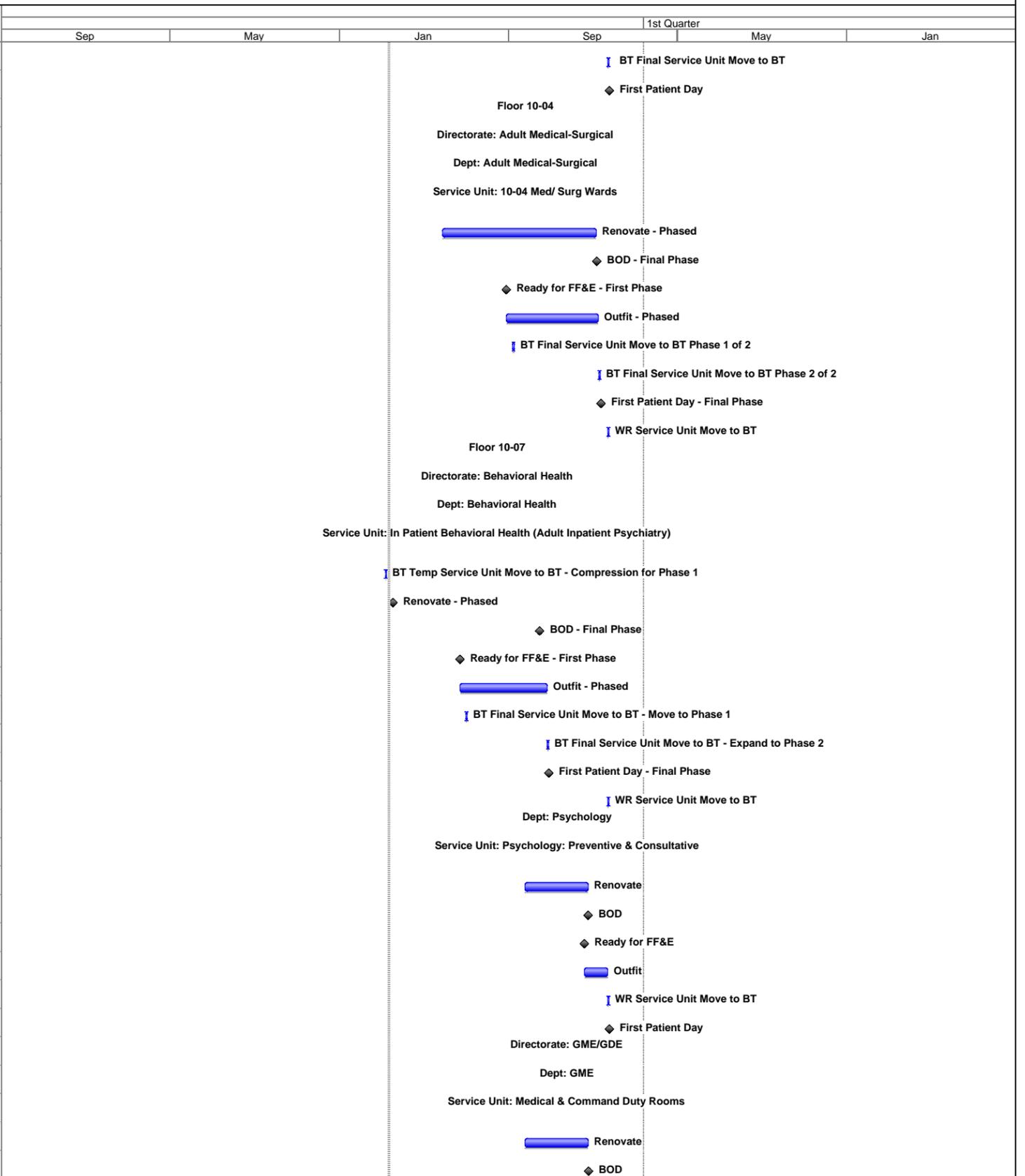| ID	Task Name	Duration	Start	Finish
1719	BT Final Service Unit Move to BT	3 days	Wed 8/3/11	Fri 8/5/11
1720	First Patient Day	0 days	Tue 8/9/11	Tue 8/9/11
1721	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1722	**Service Unit: Post Anesthia Care Unit (PACU)**	**332 days**	**Mon 5/24/10**	**Tue 8/30/11**
1723	Renovate	105 days	Mon 5/24/10	Fri 10/15/10
1724	BOD	0 days	Mon 10/18/10	Mon 10/18/10
1725	Ready for FF&E	0 days	Mon 10/4/10	Mon 10/4/10
1726	Outfit	22 days	Mon 10/4/10	Tue 11/2/10
1727	BT Final Service Unit Move to BT	3 days	Wed 11/3/10	Fri 11/5/10
1728	First Patient Day	0 days	Tue 11/9/10	Tue 11/9/10
1729	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1730	**Building 10**	**576 days**	**Wed 6/17/09**	**Thu 9/1/11**
1731	**Floor 10-03**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1732	**Directorate: Surgical Services**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1733	**Dept: Orthopedics Rehabilitation Medicine**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1734	**Service Unit: Physical Therapy-In Patient**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1735	Renovate	185 days	Fri 10/8/10	Thu 6/23/11
1736	BOD	0 days	Fri 6/24/11	Fri 6/24/11
1737	Ready for FF&E	0 days	Fri 6/10/11	Fri 6/10/11
1738	Outfit	55 days	Fri 6/10/11	Thu 8/25/11
1739	BT Final Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1740	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1741	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1742	**Directorate: Adult Medical-Surgical**	**233 days**	**Fri 10/8/10**	**Tue 8/30/11**
1743	**Dept: Adult Medical-Surgical**	**233 days**	**Fri 10/8/10**	**Tue 8/30/11**
1744	**Service Unit: 10-03 Med/ Surg Wards**	**233 days**	**Fri 10/8/10**	**Tue 8/30/11**
1745	Renovate	184 days	Fri 10/8/10	Wed 6/22/11
1746	BOD	0 days	Thu 6/23/11	Thu 6/23/11
1747	Ready for FF&E	0 days	Thu 6/9/11	Thu 6/9/11
1748	Outfit	42 days	Thu 6/9/11	Fri 8/5/11
1749	BT Final Service Unit Move to BT	5 days	Mon 8/8/11	Fri 8/12/11
1750	First Patient Day	0 days	Tue 8/16/11	Tue 8/16/11
1751	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1752	**Directorate: Pediatric Nursing**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1753	**Dept: Pediatric Nursing**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1754	**Service Unit: Pediatrics Inpatient**	**234 days**	**Fri 10/8/10**	**Thu 9/1/11**
1755	Renovate	185 days	Fri 10/8/10	Thu 6/23/11
1756	BOD	0 days	Fri 6/24/11	Fri 6/24/11
1757	Ready for FF&E	0 days	Fri 6/10/11	Fri 6/10/11
1758	Outfit	55 days	Fri 6/10/11	Thu 8/25/11

Task Milestone ◆ Rolled Up Task Rolled Up Progress External Tasks Group By Summary
Progress Summary Rolled Up Milestone ◇ Split Project Summary Deadline ⇩

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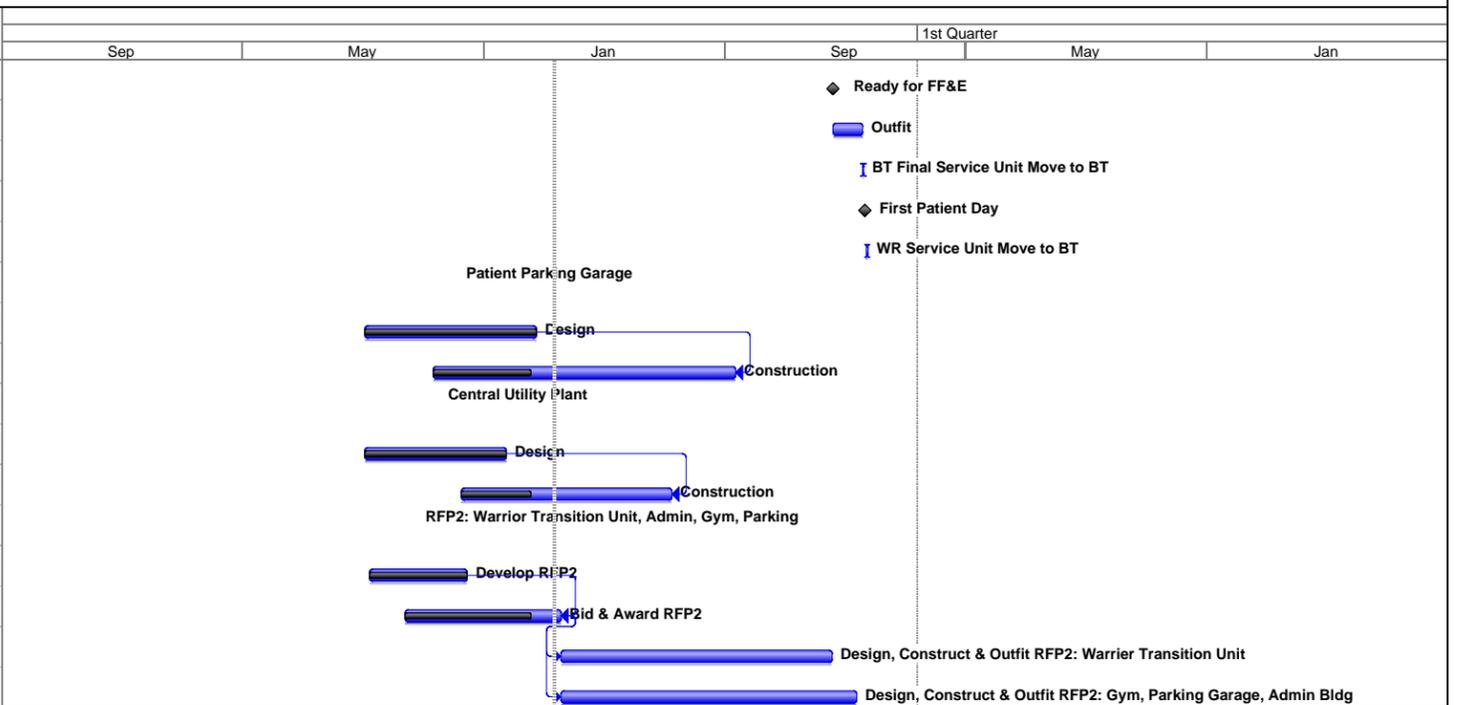| ID	Task Name	Duration	Start	Finish
1759	BT Final Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1760	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1761	**Floor 10-04**	**428 days**	**Fri 1/8/10**	**Tue 8/30/11**
1762	**Directorate: Adult Medical-Surgical**	**428 days**	**Fri 1/8/10**	**Tue 8/30/11**
1763	**Dept: Adult Medical-Surgical**	**428 days**	**Fri 1/8/10**	**Tue 8/30/11**
1764	**Service Unit: 10-04 Med/ Surg Wards**	**428 days**	**Fri 1/8/10**	**Tue 8/30/11**
1765	Renovate - Phased	396 days	Fri 1/8/10	Fri 7/15/11
1766	BOD - Final Phase	0 days	Mon 7/18/11	Mon 7/18/11
1767	Ready for FF&E - First Phase	0 days	Thu 8/26/10	Thu 8/26/10
1768	Outfit - Phased	237 days	Thu 8/26/10	Fri 7/22/11
1769	BT Final Service Unit Move to BT Phase 1 of 2	5 days	Fri 9/17/10	Thu 9/23/10
1770	BT Final Service Unit Move to BT Phase 2 of 2	5 days	Mon 7/25/11	Fri 7/29/11
1771	First Patient Day - Final Phase	0 days	Tue 8/2/11	Tue 8/2/11
1772	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1773	**Floor 10-07**	**576 days**	**Wed 6/17/09**	**Thu 9/1/11**
1774	**Directorate: Behavioral Health**	**576 days**	**Wed 6/17/09**	**Thu 9/1/11**
1775	**Dept: Behavioral Health**	**575 days**	**Wed 6/17/09**	**Tue 8/30/11**
1776	**Service Unit: In Patient Behavioral Health (Adult**	**575 days**	**Wed 6/17/09**	**Tue 8/30/11**
1777	BT Temp Service Unit Move to BT - Compression	3 days	Wed 6/17/09	Fri 6/19/09
1778	Renovate - Phased	0 days	Tue 7/14/09	Tue 7/14/09
1779	BOD - Final Phase	0 days	Fri 12/24/10	Fri 12/24/10
1780	Ready for FF&E - First Phase	0 days	Fri 3/12/10	Fri 3/12/10
1781	Outfit - Phased	224 days	Fri 3/12/10	Wed 1/19/11
1782	BT Final Service Unit Move to BT - Move to Phase	3 days	Fri 4/2/10	Tue 4/6/10
1783	BT Final Service Unit Move to BT - Expand to	3 days	Thu 1/20/11	Mon 1/24/11
1784	First Patient Day - Final Phase	0 days	Wed 1/26/11	Wed 1/26/11
1785	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1786	**Dept: Psychology**	**218 days**	**Mon 11/1/10**	**Thu 9/1/11**
1787	**Service Unit: Psychology: Preventive &**	**218 days**	**Mon 11/1/10**	**Thu 9/1/11**
1788	Renovate	164 days	Mon 11/1/10	Thu 6/16/11
1789	BOD	0 days	Fri 6/17/11	Fri 6/17/11
1790	Ready for FF&E	0 days	Fri 6/3/11	Fri 6/3/11
1791	Outfit	60 days	Fri 6/3/11	Thu 8/25/11
1792	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1793	First Patient Day	0 days	Thu 9/1/11	Thu 9/1/11
1794	**Directorate: GME/GDE**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1795	**Dept: GME**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1796	**Service Unit: Medical & Command Duty Rooms**	**217 days**	**Mon 11/1/10**	**Tue 8/30/11**
1797	Renovate	164 days	Mon 11/1/10	Thu 6/16/11
1798	BOD	0 days	Fri 6/17/11	Fri 6/17/11

Legend:
Task | Milestone ◆ | Rolled Up Task | Rolled Up Progress | External Tasks | Group By Summary
Progress | Summary | Rolled Up Milestone ◇ | Split | Project Summary | Deadline ⇩

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ID	Task Name	Duration	Start	Finish
1799	Ready for FF&E	0 days	Fri 6/3/11	Fri 6/3/11
1800	Outfit	53 days	Fri 6/3/11	Tue 8/16/11
1801	BT Final Service Unit Move to BT	3 days	Wed 8/17/11	Fri 8/19/11
1802	First Patient Day	0 days	Tue 8/23/11	Tue 8/23/11
1803	WR Service Unit Move to BT	3 days	Fri 8/26/11	Tue 8/30/11
1804	**Patient Parking Garage**	**669 days**	**Fri 3/7/08**	**Thu 9/30/10**
1805	Design	310 days	Fri 3/7/08	Thu 5/14/09
1806	Construction	546 days	Wed 8/27/08	Thu 9/30/10
1807	**Central Utility Plant**	**554 days**	**Fri 3/7/08**	**Wed 4/21/10**
1808	Design	256 days	Fri 3/7/08	Fri 2/27/09
1809	Construction	380 days	Thu 11/6/08	Wed 4/21/10
1810	**RFP2: Warrior Transition Unit, Admin, Gym, Parking**	**879 days**	**Tue 3/18/08**	**Mon 8/1/11**
1811	Develop RFP2	177 days	Tue 3/18/08	Thu 11/20/08
1812	Bid & Award RFP2	282 days	Tue 6/17/08	Wed 7/15/09
1813	Design, Construct & Outfit RFP2: Warrier Transition Unit	489 days	Thu 7/16/09	Tue 5/31/11
1814	Design, Construct & Outfit RFP2: Gym, Parking Garage, Admin	533 days	Thu 7/16/09	Mon 8/1/11

Task		Milestone	◆	Rolled Up Task	
Progress		Summary		Rolled Up Milestone	◇

Rolled Up Progress		External Tasks		Group By Summary	
Split		Project Summary		Deadline	⇩

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Inspection Name	Activity Inspected	DeWitt		MGMC		NNMC		WRAMC	
		Last	Next	Last	Next	Last	Next	Last	Next
11th Wing Occupational Safety Assessment		n/a	n/a	May-08	May-09	n/a	n/a	n/a	n/a
AAAHC (Accreditation Association for Ambulatory Healt	Ambulatory health care	n/a	n/a	Jan-08	Jan-11	n/a	n/a	n/a	n/a
ADA/CODA (Committee on Dental Accreditation)	AEGD-1	n/a	n/a	Mar-04	Mar-11	n/a	n/a	n/a	n/a
AF Government Purchase Card Surveillance	RMO	n/a	n/a	Jul-08	Jul-09	n/a	n/a	n/a	n/a
AFDW	Environmental, Safety and Occupational Health (ESOHCAMP)	n/a	n/a	Oct-05	Mar-09	n/a	n/a	n/a	n/a
AFIA	Occupational and Environmental Health; BEE Readiness (HSI)	n/a	n/a	May-08	May-11	n/a	n/a	n/a	n/a
"	Population Health	n/a	n/a	Jan-08		n/a	n/a	n/a	n/a
AFMOA South	OR/AFSO21	n/a	n/a	Oct-08	Feb-09	n/a	n/a	n/a	n/a
"	Physiology Training Unit	n/a	n/a	Jul-07	Jul-05	n/a	n/a	n/a	n/a
Air Force Audit Agency	RM (GWOT Funds)	n/a	n/a	Sep-08	Dec-08	n/a	n/a	n/a	n/a
AMC System SAV	Medical Systems	n/a	n/a	Mar-08		n/a	n/a	n/a	n/a
American College of Surgeons	Tumor Registry	n/a	n/a	Aug-06	Aug-09	n/a	n/a	n/a	n/a
American College of Surgeons Commission on Cancer	Cancer Program & Tumor Registry	n/a	n/a	n/a	n/a	Mar-06	Jun-09	n/a	n/a
American Psychological Association	Mental Health	n/a	n/a	Jul-08	n	n/a	n/a	n/a	n/a
Anti Fraud Audit	RMO	n/a	n/a	May-08		n/a	n/a	n/a	n/a
Army Community Services and Family Advocacy Program joint inspection	Department of Social Work, Family Advocacy Program	n/a	n/a	n/a	n/a	n/a	n/a	Apr-05	Feb-09
Behavioral Health Optimization Program	Mental Health	n/a	n/a	Jun-08	Indef	n/a	n/a	n/a	n/a
Cell Phone Audit	Medical Systems	n/a	n/a	Aug-08	Indef	n/a	n/a	n/a	n/a
Children's Oncology Group Inspection	Pediatric Hematology-Oncology	n/a	n/a	n/a	n/a	n/a	n/a	Spring 08	Spring 11
CNO Integrated Vulnerability Assessment (CNOIVA)	NNMC	n/a	n/a	n/a	n/a	Jan-06	Nov-09	n/a	n/a
Curriculum & Training Management Inspection	Langley & Travis APTU	n/a	n/a	Jul-08	N/A	n/a	n/a	n/a	n/a
Defense Threat Reduction Agency	Pentagon Flight Medicine Clinic	n/a	n/a	Feb-08	Annual	n/a	n/a	n/a	n/a
Department of the Army, Inspector General	Pentagon Flight Medicine Clinic	n/a	n/a	Sep-08	Annual	n/a	n/a	n/a	n/a
DES Pilot Survey	Disability Evaluation SystemPilot Program	n/a	n/a	Jul-08	Indef	May-08	Indef	n/a	n/a
DoD IG Triple AAA Audit	Third Party Collection Program, Medical Services Accounts, Medical Affirmative Claims	Jul-07	TBD	n/a	n/a	n/a	n/a	n/a	n/a
Environmental, Safety, and Occupational Health Compliance Assessment Management Program (ESOHCAMP)	ESOH programs External	n/a	n/a	Aug-06	Aug-09	n/a	n/a	n/a	n/a
"	ESOH programs Internal	n/a	n/a	Oct-07	Nov-08	n/a	n/a	n/a	n/a
"	Bio, Dental, Nut Med	n/a	n/a	Feb-08	Feb-09	n/a	n/a	n/a	n/a
Fleet & Industrial Supply Center Norfolk	Procurement Performance Mngt Assessment Program (PPMAP)	n/a	n/a	n/a	n/a	May-08	Jun-10	n/a	n/a
GAO Audit	MEB	n/a	n/a	Jul-08	Indef	n/a	n/a	n/a	n/a
Government Purchase Card Surveillance	RMO	n/a	n/a			n/a	n/a		Feb-09
Health Services Inspection	MDG	n/a	n/a	May-08	May-11	n/a	n/a	n/a	n/a

"	Dental not covered by AAAHC	n/a	n/a	Jan-08	Jan-11	n/a	n/a	n/a	n/a
Joint Commission	MTF	Mar 2007	Mar-09	May-08	May-11	Dec-07	Dec-10	Jul-08	Jul-10
Joint Service Integrated Vulnerablility Assessment (JSIVA)	Anti-Terrorism/Force Protection measures	Oct-07	Oct-10	Feb 08	Feb 11	Jan-03	Indef		Feb-09
Local Vulnerablility Assessment (11 WG)	Anti-Terrorism/Force Protection measures	n/a	n/a	Oct 07	Feb 09	n/a	n/a	n/a	n/a
Management Assistance Visit SAV	Medical Logisitics	Jun-05	Apr-09	Mar-08	??	n/a	n/a	Oct-09	Jul-10
McKenna	Life Safety Code	n/a	n/a	Aug-08	None	n/a	n/a	n/a	n/a
McKenna Full Blown Mock Survey	MDG Joint Commission	n/a	n/a	Nov-08	None	n/a	n/a	n/a	n/a
Naval Medical Inspector General Inspection	NNMC	n/a	n/a	n/a	n/a	Dec-07	Dec-10	n/a	n/a
MEDCOM	EO/EEO Programs	Apr-08	Apr-09	n/a	n/a	n/a	n/a	n/a	n/a
MEDCOM Inspector General (IG)	MTF	Mar-08	Apr-09	n/a	n/a	n/a	n/a	n/a	n/a
MEDCOM RMD Staff Assistance Visit	Third Party Collection Program, Uniform Business Office, Medical Services Accounts, Medical Affirmative Claims	Apr-06	TBD	n/a	n/a	n/a	n/a	n/a	n/a
MEDCOM WTU OIP	WTU	Apr-09	Apr-10	n/a	n/a	n/a	n/a	n/a	n/a
Military Training Network	Basic Life Support	Oct-08	Feb-09	Jul-07	??	n/a	n/a	n/a	n/a
"	Adv. Cardiac Life Support	Oct-08	Feb-09	Jul-07	??	n/a	n/a	n/a	n/a
"	Pediatric Adv. Life Support	Oct-08	Feb-09	Jul-07	??	n/a	n/a	n/a	n/a
"	Neonatal Resuscitation Prgm	n/a	n/a	Jul-07	??	n/a	n/a	n/a	n/a
MSA Quarterly Safe Audit`	Medical Services Accounts	Dec-08	Mar-09			n/a	n/a	n/a	n/a
Operational Readiness Inspection (ORI)	Emergency Response	n/a	n/a	Sep-07	Indef	n/a	n/a	n/a	n/a
Pathology Services	Third Party Collections	n/a	n/a	Feb-07	Mar-10	n/a	n/a	n/a	n/a
RMD OIP (Includes Third Party Collection Program, Uniform Business Office, Medical Services Accounts, Medical Affirmative Claims)	RMD (Third Party Collections, UBO)	Nov-06	2nd QTR FY 2009	n/a	n/a	n/a	n/a	n/a	n/a
Toxic Industrial Chemical/Material Vulnerability Assessment (TIC/TIM VA)	MCRP Team readiness for TIC/TIMs	n/a	n/a	Aug 08	N/A	n/a	n/a	n/a	n/a
Transient Monitoring Unit Review	Medical Boards/Limited Duty	n/a	n/a			Sep-08	Sep-09	n/a	n/a
Water Vulnerability Assessment (WVA)	Drinking Water Safety External	Jan-04	TBD	Nov-07	Nov-10	n/a	n/a	n/a	n/a
Water Vulnerability Assessment (WVA)	Drinking Water Safety Internal	n/a	n/a	Sep-06	Nov-08	n/a	n/a	n/a	n/a
Wounded/Ill Housing Inspection	WT Housing	Dec-08	Dec-10	n/a	n/a	n/a	n/a	n/a	n/a

GRADUATE MEDICAL EDUCATION

Inspection Name	Activity Inspected	DeWitt		MGMC		NCC		NNMC		USU		WRAIR		WRAMC	
		Last	Next	Last	Next	Last	Next	Last	Next			Last	Next	Last	Next
National Capital Consortium Program (0201011087)	Allergy and Immunology	n/a	n/a	n/a	n/a	May-05	Sep-10	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (0401021190)	Anesthesiology	n/a	n/a	n/a	n/a	May-05	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (0451021042)	Critical Care Medicine	n/a	n/a	n/a	n/a	Nov-05	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (0801021123)	Dermatology	n/a	n/a	n/a	n/a	Sep-07	Mar-11	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1202321002)	Family Medicine	n/a	n/a	n/a	n/a	Mar-03	Sep-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1205112012)	Family Medicine	Nov-04	May-10	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Nov-04	May-10
National Capital Consortium Program (1275121037)	Family Medicine - Sports Medicine	Nov-04	May-10	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Nov-04	May-10
National Capital Consortium Program (1401011006)	Internal Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-03	Apr-09
National Capital Consortium Program (1402311013)	Internal Medicine	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Jan-13	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1411011159)	Cardiovascular Disease	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1421021125)	Critical Care Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-03	Apr-09
National Capital Consortium Program (1432311126)	Endocrinology, Diabetes, & Metabolism	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Jan-13	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1442311156)	Gastroenterology	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Jan-13	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1461011127)	Infectious Disease	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-03	Apr-09
National Capital Consortium Program (1481011113)	Nephrology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-09	Apr-09
National Capital Consortium Program (1501011093)	Rheumatology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-03	Apr-08
National Capital Consortium Program (1552321088)	Hematology and Oncology	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Jan-13	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1561021082)	Pulmonary Disease and Critical Care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Oct-03	Apr-09
National Capital Consortium Program (1601021118)	Neurological Survey	n/a	n/a	n/a	n/a	May-04	Jun-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1801021144)	Neurology	n/a	n/a	n/a	n/a	Apr-07	Nov-12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1851011010)	Child Neurology	n/a	n/a	n/a	n/a	Jun-04	Nov-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1871031024)	Clinical Neurophysiology	n/a	n/a	n/a	n/a	Sep-07	May-12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (1871031028)	Clinical Neurophysiology	n/a	n/a	n/a	n/a	n/a	n/a	Aug-06	Nov-09	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (2001012002)	Nuclear Medicine	n/a	n/a	n/a	n/a	May-06	Dec-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (2201021354)	Obstetrics and Gynecology	n/a	n/a	n/a	n/a	May-07	May-12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (2401012004)	Ophthalmology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Jan-08	May-13
National Capital Consortium Program (2602321183)	Orthopaedic Surgery	n/a	n/a	n/a	n/a	Sep-06	Jun-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (2631021056)	Hand Surgery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Apr-07	Jun-12
National Capital Consortium Program (2801031132)	Otolaryngology	n/a	n/a	n/a	n/a	Mar-08	Aug-11	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3001021416)	Pathology - Anatomic and Clinical	n/a	n/a	n/a	n/a	Mar-08	Oct-12	n/a	n/a	n/a	n/a	n/a	n/a	Mar-08	Oct-12
National Capital Consortium Program (3101032001)	Forensic Pathology	n/a	n/a	n/a	n/a	May-06	Sep-11	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3201021401)	Pediatrics	n/a	n/a	n/a	n/a	Feb-04	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3261011041)	Pediatric Endocrinology	n/a	n/a	n/a	n/a	Feb-04	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3271021044)	Pediatric Hematology/Oncology	n/a	n/a	n/a	n/a	Feb-04	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3291011090)	Neonatal-Perinatal Medicine	n/a	n/a	n/a	n/a	Feb-04	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3321021010)	Pediatric Gastroenterology	n/a	n/a	n/a	n/a	Feb-04	Dec-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3351031014)	Pediatric Infectious Diseases	n/a	n/a	n/a	n/a	Feb-04	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3401021074)	Physical Medicine and Rehabilitation	n/a	n/a	n/a	n/a	Jun-07	Aug-12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (3801021002)	Preventive Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Sep-03	Oct-08	n/a	n/a
National Capital Consortium Program (3802321044)	Preventive Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Mar-13	n/a	n/a	n/a	n/a
National Capital Consortium Program A (3802377073)	Preventive Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Sep-07	Mar-13	n/a	n/a	n/a	n/a
National Capital Consortium Program (4001021287)	Psychiatry	n/a	n/a	n/a	n/a	Jan-03	Apr-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4051012002)	Child and Adolescent Psychiatry	n/a	n/a	n/a	n/a	May-03	Oct-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4061021006)	Forensic Psychiatry	n/a	n/a	n/a	n/a	Feb-06	Apr-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Program	Specialty														
National Capital Consortium Program (4071021062)	Geriatric Psychiatry	n/a	n/a	n/a	n/a	Aug-03	Apr-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4201021247)	Radiology - Diagnostic	n/a	n/a	n/a	n/a	Jun-03	Oct-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4301021113)	Radiation Oncology	n/a	n/a	n/a	n/a	Aug-06	Jul-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4401011007)	Surgery	n/a	n/a	n/a	n/a	Mar-07	Oct-12	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4402321014)	Surgery	n/a	n/a	n/a	n/a	n/a	n/a	Jan-07	Jun-10	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4501011022)	Vascular Surgery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Jun-06	Oct-08
National Capital Consortium Program (4601011003)	Thoracic Surgery	n/a	n/a	n/a	n/a	Jun-03	Jul-08	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (4801021004)	Urology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	May-03	Dec-08
National Capital Consortium Program (5202314075)	Sleep Medicine	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Jul-06	Jan-09
National Capital Consortium Program (5301004101)	Pain Medicine	n/a	n/a	n/a	n/a	May-05	Oct-09	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (7052344021)	Internal Medicine/Psychiatry (non-accredited)		n/a	n/a	n/a	Oct-96	N/A	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (7202344012)	Psychiatry/Family Medicine (non-accredited)		n/a	n/a	n/a	Oct-97	N/A	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
National Capital Consortium Program (9991000024)	Transitional Year	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Jun-07	Nov-10
APA Committee on Accreditation	Psychology Residency	n/a	n/a	Jul-08	Jul-15	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Accreditation Council for Graduate Medical Education	National Capital Consortium	Includes NNMC & WRAMC				Jan-08	Apr-08							Jan-08	Apr-08

Inspection Name	Activity Inspected	DeWitt		MGMC		NNMC		WRAMC	
		Last	Next	Last	Next	Last	Next	Last	Next
383 TRS	AMSA Phase II SAV	n/a	n/a	Jan-08	Dec-08	n/a	n/a	n/a	n/a
383 TRS	SSA Phase II SAV	n/a	n/a	Apr-08	Dec-08	n/a	n/a	n/a	n/a
383 TRS	Cardio Phase II SAV	n/a	n/a	Apr-08	Dec-08	n/a	n/a	n/a	n/a
383 TRS	Lab Phase II SAV	n/a	n/a	Aug-08	Dec-08	n/a	n/a	n/a	n/a
383 TRS	NTP Phase II SAV	n/a	n/a	Jan-08	Dec-08	n/a	n/a	n/a	n/a
AF Phase II Training SAV	Phase II Training Program	n/a	n/a	May-08	May-10	n/a	n/a	n/a	n/a
AMEDD Center and School	Interservice PA Program	n/a	n/a	Sep-08	Mar-08	n/a	n/a	n/a	n/a
AMEDD Center and School	Lab Phase II SAV	n/a	Feb-09	n/a	n/a	n/a	n/a	n/a	Mar-10
AMEDD Center and School	68D Phase II SAV	n/a	n/a	n/a	n/a	n/a	n/a	n/a	TBD
AMEDD Center and School	Interservice PA Program	n/a	n/a	n/a	n/a	n/a	n/a	n/a	TBD
AMEDD Center and School	Radiology Phase II program	Aug-08	TBD	n/a	n/a	n/a	n/a	Aug-08	TBD
Commission on Accreditation of Allied Health Education Programs (CAAHEP)	Blood Bank Fellowship	n/a	n/a	n/a	n/a	n/a	n/a	Jan-03	Jan-12
Cardiopulmonary Technician Training Program	Cardio Phase II Program	n/a	n/a	Apr-08	Oct-09	n/a	n/a	n/a	n/a
HQ AETC	Phase II Evaluation	n/a	n/a	May-08	May-01	n/a	n/a	n/a	n/a
IPAP Phase II On Site Visit	Education & Training	n/a	n/a	Sep-08	Mar-10	n/a	n/a	n/a	n/a
National Accrediting Agency for Clinical Laboratory Sciences (NAACLS)	Clinical Laboratory Officer Course (CLOC)	n/a	n/a	n/a	n/a	n/a	n/a	May-08	May-15
Naval School of Health Sciences	Nuc Med Phase II program	n/a	n/a	n/a	n/a	n/a	n/a	Jul-08	Jan-09

MEDICAL LABORATORIES

Inspection Name	Activity Inspected	DeWitt		MGMC		NNMC		WRAMC	
		Last	Next	Last	Next	Last	Next	Last	Next
American Association of Blood Banks	Lab	Nov-07	Sep-09	Aug-08	Sep-10	Sep-08	Sep-10	Nov-07	Sep-09
BUMED Navy Blood Program	ASBBC & Transfusion Services	n/a	n/a	n/a	n/a	Jun-08	Jun-10	n/a	n/a
College of American Pathologists (CAP)	Lab	Nov-07	Sep-09	Jan-08	May-09	Sep-08	Sep-10	Nov-07	Sep-09
College of American Pathologists (CAP)	Dermatology Lab	n/a	n/a	n/a	n/a	Feb-07	Feb-09	n/a	n/a
Food and Drug Administration	Lab	Jul-07	Jul-09	Jul-07	May-09	Sep-08	Sep-10	Jul-07	Jul-09
Institutional Review Board (MGMC)	Lab	n/a	n/a	Aug-07	Aug-09	n/a	n/a	n/a	n/a

ORTHOPEDICS AND REHABILITATIVE MEDICINE

Inspection Name	Activity Inspected	WRAMC	
		Last	Next
American Board of Certification	Orthotics and Prosthetic Service Lab	N/A	first inspect-ion 1st QTR FY10
JCAHO/mock JCAHO	Physical Therapy	Jul-09	Anytime
Safety/Infection Control (in house/OIP)	Physical Therapy	Sep-08	Sep-09
Commission on Accreditation of Rehabilitation Facilities Accreditation	Amputee Service	N/A	first inspect-ion FY09
Government Purchase Card Surveillance	Dept of Ortho and Rehab	Oct-08	Oct-09
Proponency Office for Rehabilitation and Reintegration Site Visit	Traumatic Brain Injury Service	N/A	Anticipat-ed Yearly visit in the near future

Inspection Name	Activity Inspected	WRAMC	
		Last	Next
ASHP Oncology Pharmacy Residency (PGY2)	Department of Pharmacy	May-06	May-12
ASHP Nuclear Medicine Pharmacy Residency (PGY2)	Department of Pharmacy	May-06	May-12
ASHP Pharmacy Practice Residency (PGY1)	Department of Pharmacy	May-04	May-10

RADIOLOGY

Inspection Name	Activity Inspected	DeWitt		MGMC		NNMC		WRAMC	
		Last	Next	Last	Next	Last	Next	Last	Next
383 TRS	Radiology Phase II SAV	n/a	n/a	Sep-08	Dec-08	n/a	n/a	n/a	n/a
AFIA	Radioactive Material (RAM) Management	n/a	n/a	Sep-08	Sep-10	n/a	n/a	n/a	n/a
AFIA/SG Radioactive Material Permit Inspection	Radiation Safety Program	n/a	n/a	n/a	Aug 11	n/a	n/a	n/a	n/a
ACGME	Radiation Oncology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Jul-09
ACGME	Nuclear Medicine	n/a	n/a	n/a	n/a	n/a	n/a	Dec-08	TBD
Air Force Physicists	Mammography equipment	n/a	n/a	Oct-08	Oct-09	n/a	n/a	n/a	n/a
American College of Radiology	Mammography process	May-08	Jun-09	Feb-06	Feb-09	n/a	n/a	May-08	Jun-09
ASHP: Nuclear Pharmacy Residency Program	Nuclear Medicine	n/a	n/a	n/a	n/a	n/a	n/a	Aug-08	Aug-10
Base Bio environmental (Andrews)	Nuclear Medicine	n/a	n/a	Jul-08	Jun-09	n/a	n/a		
Food and Drug Administration (FDA)	Mammography Quality	May-08	Jun-09	Jul-08	Jul-09	Apr-08	Apr-10	May-08	Jun-09
JACHO/HSI	Radiology compliance w/stds	Mar-07	Mar-10	Jun-08	Jun-11	n/a	n/a	Mar-07	Mar-10
JRCNMT: (Nuclear Medicine Technologist School)	Nuclear Medicine	n/a	n/a	n/a	n/a	n/a	n/a	Jun-05	Jun-12
Navy & Marine Corps Public Health Center	Nuclear Medicine (under Navy Radioactive Material Permit)	n/a	n/a	n/a	n/a	Mar-08	Mar-10	n/a	n/a
Nuclear Regulatory Commission	Nuclear Medicine	n/a	n/a	Sep-08	Sep-11	n/a	n/a	Dec-07	Jun-09
Radio isotope committee	Nuclear Medicine	n/a	n/a	Mar-07	Mar-10	n/a	n/a	n/a	n/a
Sheppard School house	Radiology phase II program	n/a	n/a	Jun-08	Jun-11	n/a	n/a	n/a	n/a
USAF Radioactive Material Permit	Nuclear Medicine	n/a	n/a	Feb-07	Feb-10	n/a	n/a	n/a	n/a
U.S. ARMY CHPPM	Nuclear Medicine	n/a	n/a	n/a	n/a	n/a	n/a	May-08	May-11

TECHNOLOGY ASSESSMENT AND
REQUIREMENTS ANALYSIS

JOINT TASK FORCE CAPITAL MEDICAL NATIONAL CAPITAL REGION

EXECUTIVE SUMMARY

Base Realignment and Closure (BRAC)

In 2005, the Base Realignment and Closure (BRAC) recommendations included closing the Walter Reed Army Medical Center (WRAMC) in Washington, D.C., and re-aligning their services with the National Naval Medical Center (NNMC) in Bethesda, Maryland, and the new hospital being built at Fort Belvoir, Virginia. Currently, four sites serve the existing population within the National Capital Region (NCR), WRAMC, NNMC, DeWitt Army Community Hospital (DACH) at Fort Belvoir, and Malcolm Grow Medical Center (MGMC) at Andrews Air Force Base, Maryland. The BRAC integration will change the way healthcare is provided in the NCR. The BRAC will result in two campuses, the North at NNMC, and the South at the new hospital at Fort Belvoir that will provide patient care for the pre-BRAC patients of WRAMC, NNMC, and DACH. WRAMC and existing DACH are scheduled to close and MGMC will remain operational and support Air Force patients and assist the NCR as needed.

The Secretary of Defense created the Joint Task Force Capital Medical (JTF CapMed) NCR to implement and oversee the BRAC integration and to open the new facility at Fort Belvoir. The JTF CapMed has been entrusted to oversee and deliver integrated healthcare in the NCR. In part, their mission is to ensure readiness, and execute the BRAC business plans.

During the fall of 2007, the JTF CapMed NCR requested that the Army's Technology Assessment and Requirements Analysis (TARA) Team at the U.S. Army Medical Materiel Agency (USAMMA), Fort Detrick, assist in assessing their equipment needs to meet the BRAC directives. From 10 March through 4 April 2008, the TARA Team visited four sites in the NCR in conjunction with their routine visit to WRAMC. The TARA Team assessed equipment at WRAMC, NNMC, DACH, and MGMC from the standpoint of the integration of services as a result of BRAC.

While developing the 5-year requirement plan for the Army (Appendix C), the team considered the proposed plans to close and merge facilities and services in the NCR. Appendix Q has a list of the equipment that the TARA Team recommends to be reutilized at the time of the BRAC. For this report, to "reutilize" equipment refers to any items excess to needs (whether as a result of closure, new construction, or transfer of services) that has useful life remaining, can be relocated, and put to use in another location. The new location may or may not be in the NCR.

The following assessment includes recommendations based on both current and future requirements (pre- and post-BRAC). The TARA Team based their future requirements on forecasted troop increases and business plans that incorporate changes to occur as a result of the 2005 BRAC. Recommendations for impacts related to BRAC are primarily based on medical integration plans that were provided to the TARA Team at the time of the site visit. Changes in these business plans could affect our recommendations. The following report focuses on the current equipment requirements by site and then considers the impact of changes after BRAC reorganization.

A representative of the Army's Office of the Surgeon General (OTSG) Radiology Consultant, the OTSG's Clinical Laboratory Sciences Consultant, the OTSG's Pharmacy Consultant, personnel of the Integrated Clinical Systems
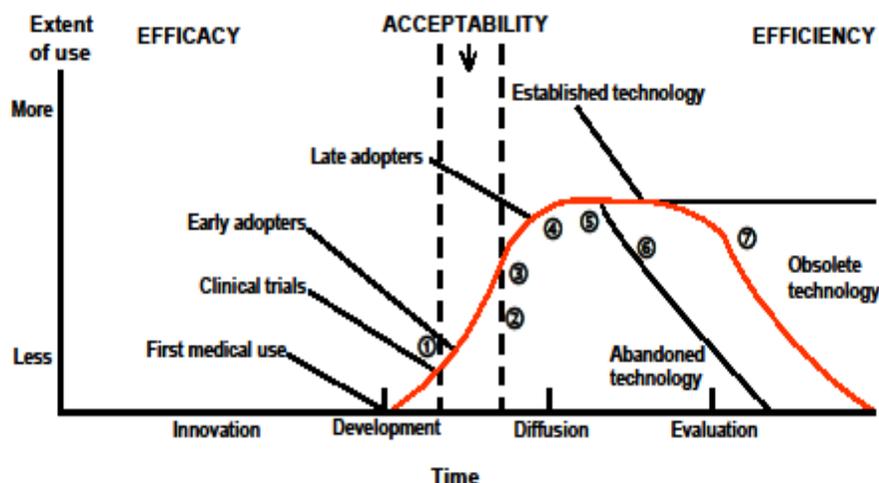
Figure 1. Technology life-cycle curve for medical equipment. 1, Promising clinical reports; 2, professional and organizational adoption; 3, public acceptance and third-party payer endorsements; 4, standard procedures and observation reports; 5, randomized clinical trials; 6, professional denunciation; and 7, erosion and professional discreditiation. (Source: Center for Health Economics and Policy Analysis, McMaster University)

Program Management Office, USAMMA, and representatives from the Air Force and Navy performed an on-site evaluation of current and future technology and management operations. This team of experts visited each site to interview departmental staff, observe scheduling and patient flow patterns, evaluate quality of service, and assess the condition and utilization of existing equipment. The TARA Team also examined the BRAC integration plans.

The TARA Team identified the following issues and recommendations for a successful transformation of the NCR under the BRAC:

- Utilize MGMC as a bridging strategy for the Nuclear Medicine Service during renovation of the NNMC Nuclear Medicine Department
- Reutilize point-of-use pharmacy systems to maximize the investment and move toward standardization when these systems complete their life cycle and are replaced
- Consider MGMC as a possible location for a center of excellence for Warfighter Refractive Eye Surgery Program (WRESP) in the South
- Replace physiological monitoring systems at WRAMC if it stays open past 2011 ($3 to $5 million)
- Expect the number of pharmaceutical prescriptions issued to significantly increase at both North and South Campus
- Implement robust bandwidth within the NCR in support of the picture archiving and communications systems (PACS), e.g., single network (fiber ring)
- Recommend that the MGMC laboratory become the center of excellence in the NCR for reference testing and phase II training

- Ensure all equipment receives an equipment control number (ECN)
- Reutilize 113 investment systems

To determine the type and number of equipment necessary for each site post-BRAC, the JTF CapMed instructed the TARA Team to assume the patient workload for the NCR will largely be split between the North Campus and the South Campus at the new hospital at Fort Belvoir. The workload currently handled by the NNMC, WRAMC, and DACH will be divided at approximately 60 percent (North Campus) and 40 percent (South Campus).

Appendix A contains an example of the method the TARA Team uses to calculate their utilization rates for diagnostic imaging equipment and sterilizers. Appendix B explains the radiation therapy equipment utilization, and D through P contain the specific modality workload and utilization rates by site, both pre- and post-BRAC. The TARA Team analyzed the current workload as well as the projected workload after the BRAC. Appendix R contains the forecasted number of systems needed by modality for each Campus and the number of available pieces of equipment in the NCR to be reutilized.

INTRODUCTION TO THE TARA PROCESS

The Strategic Technology and Clinical Policies Council (STCPC) formally adopted the TARA program in January 1995, directing full integration of clinical consultants and requiring a TARA site visit to every Army Medical Department (AMEDD) medical activity (MEDDAC) every 4 to 5 years and medical center (MEDCEN) on a 3-year basis. The

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TARA program has resulted in process improvements, expedited modernization of equipment, and generated a cost avoidance of about $1.6 million per facility since 1995. The equipment reviewed falls within the Army's Medical Care Support Equipment (MEDCASE, cost greater than $250,000) or Super Capital Equipment Expense Program (SuperCEEP, cost between $100,000 and $250,000).

This TARA provides an unbiased review of the clinical processes, requirements, operations, and equipment for diagnostic imaging, radiation therapy systems, pharmacy robotics, physiological monitoring, nurse call systems, sterilizers, lasers, endoscopy, microscopy, and laboratory services at the facility. Our goal is to provide information to senior decision makers on the clinical and technological resources required to accomplish business plan missions and to develop acquisition strategies that ensure optimal clinical outcomes.

Major TARA components

1. Assessment of clinical operations: The OTSG specialty consultants or senior clinicians conduct the assessment by focusing on staffing, customer service, quality assurance, risk management, patient flow, task performance, and integration with other health care issues. This review incorporates the facility's input on workforce design, functional success, and mission, and compares the functional operation to accepted practice models. This evaluation also addresses leader development, training, and military-relevant management issues.

2. Assessment of requirements: The TARA Team applies commercial equipment utilization factors tempered by issues unique to military hospitals to assess the facility's workload. These utilization factors provide benchmarks with which the TARA Team can begin the evaluation process.

3. Assessment of operations: The TARA Team evaluates the use of existing equipment by assessing several factors such as the procedural mix, staffing, work schedule, patient flow, throughput, quality assurance, and risk management.

4. Equipment Assessment: The TARA Team conducts a comprehensive evaluation of existing equipment, as well as the issues that may impact equipment requirements such as

BRAC implementation. The TARA Team also determines whether the facility uses abandoned or obsolete technology and whether the equipment meets standards for acceptability (Figure 1). The TARA is not intended as a substitute for the facility's own routine evaluation of their operations. Every site should reevaluate their requirements periodically, especially in the event of a major change in mission.

Equipment Tracking

When equipment enters a facility, the facility must assign an ECN and record it in the property book. All equipment in the hospital, even leased, must have an ECN to ensure that the equipment is checked by biomedical maintenance personnel when it enters the facility, and that maintenance is routinely performed and documented.

Report Layout

The report has three distinct sections. The first covers the Diagnostic Imaging and Patient Care Equipment, both from the clinical perspective as well as the equipment analysis and assessment. This first section is divided by each MTF and covers all the diagnostic imaging and patient care modalities. The second section discusses the review of equipment in the Department of Pathology throughout the NCR. Again this section is divided by each MTF. The final section of the report covers the PACS review of the NCR and also divides the write-up by site. All the write-ups give an overview of the general recommendations per modality. For equipment details and specific recommendations, please refer to the equipment recommendation tables following each site's write-up.

Although the primary purpose of this report is the joint service assessment of the equipment within the NCR to prepare for the BRAC, the TARA review is also a routine Army process. Therefore, the Army personnel on this trip also performed their routine review of both WRAMC and DACH equipment as part of the normal TARA process. Because of this secondary purpose, Appendix C contains a list of Army-only requirements that would have been routinely generated by the Army for Army facilities after a TARA visit.

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Section C - Descriptions and Specifications

PWS

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Section C: Performance Work Statement (PWS)
For Non-Personal Services

Initial Outfitting and Transition (IO&T)
Acquisition for National Capital Region (NCR)
North (WRNMMC) and South (FBCH) Projects

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C.1.0   GENERAL

This is a non-personal services contract to provide Initial Outfitting and Transition (IO&T) services to support one new military medical facility, and the new additions and newly renovated spaces at one military medical facility in the National Capital Region (NCR). The Joint Task Force National Capital Region - Medical (JTF CapMed) seeks Contractor support to perform tasks such as hospital transitioning and activation, provisioning/installing materiel, provisioning/installing furniture/furnishings, provisioning/installing medical, non-medical, and Information Technology (IT) equipment, providing initial transition and equipment training (operational and maintenance), and moving reused equipment and materiel. The Walter Reed National Military Medical Center (WRNMMC) in Bethesda, MD (North Project) and the new Fort Belvoir Community Hospital (FBCH) at Fort Belvoir, VA (South Project) are the focal point of these requirements as directed under the Base Realignment and Closure (BRAC) 2005 law.

C.1.1   Overall Goal

The overall goal of this contract is to ensure the IO&T of WRNMMC and FBCH is completed in accordance with the schedule provided in Section F of the contract, within budget, and in accordance with the Contractor's approved plans. The Contractor shall use proven best practices that minimize any negative impact on staff operations and the patient healthcare mission.

C.1.2   Background

The 2005 BRAC Commission recommended relocating certain Walter Reed Army Medical Center activities from Washington, D.C., to the National Naval Medical Center and establishing it as the Walter Reed National Military Medical Center (hereafter referred to as "the North Project"). This 345-bed medical center will provide tertiary, subspecialty, and complex medical services. In addition, to supplement the new medical center services, a new community hospital will be built at Fort Belvoir, VA. This new 120-bed hospital, Fort Belvoir Community Hospital, is referred to as "the South Project." The South Project hospital will provide primary and secondary (specialty services to include neurology, etc.) services. Both of the health facilities will support various medical education missions including but not limited to Graduate Medical Education (GME), non-GME, and enlisted specialty training.

BRAC law requires construction of the two facilities to be completed by 15 September 2011. Historically, providing the resources required to accomplish a transition facility support service function was accomplished (a) by assigning additional personnel to a specific project site (Health Facility Project Officers), (b) through interim manpower allocations (internal reassignments of in-house staff), or (c) by hiring temporary employees for specific support (logistics managers). While these methods have been successful in a low volume environment, they will not support the immediate and future requirements of the JTF CapMed- the organization tasked with implementing the above BRAC recommendation.

C.2.0   SCOPE

The selected IO&T Contactor must support the continuous and seamless provision of the healthcare service mission to patients in all locations. The selected IO&T Contractor must be able to perform specialized hospital transition

and activation services, provisioning/installing materiel, provisioning/installing furniture/furnishings, provisioning/installing medical, non-medical, and IT equipment, and moving reusable equipment, materiel, and other items (e.g., files, patient records, journals, books, special artifacts etc.) as specified by the Government, to include:

- Provisioning of medical and non-medical equipment
- Provisioning of furniture and furnishings
- Equipment standardization as required by the Government across both new and re-used equipment
- Equipment transition and relocation services
- Property management accountability
- Transition of Government records and files
- Formal safety testing, calibration, verification, and certification of all equipment, including reuse
- User and maintenance training
- Receipt, storage, and any required warehousing of new and existing equipment
- Installation of equipment, technical inspection, and managing vendor-installation of equipment
- Coordinate equipment operation and maintenance training consistent with vendor recommendations and/or requirements
- Participation in the final turnover and close-out for these NCR projects as required
- Decontamination, surplus, and disposal services as required

Standardization of medical equipment across the North and South Projects is an important aspect of this acquisition and shall be a requirement of the Contractor. Some equipment to be provisioned by the Contractor will be standardized by the Government; the Government will provide the required information to the Contractor by way of Government Furnished Information (GFI) (per Section C.5 of this document). The Government will identify equipment by Joint Schedule Number (JSN) and the specified make and model; the Contractor shall provision this equipment to ensure standardization of North and South Projects. For the purposes of this effort "standardization" means buying identical manufacturer's make and model for an identified JSN equipment item for North and South Project requirements to facilitate training, maintainability, interoperability, and use, to the extent possible. In instances where sufficient quantities are not available the Contractor shall ensure that specifications of the requirement are met when selecting the manufacturer to meet the remaining quantities.

C.2.1   Project Requirements

In support of the tasks enumerated below, the Contractor shall furnish extensive technical and administrative expertise to ensure the expeditious accomplishment of these tasks.

- The Contractor shall provide hospital transition and activation services, project management services, and provisioning of medical and non-medical equipment, data processing equipment (IT), and furniture and furnishings, consistent with the Government-provided architectural and engineering requirements of the facilities being supported with this work.
- The Contractor shall document a detailed, realistic Project Management Plan that shall serve as the management guideline for the project for its tasks. This Project Management Plan (Deliverable 1, described in Section C.3.2) shall be built to include the tasks, time frames, and responsibilities for every Contractor activity (including Small Business utilization) required to support the Government in achieving a successful transition.
- The Contractor shall provision and arrange for the installation of the required medical equipment (Attachment 1).
- The Contractor shall provision and schedule for the installation of the required non-medical equipment (Attachment 2).
- The Contractor shall provision and arrange for the installation of the required IT equipment (Attachment 3), in compliance with Defense Information Assurance Certifications and Accreditation Process (DIACAP) requirements.

- The Contractor shall provision the required furniture and furnishings called out in Attachment 4 and install them in accordance with the Comprehensive Interior Design Package that is identified as GFI in Section C.5.0 of this document.
- The Contractor shall implement standardization decisions when provisioning and equipping the North and South Projects.
- The Contractor shall coordinate with the Government to prevent delivery conflicts with construction schedules and Other Contractor Provisioned and Installed Equipment (OCPIE) (Attachment 5).
- The Contractor shall arrange for the removal, packing, relocation, unpacking, and reinstallation of reuse equipment (Attachment 6)
- The Contractor shall provide hospital transition services supporting the relocation of staff office files and equipment, equipping of the clinics, implementing standardization decisions, applying for warranties for all new equipment, and training on all new equipment.
- The Contractor shall apply National Fire Protection Assoc. (NFPA), Occupational Safety and Health Act (OSHA), American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE), Americans with Disabilities Act (ADA), other health and safety codes, and medical standards to fully identify, integrate, and apply requirements to all provided services.
- The Contractor shall provide for the appropriate transitioning of official Government records/files, including patient records and other sensitive protected information. The Contractor shall abide by all applicable Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security requirements regarding health information as defined in this contract.

Information provided in the Attachments is current as of the release of the Request for Proposal (RFP). The Government will provide updated information to the Contractor, as available.

C.2.2   Hospital Transition and Activation Services and Project Management

The Contractor shall provide hospital transition and activation services appropriate to this effort. Contractor activities may include, but are not limited to, controlling project cost and schedule; integration of North and South Projects; ensuring quality of services provided. Additional activities may include:
- Interim and/or final development and facilitation of transition team structure and organization
- Documentation of clinical phasing
- Signage and Way-finding programs to facilitate transition and relocation
- Move sequencing, preparation, and planning
- "Move Day" management
- Patient Safety Planning
- Administration Phasing and Strategy
- Staff Communication Planning
- Patient and Community Outreach Planning
- Accreditation and Certification Coordination
- Strategy for medical support services to support the hospital transition plan

The Contractor shall also manage deliveries of equipment, materials, and services provided under this contract (e.g., Just-In-Time (JIT), warehousing, drop-shipment, etc.); managing risk; developing and adhering to a Work Breakdown Structure (WBS); and scheduling activities.

The Contractor shall use appropriate project management software as necessary for documentation and reporting. The Contractor shall coordinate equipment with the facility design contractor, and coordinate furniture placement with the interior design development services Contractor, for both North and South Projects.

In order to facilitate its technical management of this effort, the Contractor shall manage the delivery of all services provided. The Contractor shall include full-service transition capability in all key areas determined by the Contractor's approach. As examples, the Government anticipates requirements for expertise in the following areas:

- Medical Subject Matter Expert in hospital transition and activation, and clinical planning
- Medical materiel
- Certified Biomedical Technician or military equivalent
- Medical logistics
- Hospital Program Management
- Hospital Facilities Management
- Hospital Support Services
- Hospital Safety and Risk Management
- Education and Training
- Property management and equipment accountability
- Product Provisioning
- Equipment inventory control
- Medical Logistics planning
- Bio-Medical Maintenance planning
- IT provisioning and DoD Information Assurance Certification
- Warehousing/Storage
- Secure handling of warehoused items and Government files and records
- Handling patient records and other sensitive protected information
- Communications planning
- Defense Medical Logistics Standard Support (DMLSS) accounting training and evaluation
- Equipment Installation and Testing
- Transportation and Movement Management

The specific staffing to perform the required transition project management services is entirely at the discretion of the Contractor, and shall be in accordance with the Contractor's approved Project Management Plan. It is anticipated by the Government that there will be a qualified Project Manager (PM) within an established Project Management Office (PMO), to meet performance outcomes. Key personnel, as determined by the Contractor's approach, shall be submitted and listed with the proposal. The Government anticipates that the Contractor would select PMO staff that includes personnel who have met the education requirements and passed appropriate examinations typical certifications could include Certified Materials & Resources Professional (CMRP), Certified Medical Manager (CMM), or other Professional Logistician Certifications relevant to the task of providing hospital transition and activation service support (e.g., CAVS, CHESP, CHFM, or CPHRM) as determined by the Contractor.

In accordance with its approach the Contractor shall have a presence to support four (4) locations on a continuous basis within commuting distance (50 miles) of the following sites:

- JTF CapMed, Bethesda MD
- WRNMMC, North Project, Bethesda MD
- FBCH, South Project, Fort Belvoir, VA
- Walter Reed Army Medical Center (WRAMC) Washington DC

C.2.3   Comprehensive Equipment Services

The Contractor shall provide comprehensive equipment services for medical, non-medical, and IT equipment, and shall coordinate with the Project Managers (North and South), clinic personnel, Original Equipment Manufacturer (OEM), builder(s), and architect(s), as needed, to ensure that all access, space, power, and cooling requirements are met. In accordance with its approach, the Contractor shall:

- Provide acquisition timelines
- Confirm with the Government that the as-designed equipment plans are consistent with the current requirements prior to provisioning
- Provide market research

- Expedite planning for items and incorporation of lead times into the transition schedule
- Standardize across new and reused equipment
- Provide biomedical equipment maintenance sustainment strategy
- Provide cut sheets and associated documentation
- Use an online equipment database capable of managing the status of the entire Initial Outfitting (IO) of furniture, furnishings, and equipment requirements
- Update the database in real time as status changes; notifying the Government Contracting Officer's Representative (COR) and end user if there are any issues with the manufacturer of a particular product; and offer alternatives to meet delivery and installation requirements
- Coordinate equipment training for clinical staff and equipment maintenance personnel as required
- Negotiate full manufacturer's warranty for each new piece of equipment such that the benefit of the full warranty is available to the Government for at least one year from the date of start of delivery of healthcare
- Provide capital equipment inventory to include the collection of data (asset tag number, Radio-frequency identification (RFID) number, item description, location, manufacturer, condition, age and serial number) from all equipment with a purchase value of over $500 as well as the retention and turnover to the Government of all hard-copy purchase receipts
- Place all items in electronic format (Portable Document Format (PDF)) on an Internet-based document management site (cut sheets and invoice documents). At the end of the project, all documents shall be provided on a Compact Disk (CD) for turnover to the Government to serve as final documentation for the Government in the event of an audit.

The Contractor shall track the progress of all items. The Contractor shall not be responsible for provisioning the items in Attachment 5 (OCPIE). The Contractor shall coordinate with the Government to prevent delivery conflicts with construction schedules and OCPIE, to include scheduling, movement, and delivery, as necessary.

The Contractor shall obtain, receive, store (as necessary), and install equipment consistent with OEM requirements, facility design documents, and interior design packages provided by the Government. The Contractor shall document its approach to standardization in a Standardization Plan (Deliverable 2).

C.2.3.1 Equipment Provisioning and Associated Services

The Contractor shall provide comprehensive equipment provisioning services for all identified equipment and/or Information Management/ Information Technology (IM/IT) equipment and systems. The equipment provisioned shall meet the requirements listed above (see Section C.2.3 Comprehensive Equipment Services).

Government sources of supply will be made available to the Contractor in accordance with Federal Acquisition Regulation (FAR) 51.1, Contractor Use of Government Supply Sources. The Contractor shall NOT use Government sources of supply to procure services in support of this contract.

Equipment provisioning services shall include:

- Providing real-time or near real-time information enabling the Government Contracting Officer (KO), Government COR, and/or Government Contracting Officer's Technical Representative (COTR) to see the status of any item over a threshold of $3,000 in the Contractor's system. This requirement may be met by providing read-only access by the KO, COR, and/or the COTR(s) to a subset of the tools that the Contractor's staff intends to use.
- Implementation of the competitive process to obtain equipment
- Ongoing reconciliation of the equipment budget and schedule with Government officials
- Coordination with the Government through the COR for all aspects of phasing of the projects for completeness
- Coordinate with the Government on technology upgrades for medical equipment to ensure currency of technology when provisioned.

- Attendance at transition planning meetings and scheduled Executive Interim Program Reviews (IPRs) in order to appropriately monitor project and ensure occupancy activities; meeting frequency is anticipated to be every two weeks in Bethesda, MD
- Set up day-to-day meetings at the work locations (construction, etc.)
- Development of system description documents for user education and use
- Preparation of transition manuals
- Construction delivery schedule monitoring to ensure Just in Time (JIT) delivery of equipment
- Appropriate security of all equipment and materials under the Contractor's control until turned over to the Government
- Installation of equipment in accordance with OEM procedures

C.2.3.2 Equipment Transition and Relocation Services

The Contractor shall provide comprehensive equipment transition and relocation services for all equipment and systems identified for reuse and/or relocation and document how it will accomplish its part of these services in an Equipment Reuse Plan (Deliverable 3, described in Section C.3.4). The Contractor shall coordinate these services with the designated Government Property Book Officers through the COR prior to any equipment moves to ensure that property accountability is maintained.

The Government will ensure that sites from which reuse equipment is removed are free of hazardous materials.

The Government will perform surface decontamination/disinfection on all equipment to be moved; however, the Contractor shall provide additional decontamination/disinfection as the equipment is readied for relocation, to include surfaces that become exposed/accessible.

The Contractor shall ensure that pests and vermin are not transported with reuse/relocated items, consistent with industry best practices. Furthermore, if any items are warehoused by the Contractor, the Contractor shall ensure that these items are free of pests and vermin, consistent with industry best practices.

The Government will identify the equipment to be relocated, to include all associated components of the parent equipment (Attachment 6). The equipment shall be moved in accordance with commercial best practices. The Contractor shall observe all requirements from the OEM, or owner (moving, training, or calibration) for proprietary equipment identified in Attachment 6. Equipment relocation services shall include, but not be limited to, the following:

- Detailed initial outfitting and move procedures
- Security of all equipment and materials until turned over to the Government
- Obtaining/collecting/locating from the Government all available manuals and warranty information for equipment to be reused/relocated
- Document the operational condition of equipment to be moved
- Disconnecting equipment and preparing for packing
- Equipment packing
- Moving equipment and any needed storage, and, when necessary, ensure that moving and storage are in accordance with OEM requirements
- Equipment unpacking
- Installing reuse equipment and ensuring proper operation and, when necessary, ensure installation is in accordance with OEM requirements
- Removal of all dunnage and packing materials (with Contractor dumpsters) and maintain the facility in a state of general cleanliness

The Contractor shall ensure transportation of the re-used equipment does not void the existing warranty. Re-used equipment must be kept in service under the current warranties until the warranties can be amended by the

Government to take effect at the new location. Additionally, the Contractor shall update the warranty information to identify the new location of the re-used equipment.

C.2.3.2.1 Government Documents, Office Files, Official Records, and Non-Medical Equipment

The Contractor shall provide comprehensive equipment transition and relocation services for all Government documents, office files, official records, and office equipment consistent with the non-medical equipment list (Attachment 2) and information provided in the Migration Plan (see GFI, Section C.5 of this document). The Contractor shall move paper records, including patient records, journals, books, documents, as well as Government artwork, office equipment, and other typical office contents. Office equipment, which may include printers, copiers, fax machines, etc., shall be moved in accordance with best commercial practices.

C.2.3.2.2 Shipment, Receipt and Installation

Relocation of all equipment shall include ensuring appropriate packaging and packing, providing for necessary insurance, and ensuring ability to track shipments. The Contractor shall receive, unpack, and dispose of packing materials; and configure, set up, and demonstrate proper system functioning to comply with planned and approved configurations.

The Contractor shall ensure that proper care is taken in equipment installation and in the placement of all furnishings in order to retain the condition of the floors and walls in the new, renovated, and existing facilities. The Government will hold the Contractor financially liable for any damage to the facilities or equipment that may result from carelessness or insufficient attention to relevant best practices.

C.2.3.2.3 Maintenance Support

The Contractor shall coordinate turning over maintenance management and operations to Government personnel or other Contractors at the new locations. This shall include the transfer of hardware warranties and software licenses and all System/Equipment documentation required to install, operate, maintain, and administer systems and equipment.

C.2.4   Transition of Government Records and Files

The Contractor shall ensure the secure transition of Government records and files, to include Personally Identifiable Information (PII) and Protected Health Information (PHI). The handling of these records shall be in accordance with Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security requirements regarding health information as defined in this contract, and in DoD 6025.18-R and DoD 8580.02-R, as amended. Additional requirements shall be addressed when implemented.

C.2.5   Formal Testing and Calibration

The Contractor shall coordinate with the COR to identify participants in test activities for all equipment in the clinics and medical treatment facilities as well as the roles and responsibilities of each participant. The Contractor shall identify in a Test and Calibration Plan (Deliverable 4, described in Section C.3.4) the specific calibration and test procedures consistent with vendor/manufacturer recommendations. The Contractor shall coordinate with the COR to schedule test activities. In no event shall the Contractor commit Government resources to a test event or test schedule prior to Government approval.

C.2.6   Training

The training provided shall be in accordance with the approved Training Plan (Deliverable 5, described in Section C.3.5) and shall be sufficient to ensure patient and worker safety, to preserve all warranties, and to optimize the life of the equipment. Prior to final system installation and the acceptance phase of any project, the Contractor may be

required to assist the gaining unit in the coordination of the proper training and any needed certification of personnel assigned the responsibility of operating and maintaining the equipment. Training shall consist of equipment operation and maintenance, proper in-service training, or credentialing of equipment operators as appropriate to equipment and regulated use. The Contractor shall be prepared to assist in coordinating the provision of all training materials, student and instructor schedules and recording devices as required. Procedures for completion of the installation and testing services shall be in compliance with Joint Commission, NFPA, OSHA, ASHRAE, ADA and other DoD medical standards. The Contractor shall be required to coordinate with other contractors providing equipment to minimize potential schedule conflicts for training.

The Contractor shall work with the Government clinical, physician, and support service staff to develop the scenarios for, and facilitate "a day in the life exercise" for each operational group to orient them to the new facility, and make ready for the first day of operations.

C.2.6.1 Training Materials

Following Government approval of the Training Plan, the Contractor shall ensure that each vendor/equipment manufacturer provides the standard training materials, such as course objectives, student guides, course materials, training manuals, consumable supplies to facilitate training, distance learning tools and computer-based tools, as appropriate. All training materials shall be provided in reproducible format.

C.2.6.2 Training Presentation

The Contractor shall schedule and oversee the vendor/equipment manufacturer conduct of Government-approved training programs. Training may include train-the-trainer or training students. Following completion of the training, the Contractor shall document lessons learned in the next Monthly Progress Report (Deliverable 9, described in Section C.3.10) and modify the Training Plan and resources as appropriate for continued use by Government personnel providing additional training to required end-users. The Contractor shall provide all management, materials, tools, supervision, labor, and equipment to support the installation and testing of all equipment and/or systems prior to installation and/or after the equipment is installed, as appropriate. The Contractor shall certify that all equipment and system testing and installation are in accordance with the equipment manufacturer's recommendations.

C.2.7 Final Turnover and Close Out

The Contractor shall provide all management, materials, tools, supervision, labor, and equipment to facilitate the turnover of applicable documents, and close out the project.

For the new facilities (WRNMMC and FBCH), the Contractor shall input all provisioned and moved equipment information into the Government logistics automated information system (DMLSS), with oversight by the Government. Additionally, limited transition services from the Contractor shall be required during Post-Occupancy Evaluation (POE). The Contractor shall be required to participate in, and provide consultation to, the POE.

Upon completion of all contracted activities at each site, the Contractor shall provide formal notice of completion to the Government KO and COR.

The Contractor shall ensure all Government specific forms and documentation are completed and close out the project in accordance with Government requirements.

C.3.0 DELIVERABLES

C.3.1 Documentation Guidelines

Reports and documents delivered by the Contractor in performance of this contract shall be considered "Technical Data" as defined in the applicable "Rights in Data" clause of the General Provisions. All documentation shall reflect the latest version number, unless specifically directed otherwise by the Government. All documentation shall be

prepared in accordance with standard industry practices, ensuring electronically produced documents, which reflect logical flow of material, tables of contents, indexes and page numbering. Where applicable, the Contractor's attention is called to the availability of commercial, industry, federal, and military guides, instructions, and standards for many of the topics addressed in this contract.

The Contractor shall submit all deliverables for Government review and approval. Any revisions or modifications shall require subsequent Government review and approval.

C.3.2 Project Management Plan (Deliverable 1)

The Contractor shall submit a draft Project Management Plan with its Proposal for Government approval consistent with the terms specified in the contract. Following Government approval of this draft plan, the Contractor shall finalize this plan. The finalized plan shall be applied by the Contractor to manage, track, and evaluate the project or task performance. The Contractor shall provide a detailed description of their approach to manage hospital transition and activation services. The Project Management Plan shall consist of control policies and procedures in accordance with standard industry practices for project administration, execution, and tracking. In this plan, the Contractor shall describe its overall management approach, policies, and procedures, including suggested project metrics, as well as provide an overview of the following areas:

- The Contractor's approach to ensuring the orderly movement of medical and non-medical equipment (detailed steps and procedures to be provided in the Contractor's Movement Plan—Deliverable 1-A— Appendix A to the Project Management Plan)
- The Contractor's approach to transitioning all maintenance and operations of equipment to the Government. This shall include ensuring that all equipment warranties are maintained (detailed steps and procedures to be provided in the Contractor's Warranty Management Plan—Deliverable 1-B— Appendix B to the Project Management Plan).
- The Contractor's approach to staffing and Key Personnel assignment (organized by project phase; transition services, activation, and turnover in the Contractor's Staffing Plan—Deliverable 1-C— Appendix C to the Project Management Plan)
- The Contractor's approach to subcontract management (with specific goals for use of subcontractors, by role, in the efforts to be performed under this contract provided in the Contractor's Subcontract Management Plan—Deliverable 1-D—Appendix D to the Project Management Plan)
- The Contractor's approach to risk management (with schedule, cost and technical/management risks and detailing the Contractor's approach to addressing each of these clearly identified in a detailed Risk Management Plan—Deliverable 1-E—Appendix E to the Project Management Plan)

C.3.3   Standardization Plan (Deliverable 2)

The Contractor shall develop a Standardization Plan (Deliverable 2) documenting methodology to be used across the NCR that ensures the standardization and interoperability of medical equipment systems where appropriate.

C.3.4   Equipment Reuse Plan (Deliverable 3)

The Contractor shall develop an Equipment Reuse Plan (Deliverable 3) including phasing the de-installation, packing, delivery, and installation of all "re-used" medical and other equipment in coordination with new items as appropriate.

C.3.5   Test and Calibration Plan (Deliverable 4)

The Contractor shall develop a Test and Calibration Plan (Deliverable 4). In this plan, the Contractor shall ensure that all the Contractor's activities detailed under Section C.2.5 above are addressed. For each discrete event, the Contractor shall ensure that specific procedures are in place in accordance with manufacturer recommendations for all test participant categories. This plan shall identify who is responsible for executing the event, exactly what actions/processes are involved, how the event will be documented, and the required outcome.

C.3.6   Training Plan (Deliverable 5)

The Contractor shall plan for and coordinate formal training with each vendor/equipment manufacturer for new and reused equipment that is installed under this contract and detail its approach in a Training Plan (Deliverable 5). The Contractor shall ensure that a training schedule is developed which allows for each vendor/equipment manufacturer to train designated user and maintenance staff. The training plan shall ensure the coordination of the proper training and credentialing of personnel assigned the responsibility of operating and maintaining the equipment in the gaining units. Following Government approval of this plan, the Contractor shall develop a training program to specify training approaches, methods, schedules, tools, and curricula, and track the performance of all training related to the equipment moved or provisioned by the Contractor.

C.3.7   Tracking Tool User Manual (Deliverable 6)

The Contractor shall develop a Tracking Tool User Manual (Deliverable 6) that describes its existing inventory tracking system that has been tailored to meet the requirements of this contract. In this manual, the Contractor shall document for Government users all system capabilities and how to best access and display information such as item order date, quantity ordered, price (both list and final negotiated price), scheduled delivery date, and installation date. The procedures described shall allow Government representatives limited access to the data for review and verification.

C.3.8   Quality Control Plan (Deliverable 7)

The Contractor shall prepare and adhere to a Quality Control Plan (QCP) (Deliverable 7). The Government will approve the Contractor's plan, and the QCP shall be updated as necessary following award. The QCP shall document how the Contractor shall meet and comply with established quality standards. At a minimum, the QCP must include a Quality Assurance (QA) inspection plan, a QA staffing plan, and an outline of the procedures that the Contractor shall use to maintain quality, timeliness, responsiveness, customer satisfaction, and any other requirements set forth in this solicitation.

C.3.9   Integrated Master Schedule (IMS) (Deliverable 8)

The Contractor shall establish an integrated project schedule depicting for this task: milestones, dependencies, planned duration, planned start and finish dates, and associated resources. The schedule shall contain the planned events and milestones, accomplishments, exit criteria, and activities from contract award to the completion of the contract. The Contractor shall quantify risk in hours, days, or weeks of delay and provide optimistic, pessimistic, and most likely duration for each IMS milestone. The Contractor shall integrate its schedules with the Government-provided schedules of other Contractors, as appropriate. The integrated project schedule shall be compatible and coordinated with the JTF CapMed IMS and IM/IT Integrated Project Planning, Scheduling, and Reporting System (IPPSRS). Activities on the critical path shall be highlighted.

C.3.10   Monthly Progress Report (Deliverable 9)

The Contractor shall prepare and deliver monthly progress reports for the Government.

For equipment, the Monthly Progress Report (Deliverable 9) shall outline problems encountered and any schedule deviations. Similarly, for all deliverables, the Monthly Progress Report shall outline problems encountered and any schedule deviations. In particular, the Contractor shall identify events and actions that require substantial updates to any and all plans (Deliverables 1, 1-A, 1-B, 1-C, 1-D, 1-E, 2, 3, 4, 5, 6, 7, 8, 9,10, and 11) and shall submit an update of that plan together with the Monthly Progress Report.

The Monthly Progress Report shall measure the Contractor's price and schedule performance using the Government-approved WBS, and include a report on the critical path for the project and the current price and level of effort (e.g., equipment ordered).

For all services, the Monthly Progress Report shall measure the Contractor's cost and schedule performance, and shall include the current cost and level of effort (e.g., hours worked).

C.3.11   Subcontract Expenditures Report (Deliverable 10)

The Contractor shall prepare and deliver a Subcontract Expenditures Report (Deliverable 10) that discloses actual subcontract expenditures by company name and business or socioeconomic category (e.g., Woman Owned Business, Veteran Owned Business, Indian Incentive Program, Historically Black Colleges and Universities, Minority Institutions, etc.).

C.3.12   Tracking Tool Report (Deliverable 11)

The Contractor shall provide a Tracking Tool Report (Deliverable 11) to the Government monthly. The Contractor shall establish, maintain, and use in the performance of this contract, an integrated performance management system. To establish the integrated performance management system, the Tracking Tool shall be linked to and supported by the Contractor's management processes and systems to include the integrated master schedule, contract work breakdown structure, change management, material management, procurement, cost estimating, and accounting. The correlation and integration of these systems and processes shall provide for early indication of cost and schedule problems, and their relation to technical achievement.

The Contractor shall engage jointly with the Government's program manager in Integrated Baseline Reviews (IBRs) to evaluate the risks inherent in the contract's planned performance measurement baseline. Initially, this shall occur as soon as feasible but not later than six months after contract award, and subsequently, following all major changes to the baseline. Each IBR should verify that the Contractor is using a reliable performance measurement baseline, which includes the entire contract scope of work, is consistent with contract schedule requirements, and has adequate resources assigned. Each IBR should also record any indications that effective cost and schedule performance is not occurring. IBRs should also be conducted on subcontracts. The Prime Contractor shall lead the subcontractor IBRs, with active participation by the Government.

The Contractor shall require all subcontractors to furnish cost and schedule performance reporting, when appropriate, based on the dollar value. Each subcontractor's reported cost and schedule information shall be incorporated.

C.3.13   Schedule of Deliverables

The schedule of deliverables that the Contractor shall adhere to throughout the Period of Performance (POP) of this contract is shown in the table below.

Item	Ref	Title	Govt Approval and Acceptance Period	Dist	E	H	Initial	Subsequent
Deliverable 1	C.3.2	Project Management Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal	14 DACA* (Final) Every 6 MACA* (Updates)
Deliverable 1-A	C.3.2	Movement Plan	Y/10 Working Days, Final approval 5 days prior to execution	PM COR COTR KO	1 1 2 Letter	0 0 0 1	30 DACA	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 1-B	C.3.2	Warranty Management Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal	45 DACA (Final) Every 6 MACA (Updates)
Deliverable 1-C	C.3.2	Staffing Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal and follow-up 30 DACA	120 DACA (Final) As Required (Updates)
Deliverable 1-D	C.3.2	Subcontract Management Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal	75 DACA (Final) As Required (Updates)
Deliverable 1-E	C.3.2	Risk Management Plan	Y/10 Working Days	PM COR	1 1	0 0	With Proposal	90 DACA (Final) As Required

Item	Ref	Title	Govt Approval and Acceptance Period	Dist	E	H	Initial	Subsequent
				COTR KO	2 Letter	0 1		(Updates)
Deliverable 2	C.3.3	Standardization Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	45 DACA	120 DACA (Final) As Required (Updates)
Deliverable 3	C.3.4	Equipment Reuse Plan	Y/10 Working Days, Final approval 5 days prior to execution	PM COR COTR KO	1 1 2 Letter	0 0 0 1	30 DACA	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 4	C.3.5	Test and Calibration Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	90 DACA	120 DACA (Final)
Deliverable 5	C.3.6	Training Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	30 DACA	120 DACA (Final) Every 6 MACA (Updates)
Deliverable 6	C.3.7	Tracking Tool User Manual	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal	14 DACA (Final) Every 6 MACA (Updates)
Deliverable 7	C.3.8	Quality Control Plan	Y/10 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	With Proposal and follow-up 30 DACA	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 8	C.3.9	Integrated Master Schedule (IMS)	Y/10 Working Days	PM COR COTR	1 1 2	0 0 0	30 DACA	Every 6 MACA (Updates)

Item	Ref	Title	Govt Approval and Acceptance Period	Dist	E	H	Initial	Subsequent
				KO	Letter	1		
Deliverable 9	C.3.10	Monthly Progress Report	Y/5 Working Days	PM COR COTR KO	1 1 2 Letter	0 0 0 1	14 DACA	Monthly by the 8th day of the following month of the Contractor's fiscal calendar (Updates)
Deliverable 10	C.3.11	Subcontract Expenditures Report	Y/5 Working Days	PM COR COTR KO	1 1 2 1 plus Letter	0 0 0 1	14 DACA	Monthly by the 8th day of the following month of the Contractor's fiscal calendar (Updates)
Deliverable 11	C.3.12	Tracking Tool Report	Y/5 Working Days	PM COR COTR KO	1 1 2 1 plus Letter	0 0 0 1	14 DACA	Monthly by the 8th day of the following month of the Contractor's fiscal calendar (Updates)
Deliverable 12	H.9	Data Use Agreement Plan	Y/5 Working Days	COR AM	1 1	1 1	As required	Update as Required
*DACA Days After Contract Award								
*MACA Months After Contract Award								

C.4.0   OTHER TERMS, CONDITIONS, AND PROVISIONS

C.4.1   Contractor Personnel Performance/Replacement

For temporary and/or permanent replacement of Key Personnel (Project Manager and other positions designated by the Contractor as key), the Contractor shall provide a resume for each individual to the COR. Resumes shall be provided at least two weeks (or as mutually agreed upon) prior to making any personnel changes. Any replacement personnel shall have equal or better qualifications as the individual being replaced; the Government reserves the right to reject unqualified personnel. Also, Contractor personnel must submit necessary information to be granted access to Government systems prior to reporting for work under this contract.

C.4.2   Other Direct Costs (ODC)

Other Direct Costs are materials or services in direct support within the scope of fulfilling the requirement and are not the primary purpose of the contract. For this acquisition, ODCs will include any fixed-price subcontract. Other Direct Costs, other than travel, may include General and Administrative charges (G&A) or Material and Handling charges (M&H). Fee or profit is unallowable on any ODC.

Other Direct Costs shall be fully supported in compliance with all competition requirements of the FAR, specifically Part 31, "Contract Cost Principles and Procedures." The ODC charges received by the Contractor are subject to periodic Government conducted Defense Contract Audit Agency (DCAA) audits and to adjustment of the Final Contract Closeout Audit conducted by DCAA.

C.4.3   Access to Government Data Processing Equipment

It is expected that the Contractor shall have some level of interface (including, but not limited to data entry, validation and report querying) required with the DMLSS. This includes but is not limited to the facility management and equipment modules. Therefore, the Contractor shall provide, as required, personnel able to perform these tasks, including the ability to successfully pass any required background checks and possessing proof of United States citizenship.

C.4.4   Contractor Verification System (CVS) for Contractor at Government Facilities

Contractor shall comply with agency personal identity verification procedures identified in the contract that implement Homeland Security Presidential Directive-12 (HSPD-12), Office of Management and Budget (OMB) guidance M-05-24, and Federal Information Processing Standards Publication (FIPS PUB) Number 201.

The Contractor shall comply with agency personal identity verification procedures in all subcontracts when the subcontractor is required to have physical access to a federally-controlled facility or access to a Federal information system.

The Contractor shall ensure compliance with the provisions set forth below. For purposes of FAR Clause 52.204-9, the Government will designate a Trusted Agent (TA), and the Contractor shall designate a Facility Security Officer (FSO), for this contract. The Government reserves the right to amend or supplement these provisions pursuant to the Changes clause in the contract.

C.4.5   Quality Assurance

The Government will review Monthly Progress Reports and will attend regular task performance review meetings with the Contractor to survey quality of products and services.

C.4.5.1 Quality Assurance Surveillance Plan (QASP)

The Government intends to utilize a Quality Assurance Surveillance Plan (QASP) to monitor the quality of the Contractor's performance. The oversight provided for in the order and in the QASP will help to ensure that service levels reach and maintain the required levels throughout the contract term. Further, the QASP provides the COR with a proactive way to avoid unacceptable or deficient performance, and provides verifiable input for the required Past Performance Information Assessments. The QASP shall be finalized immediately following award and a copy provided to the Contractor after award. The QASP is a living document and may be updated by the Government as necessary.

C.4.5.2 Performance Requirements Summary Matrix

By monitoring the Contractor, the COR will determine whether the performance levels set forth in the order have been attained. Performance standards are specified in the following Performance Requirements Summary Matrix in the Standard and Acceptable Quality Level columns.

C.4.5.3 Performance Evaluation Process

The Contractor Performance Assessment Reporting System (CPARS) has been adopted by JTF CapMed to electronically capture assessment data and manage the evaluation process. CPARS is used to assesses a Contractor's performance and provide a record, both positive and negative, on a given contract during a specific period of time. The CPARS process is designed with a series of checks and balances to facilitate the objective and consistent evaluation of Contractor performance. Both Government and Contractor program management perspectives are captured on the CPARS form and together make a complete CPARS. Once the Assessing Official completes the proposed assessment for the period of performance, the CPARS is released to the appropriate Government Contractor Representative for review and comment. User ID and Password will be provided to the designated Government Contractor Representative upon contract award. The Contractor has 30 days after the Government's evaluation is completed to comment on the evaluation. The Government Contractor Representative must either concur or non-concur to each CPARS. If the Contractor concurs with the proposed assessment and the Reviewing Official does not wish to see the CPARS, the Assessing Official may close out the CPARS. Otherwise, the Contractor must forward the CPARS to the Reviewing Official for them to review, enter comments if appropriate, and close out. At the Reviewing Official's option direct the Assessing Official to forward every CPARS for review.

Task	Indicator	Standard	Acceptable Quality Level	Surveillance Method	Incentive
Hospital Transition and Activation Services and Project Management	Paragraph C.2.2 Contractor provides hospital transition services.	Qualified personnel are available and in location as needed to properly perform tasks as specified.	Contractor-provided staffing is qualified in sufficient quantities in all areas specified to ensure the quality delivery of all services specified in this task.	Feedback from Oversight Board, Direct Observation and 100% Inspection by COR	Favorable Past Performance Rating
Small Business Participation	Paragraph C.2.1 Utilization of Small Business	Small Business is utilized consistent with the Government-approved Small Business Subcontracting Plan	Small Business is utilized consistent with the Government-approved Small Business Subcontracting Plan	Review of quarterly small business utilization reports	Favorable Past Performance Rating

Comprehensive Equipment Services	Paragraph C.2.3 Comprehensive equipment services for both medical and non-medical equipment and systems.	Planning efforts are sufficient, timely, and accurate to support standardization and proper execution of all comprehensive equipment service tasks.	All Plans delivered reflect required lead-times and resource requirements to support standardization and comprehensive equipment services. All Plans contribute to meeting the specified start of healthcare delivery	100% inspection and assessment of all Planning deliverables by the COR Feedback from Government users of the various Plans delivered	Favorable Past Performance Rating
Equipment Provisioning and Associated Services	Paragraph C.2.3.1 Comprehensive equipment provisioning services for all identified equipment.	Provisioned equipment meets delivery schedule and operates as intended.	All provisioned equipment is correct, delivered on time, right quantity, undamaged, and operates as intended	Monthly Reports and 100% Inspection by the COR	Favorable Past Performance Rating
Equipment Transition and Relocation Services	Paragraph C.2.3.2 Comprehensive equipment transition and relocation services for all equipment and systems identified for reuse and/or relocation Equipment Reuse Plan (Deliverable 2).	Equipment transition and relocation activities are properly coordinated and accomplished to maintain property accountability.	All relocated equipment is properly moved without loss of accountability.	Monthly Reports and 100% Inspection by the COR	Favorable Past Performance Rating
Government Documents, Office Files, Official Records, and Non-Medical Equipment	Paragraph C.2.3.2.1 Secure transition of Government records and files, to include Personally Identifiable Information (PII) and Protected Health Information (PHI).	In accordance with HIPAA Privacy and Security requirements regarding health information as defined in this contract, and in DoD 6025.18-R and DoD 8580.02-R,	Secure transition of all Government records and files without loss or comprise for PII data.	Monthly Reports and 100% Inspection by the COR	Favorable Past Performance Rating

Formal Testing and Calibration	Paragraph C.2.5 Identify participants in test activities for all equipment in the clinics and medical treatment facilities. Coordinate with the COR to schedule test activities.	Coordination of Formal Testing and Calibration activities, documenting results consistent with OEM recommendations and Government requirements.	All required testing and calibration is completed, and documented consist with OEM recommendations and Government requirements on schedule.	Monthly Reports and 100% Inspection by the COR	Favorable Past Performance Rating
Training	Paragraph C.2.6 Provide training in accordance with the approved Training Plan.	Training sufficient to ensure proper use, patient and worker safety, preserve all warranties, and optimize the life of the equipment.	All designated staff trained according to approved Training Plan. No staff or patient safety issues caused by improper training. Warranties not compromised.	End User Feedback, Monthly Reports and 100% Inspection by the COR	Favorable Past Performance Rating
Final Turnover and Close Out	Paragraph C.2.7 Turnover of applicable documents, and close out the project.	Applicable project documents for the project are turned over to the Government to facilitate proper contract close out. All equipment information appropriately input into the Government Property Book (DMLSS). Consultation provided for the POE.	All management documentation and equipment is provided to the Government to complete the turnover and close out of the project. All equipment appropriately entered into the Government Property Book (DMLSS).	Monthly Reports and 100% Inspection by the COR Inspection of DMLSS Feedback from Property Book Officers.	Favorable Past Performance Rating

C.5.0   GOVERNMENT FURNISHED INFORMATION (GFI) Government Furnished
Information will be made available by DVD on request by submitting the signed Non Disclosure/Non-Use
Agreement, Government Furnished Information (Attachment 15), by email to Dean Engle,
dean.engle@amedd.army.mil.

- Architectural and engineering design drawings – North Project
- Construction Master Schedule – North Project
- Architectural and engineering design drawings – South Project
- Construction Master Schedule – South Project
- Transition Cells, Project Team, and Organizational Charts
- Joint Task Force Organizational Charts
- Work Planning Estimates – information on North and South Projects' square footage, staffing movement, and volume (net square footage) of files to be relocated

The following documents will be made available upon award
- Migration Plans
- Comprehensive Interior Design Package – North Project
- Comprehensive Interior Design Package – South Project
- Concept of Operations
- Program Integrated Master Schedule
- Equipment Descriptions
- Equipment List (Updated Versions of Attachments 1, 2, 3, and 4 based on 100% design)

C.6.0   APPLICABLE REGULATIONS AND MANUALS (Current Editions)

- American with Disabilities Act and Architectural Barriers Act Accessibility Guidelines
- ADA Standards for Accessible Design, Department of Justice, 28CFR Part 36
- ANSI C2 - 2007 - National Electrical Safety Code
- ANSI/IESNA RP-29-06 – Lighting for Hospital and Health Care Facilities
- ANSI/TIA/EIA 606 - Admin Standard for Telecomm Infrastructure of Commercial Buildings
- AR 420-1 Chapter 25, Section 2 Army Energy Program, Fire and Emergency Services
- Army and Navy Installation Information Infrastructure Architecture (I3A)
- Army and Navy Networthiness Checklist
- Illuminating Engineering Society of North America (IESNA) Lighting Handbook
- MIL-HDBK-411B - Power and the Environment for Sensitive DOD Electronic Equipment
- MIL-HDBK-419/1A - Grounding, Bonding and Shielding for Electronic Equipment and Facilities, Volume 1 of 2, Theory
- MIL-HDBK-419/2A - Grounding, Bonding and Shielding for Electronic Equipment and Facilities, Volume 2 of 2, Applications
- MIL-HDBK-411B – Power and the Environment for Sensitive DOD Electronic Equipment
- NFPA 1 Fire Protection Code
- NFPA 10 Standard for Portable Fire Extinguishers
- NFPA 30 Flammable and Combustible Liquid Code
- NFPA 70 - National Electrical Code
- NFPA 72 - National Fire Alarm Code
- NFPA 96 - Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations
- NFPA 99 - Standard for Health Care Facilities
- NFPA 101 - Life Safety Code
- The Joint Commission Accreditation Comprehensive Accreditation Manuals
- UFC 4-510-01 - Design: Medical Military Facilities

- UFC 4-021-01 - Design and O&M: Mass Notification Systems
- MIL-STD-1691 CONSTRUCTION AND MATERIAL SCHEDULE FOR MILITARY MEDICAL AND DENTAL FACILITIES http://www.wbdg.org/ccb/M1691/1691.pdf

C.7.0   ATTACHMENTS (SEE SECTION J)

ATTACHMENT 1
Medical Equipment to be Provisioned and Installed by the Contractor

ATTACHMENT 2
Non-Medical Equipment to be Provisioned and Installed by the Contractor

ATTACHMENT 3
Data Processing Equipment (IT) to be Provisioned and Installed by the Contractor

ATTACHMENT 4
Furniture and Furnishings to be Provisioned and Installed by the Contractor

ATTACHMENT 5
Other Contractor Provisioned and Installed Equipment (OCPIE)

ATTACHMENT 6
Reuse Equipment to be Uninstalled, Moved/Relocated, and Reinstalled by the Contractor

List of Acronyms

ADA	Americans with Disabilities Act
ANSI/EIA	American National Standards Institute/Electronic Industries Alliance –
AR	Army Regulation
ASHRAE	American Society of Heating, Refrigeration, Air Conditioning Engineers
CAVS	Certified Administrator of Volunteer Services
CD	Compact Disk
CHESP	Certified Healthcare Environmental Services Professional
CHFM	Certified Healthcare Facility Manager
CLIN	Contract Line Item Number
CMM	Certified Medical Manager
CMRP	Certified Materials & Resources Professional
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CPHRM	Certified Professional in Healthcare Risk Management
CVS	Contractor Verification System
DACA	Days After Contract Award
DCAA	Defense Contract Audit Agency
DFARS	Defense Federal Acquisition Regulation Supplement
DIACAP	Defense Information Assurance Certifications and Accreditation Process
DMLSS	Defense Medical Logistics Standard Support
DoD	Department of Defense
FAR	Federal Acquisition Regulation
FBCH	Fort Belvoir Community Hospital
FIPS PUB	Federal Information Processing Standards Publication
FSO	Facility Security Officer
G&A	General and Administrative
GFE	Government Furnished Equipment
GFI	Government Furnished Information
GME	Graduate Medical Education
HBCUs	Historically Black Colleges and Universities
HIPAA	Health Insurance Portability and Accountability Act
HSPD	Homeland Security Presidential Directive
I3A	Installation Information Infrastructure Architecture
IBRs	Integrated Baseline Reviews
IESNA	Illuminating Engineering Society of North America
IIP	Indian Incentive Program
IM/IT	Information Management/ Information Technology
IMS	Integrated Master Schedule
IO	Initial Outfitting
IO&T	Initial Outfitting and Transition
IPPSRS	Integrated Project Planning, Scheduling, and Reporting System
IPR	Interim Program Review
IT	Information Technology
JIT	Just in Time
JSN	Joint Schedule Number
JTF CapMed	Joint Task Force NCR - Medical
KO	Contracting Officer
M&H	Material and Handling
MACA	Months After Contract Award
MIS	Minority Institutions
NCR	National Capital Region

NFPA	National Fire Protection Association
O&M	Operations and Maintenance
OCPIE	Other Contractor Provisioned and Installed Equipment
ODC	Other Direct Costs
OEM	Original Equipment Manufacturer
OMB	Office of Management and Budget
OSHA	Occupational Safety and Health Act
PDF	Portable Document Format
PHI	Protected Health Information
PII	Personally Identifiable Information
PM	Project Manager
PMO	Project Management Office
POE	Post-Occupancy Evaluation
POP	Period of Performance
PWS	Performance Work Statement
QCP	Quality Control Plan
RFID	Radio-frequency identification
RFP	Request for Proposal
TA	Trusted Agent
TIA	Telecommunications Industry Association
UFC	Unified Facilities Criteria
USAMRAA	U.S. Army Medical Research Acquisition Activity
VOB	Veteran Owned Business
WBS	Work Breakdown Structure
WOB	Woman Owned Business
WRNMMC	Walter Reed National Military Medical Center

Glossary of Terms

Acculturation - Cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture; *also*: a merging of cultures as a result of prolonged contact.
Source: **http://www.merriam-webster.com/dictionary/acculturation**

Campaign Plan - (DOD) A joint operation plan for a series of related major operations aimed at achieving strategic or operational objectives within a given time and space. Source: DOD Dictionary of Military and Associated Terms. US Department of Defense 2009.

Campaign Planning - (DOD) The process whereby combatant commanders and subordinate joint force commanders translate national or theater strategy into operational concepts through the development of an operation plan for a campaign. Campaign planning may begin during contingency planning when the actual threat, national guidance, and available resources become evident, but is normally not completed until after the President or Secretary of Defense selects the course of action during crisis action planning. Campaign planning is conducted when contemplated military operations exceed the scope of a single major joint operation. Source: DOD Dictionary of Military and Associated Terms. US Department of Defense 2009.

Center of Gravity - The source of power that provides moral or physical strength, freedom of action, or will to act. (JP 3-0, 13 Feb 2008)

Clinical Transitioning - Ensuring that people, processes, and technology come together in a way that provides seamless, effective, high-quality care, from day one of occupancy in the new location. Source: Booz, Allen, Hamilton JTF CAPMED Transition War-game Final Report Mar 2009

Current Operations Division - The Readiness arm of JTF CAPMED and J3 Healthcare Operations Directorate. Source: JTF

Decisive Point - (joint) A geographic place, specific key event, critical factor, or function that, when acted upon, allows commanders to gain a marked advantage over an adversary or contribute materially to achieving success. Source: JP 3-0, 13 Feb 2008 [Note: In this context, adversary also refers to enemies.]

Defense Medical Human Resources System Internet - (DMRSi) Personnel system used by the Human Resources community to support personnel actions for JTF personnel throughout the JOA. Source: DOD

DOTMLPF - An acronym standing for doctrine, organization, training, materiel, leadership and education, personnel, and facilities. This is the same solution tool that joint planners use in the Joint Capabilities Integration Development system (JCIDS) and is in alignment with the Joint Staff and Echelon I commands. CJCS 3170.O1F JCIDS explains how DOTMLPF is used when validating capabilities requests and is located at www.dtic.mil/cjcs_directives/cdata/unlimit/3170_01.pdf.

joint doctrine – Fundamental principles that guide the employment of US military forces in coordinated action toward a common objective. Though neither policy nor strategy, joint doctrine serves to make US policy and strategy effective in the application of US military power. Joint doctrine is based on extant capabilities. Joint doctrine is authoritative guidance and will be followed except when, in the judgment of the commander, exceptional circumstances dictate otherwise. (CJCSI 5120.02)

joint organization - A [joint] unit or element with varied functions enabled by a structure through which individuals cooperate systematically to accomplish a common mission and directly provide or support [joint] warfighting capabilities. Subordinate units/elements coordinate with other units/elements and, as a whole, enable the higher-level [joint] unit/element to accomplish its mission. This includes the joint manpower (military, civilian, and contractor support) required to operate, sustain, and reconstitute joint warfighting capabilities.

joint training – Training, including mission rehearsals, of individuals, units, and staffs using joint doctrine or joint tactics, techniques, and procedures to prepare joint forces or joint staffs to respond to strategic, operational, or tactical requirements considered necessary by the combatant commanders to execute their assigned or anticipated missions.

joint materiel – All items (including ships, tanks, self-propelled weapons, aircraft, etc., and related spares, repair parts, and support equipment, but excluding real property, installations, and utilities) necessary to equip, operate, maintain, and support [joint] military activities without distinction as to its application for administrative or combat purposes.

joint leadership and education – Professional development of the joint commander is the product of a learning continuum that comprises training, experience, education, and self-improvement. The role of Professional Military Education and Joint Professional Military Education is to provide the education needed to complement training, experience, and self-improvement to produce the most professionally competent individual possible.

joint personnel – The personnel component primarily ensures that qualified personnel exist to support joint capabilities. This is accomplished through synchronized efforts of joint force commanders and Service components to optimize personnel support to the joint force to ensure success of ongoing peacetime, contingency, and wartime operations.

joint facilities – Real property consisting of one or more of the following: a building, a structure, a utility system, pavement, and underlying land. Key facilities are selected command installations and industrial facilities of primary importance to the support of military operations or military production programs. A key facilities list is prepared under the policy direction of the Joint Chiefs of Staff.

Enculturate - The process by which an individual learns the traditional content of a culture and assimilates its practices and values
Source: **http://www.merriam-webster.com/dictionary/acculturation**

Fort Belvoir Community Hospital – A new hospital on the grounds of Fort Belvoir, Virginia projected to open in 2011. It will replace the Dewitt Army Community Hospital and serve as one of two fully joint military medical treatment facilities in the NCR. Source: JTF

Full Operating Capability - (DoD) acquisition term to depict when a specific activity reaches maturity.
Source: Defense Acquisition Guidebook and
 http://acronyms.thefreedictionary.com/Full+Operational+Clearance
The full capability to employ effectively a weapon, item of equipment, or system of approved specific characteristics, which is manned and operated by a trained, equipped, and supported military force. This date will be based on when all the new systems have been produced, handed off to the using units, and those units have attained the capability to use the system in an operational sense. Source: Joint Pub 1-02

Guaranteed Placement Program - A Civilian personnel initiative intended to assure continued employment for existing civilian work force throughout and after the transition process. Source: JTF

Integration - The act or process of making whole. The JTF Integration Division (J5I) is assigned to the JTF CAPMED Plans and Policy Directorate. Source: Merriam-Webster Dictionary Online n the MTP, integration refers to the acculturation of people, processes and services into one integrated healthcare facility or network.

Integrated Master Schedule – A project schedule that aggregates and integrates all the detail, discrete work and planning activities supporting the execution of events and leading to the successful transition of WRAMC to the new WRNMMC and FBCH. The JTF IMS assimilates and tracks milestones and tasks from multiple schedules, including geographic and JTF functional schedules into one master schedule. Source: Booz, Allen, Hamilton. Or The compilation of five-separate schedules and the subsequent development of the interdependencies between those schedules. The schedules are based upon a tested BRAC methodology that tracks activities at moving and gaining functions. The five project schedules are: WRAMC Moves, NNMC Moves, WRNMMC

Gains, DACH Moves and FBCH Gains. (Also called IMS.) Source: 2721 Milestone Schedule Report & 8020 Restriction Waiver v.37 released by CJTF Mar 09

Initial Operating Capability - The first attainment of the capability to employ effectively a weapon, item of equipment, or system of approved specific characteristics that is manned or operated by an adequately trained, equipped, and supported military unit or force. Also called IOC. Source: JP 1-02,

Joint Operation Planning Process - (DOD) An orderly, analytical process that consists of a logical set of steps to analyze a mission; develop, analyze, and compare alternative courses of action against criteria of success and each other; select the best course of action; and produce a joint operation plan or order. Also called JOPP. See also joint operation planning; Joint Operation Planning and Execution System**.** Source: DOD Dictionary of Military and Associated Terms. US Department of Defense 2009

Joint concept - Links strategic guidance to the development and employment of future joint force capabilities and serve as "engines for transformation" that may ultimately lead to doctrine, organization, training, materiel, leadership and education, personnel and facilities (DOTMLPF) and policy changes.

Joint Operations Area - An area of land, sea, and airspace, defined by a geographic combatant commander or subordinate unified commander, in which a joint force commander (normally a joint task force commander) conducts military operations to accomplish a specific mission. Also called JOA. Source: JP 1-02 For the JTF CAPMED that area bounded by the NCR TRICARE Sub-regions of the JTF CAPMED Military Medical Units.

Joint Task Force National Capital Region Medical - JTF CAPMED is a standing joint task force reporting to the Secretary of Defense through the Deputy Secretary of Defense charged with delivering integrated healthcare in the NCR, ensuring readiness, and executing BRAC business plans necessary to transition the current four NCR military hospitals into the new world-class hospitals and developing a single, integrated medical culture throughout the NCR. JTF CAPMED achieved fully operational capable status on 30 Sep 08 and is headquartered in Bethesda, Maryland. Source: DOD

Joint Table of Distribution - A manpower document that identifies the positions and enumerates the spaces that have been approved for each organizational element of a joint activity for a specific fiscal year (authorization year), and those spaces which have been accepted for planning and programming purposes for the four subsequent fiscal years (program years). Also called JTD Source: http://www.js.pentagon.mil/doctrine/

Line of Effort – A line that links multiple tasks and missions using the logic of purpose—cause and effect—to focus efforts toward establishing operational and strategic conditions. Source: JP 3-0, 13 Feb 2008

Line of Operations - (DOD) 1. A logical line that connects actions on nodes and/or decisive points related in time and purpose with an objective(s). 2. A physical line that defines the interior or exterior orientation of the force in relation to the enemy or that connects actions on nodes and/or decisive points related in time and space to an objective(s). (Also called LOO.)   Source: JP 3-0. DOD Dictionary of Military and Associated Terms. US Department of Defense 2009.

Master Transition Plan – A plan to master seamless coordinated transition for the formation of the WRNMMC, standup of the new regional FBCH, and closures of WRAMC, NNMC and MGMC. Meets Congressional reporting requirements of NDAA 2008 and 2009 (Also called MTP) Source: CJTF CAPMED Info Memo dated 21 Jan 09.

Measure of Effectiveness - (Joint) A criterion used to assess changes in system behavior, capability, or operational environment that is tied to measuring the attainment of an end state, achievement of an objective, or creation of an effect. Source: JP 3-0, 13 Feb 2008

Measure of Performance - (Joint) A criterion used to assess friendly actions that is tied to measuring task accomplishment. Source: JP 3-0, 13 Feb 2008

Medical Treatment Facility - A military medical center, hospital or clinic providing healthcare to military personnel, retired military, and their eligible family members. Source: DoD

Mission Statement - A short sentence or paragraph that describes the organization's essential task (or tasks) and purpose-a clear statement of the action to be taken and the reason for doing so. The mission statement contains the elements of who, what, when, where, and why, but seldom specifies how. Source: JP 1-02,

National Capital Region – The NCR JOA comprises roughly 2,500 square miles and consists of the District of Columbia; Montgomery and Prince Georges Counties in Maryland; Arlington, Fairfax, Loudoun, and Prince William Counties in Virginia.
As defined in the National Planning Act, the "NCR" means -.
 (A) the District of Columbia;
 (B) Montgomery and Prince Georges Counties in Maryland;
 (C) Arlington, Fairfax, Loudoun, and Prince William Counties in Virginia;
 (D) all cities in Maryland or Virginia in the geographic area bounded by the outer boundaries of the combined area of the counties listed in subparagraphs (B) and (C). Source: TITLE 40 > SUBTITLE II > PART D > CHAPTER 87 > SUBCHAPTER I > § 8702Prev | Next § 8702.

National Defense Authorization Act (FY08), Section 1674.
'Requires that the funds available for Walter Reed Army Medical Center for a fiscal year be the same amount as that expended by the commander of the Center in FY2006 until the Secretary submits to the defense and appropriations committees a plan for the provision of health care for military beneficiaries and their dependents in the National

Capital Region. Requires the Secretary to certify to such committees, on a quarterly basis, that Walter Reed's patients, equipment, and administrative functions have not been moved or disestablished until the expanded facilities at the National Naval Medical Center, Bethesda, Maryland, and DeWitt Army Community Hospital, Fort Belvoir, Virginia, have sufficient staff, equipment, and capacity to provide at least the same level of care provided at Walter Reed during FY2006.'

National Defense Authorization Act (FY09), Section 2721 – Conditions on Closure of Walter Reed Army Medical Hospital and Relocation of Operations to National Naval Medical Center and Fort Belvoir.
'This section would direct the Department of Defense to cease construction beyond work necessary to complete the foundation of the replacement facilities until the Secretary of Defense certifies the following items have been completed: 90 percent of the construction design; an independent cost estimate to complete the realignment of the Walter Reed Army Medical Center; and a milestone schedule to complete the proposed realignment.'
'The committee remains committed to implementing the Department's goal of transforming the National Capitol Region Health Care System into a world class medical center at the hub of our nation's premiere regional health care system serving our military and our nation. As such, it is critical to ensure that this vision is integrated into the ongoing design and construction required of the realignment of the Walter Reed Army Medical Center. Therefore, the committee believes that a higher level of design is required before vertical construction commences, better cost controls are implemented, and a comprehensive schedule is complete to ensure a seamless transition from existing capabilities into a world class medical system.'

Operational control - Command authority that may be exercised by commanders at any echelon at or below the level of combatant command. Operational control is inherent command. Operational control is the authority to perform those functions of command over subordinate forces involving organizing and employing commands and forces, assigning tasks, designating objectives, and giving authoritative direction necessary to accomplish the mission. Operational control includes authoritative direction over all aspects of military operations and joint training necessary to accomplish missions assigned to the command. Operational control should be exercised through the commanders of subordinate organizations. Normally this authority is exercised through subordinate joint force commanders and Service and/or functional component commanders. Operational control normally provides full authority to organize commands and forces and to employ those forces as the commander in operational control considers necessary to accomplish assigned missions; it does not, in and of itself, include authoritative direction for logistics or matters of administration, discipline, internal organization, or unit training. Also called OPCON.

Paralympics - Multi-sport events for athletes with physical and visual disabilities. Source: JTF

Physical Transitioning - Managing the activities associated with the "physical" move of patients, people, furnishings, and equipment to receiving locations. Source: Booz, Allen, Hamilton JTF CAPMED Transition War-game Final Report Mar 2009

Program for Design - The PFD is a document that lists every space within the proposed medical facility. The PFD is organized by Department and then by major functional area or sub-department. Each line item within the document indicates the "official" name of the space, the unit size of that space, the number of spaces being allocated to the applicable department and section, the number of anticipated occupants assigned to each space, programmer comments/remarks and the codes that in turn relate to the MFRCL (room contents list) and room design criteria. The PFD is the base document that converts the operational needs of the medical organization into functional spaces that the Architectural Designer then uses to design the medical facility. Source: US Army Health Facility Planning Agency

Strategic Communication - Communicating a concept, a process, or data that satisfies an organization's goals or objectives to coordinate actions and activities of an operationally significant nature. Source: JTF

Tactical control - Command authority over assigned or attached forces or commands, or military capability or forces made available for tasking, that is limited to the detailed direction and control of movements or maneuvers within the operational area necessary to accomplish missions or tasks assigned. Tactical control is inherent in operational control. Tactical control may be delegated to, and exercised at any level at or below the level of combatant command. Tactical control provides sufficient authority for controlling and directing the application of force or tactical use of combat support
assets within the assigned mission or task. Also called TACON.

Transformation - Creating the future of warfare and national defense while improving how the department, and all of its various parts, does business in order to support and sustain our position as the world's pre-eminent military power within current and expected resource limits.
Source: **http://www.gao.gov/cghome/2003/hscek/text18.html**

Transition - Transition as referred to in the MTP is the actual movement through phase of patients, staff, equipment and services from WRAMC to WRNMMC and FBCH. Transition planning ensures that people, processes and technology come together to provide seamless, effective, high quality care, from day one of occupancy in the new location.

Transition Phase.
The period of activity within the National Capital Region Medical from current state until Full Operational Capability (FOC) status, on 15 September 2011.

Unit Identification Code — A six-character, alphanumeric code that uniquely identifies each Active, Reserve, and National Guard unit of the Armed Forces. Also called UIC.

Walter Reed National Military Medical Center - A World-class, jointly-manned military medical center on the Bethesda, Maryland campus replacing both the Walter Reed Army Medical Center and National Naval Medical Center and will serve as the cornerstone for military healthcare. Source: JTF

Warriors in Transition - (Army) Warriors in Transition are Active or Reserve Component Soldiers who meet the appropriate criteria to fall under the provisions for assignment or attachment to the Warrior Transition Units (WTUs). Source: Army Warrior Care & Transition Plan Information Paper (2008).
http://www.army.mil/aps/08/information_papers/sustain/Army_Warrior_Care.html

Warrior in Transition Unit - (Army) The focus of the Warriors in Transition Units are Soldiers who were wounded, ill or injured in theater and /or with complex medical requirements that require intensive case management. Warriors in Transition do not include Initial Entry Training, Advanced Individual Training, or One Station Unit Training Soldiers except in extraordinary circumstances. Exceptions to this definition must be approved by the local military treatment facility and the Soldier's unit commander. The continuum of care includes family members and both Department of Veterans Affairs and civilian healthcare providers. Source: Army Warrior Care & Transition Plan Information Paper (2008)
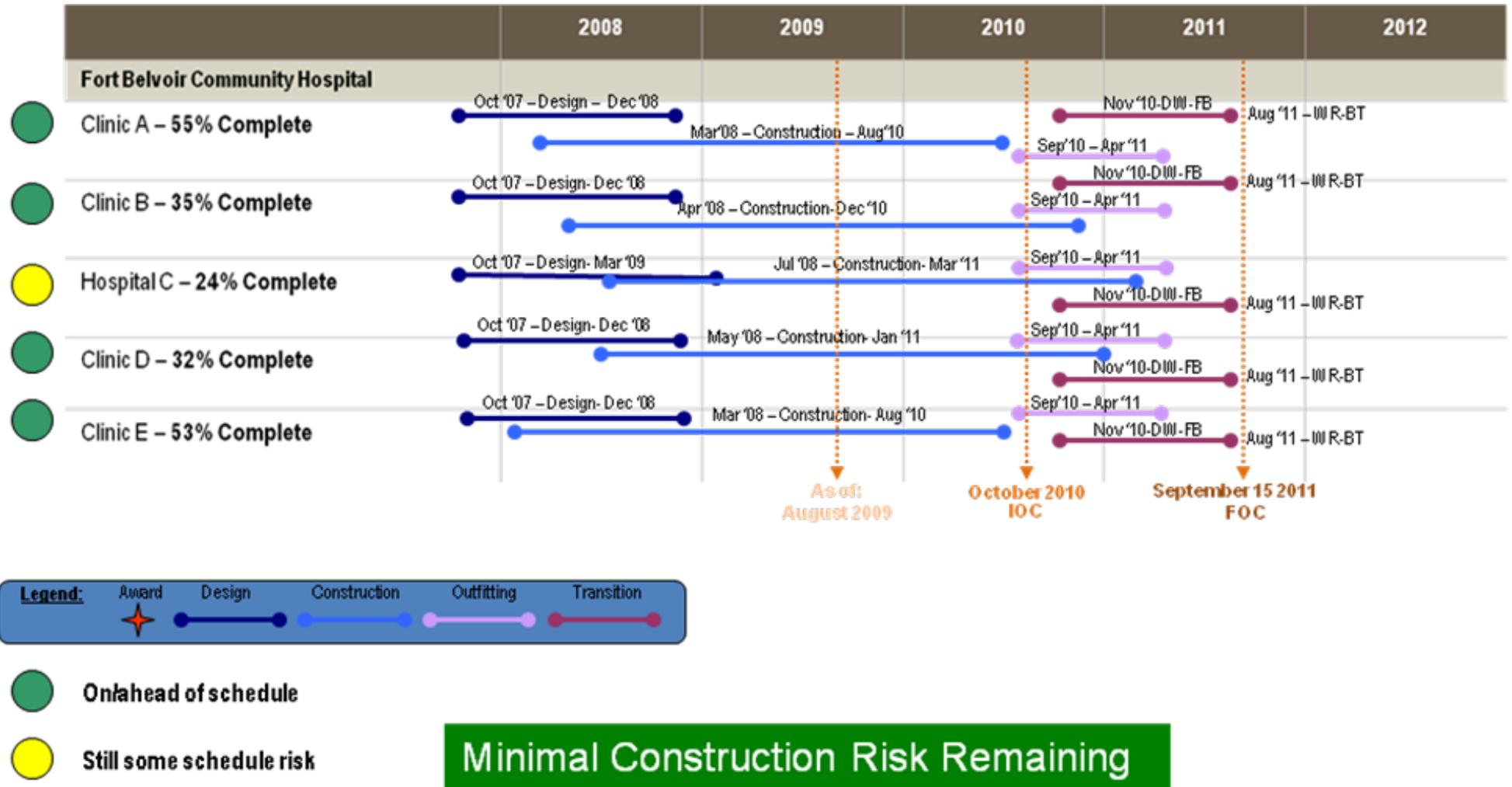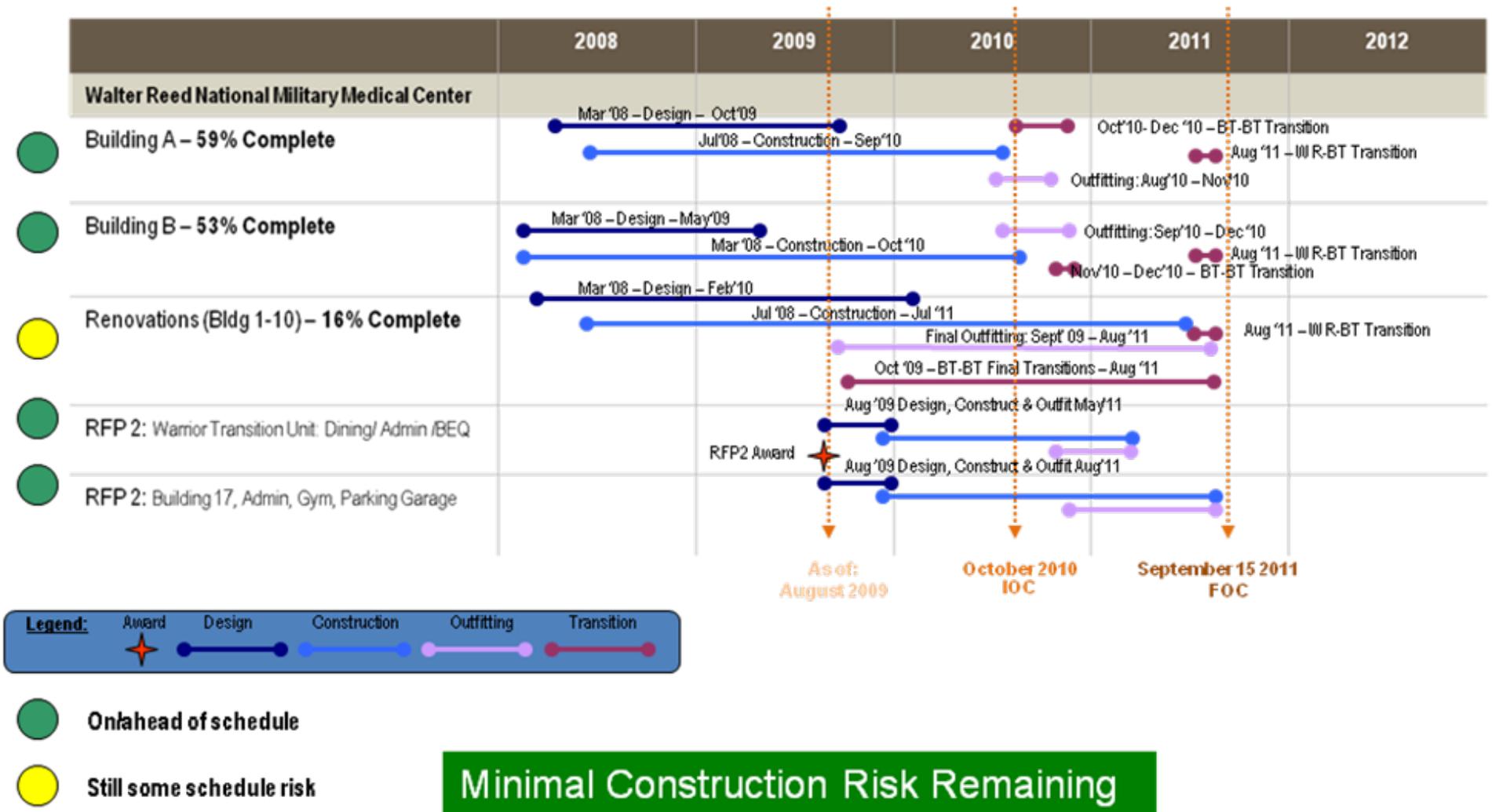**http://www.army.mil/aps/08/information_papers/sustain/Army_Warrior_Care.html**

APPENDIX B

JTF CAPMED CONSTRUCTION AND TRANSISTION SCHEDULE
as of 9/22/09

Planning dates projected / actual dates dependent upon pending contractual action(s)

	2008	2009	2010	2011	2012

Fort Belvoir Community Hospital

Clinic A – 55% Complete
Oct '07 – Design – Dec '08
Mar '08 – Construction – Aug '10
Sep'10 – Apr '11
Nov '10-DW-FB
Aug '11 – WR-BT

Clinic B – 35% Complete
Oct '07 – Design- Dec '08
Apr '08 – Construction- Dec '10
Sep'10 – Apr '11
Nov '10-DW-FB
Aug '11 – WR-BT

Hospital C – 24% Complete
Oct '07 – Design- Mar '09
Jul '08 – Construction- Mar '11
Sep'10 – Apr '11
Nov '10-DW-FB
Aug '11 – WR-BT

Clinic D – 32% Complete
Oct '07 – Design- Dec '08
May '08 – Construction- Jan '11
Sep'10 – Apr '11
Nov '10-DW-FB
Aug '11 – WR-BT

Clinic E – 53% Complete
Oct '07 – Design- Dec '08
Mar '08 – Construction- Aug '10
Sep'10 – Apr '11
Nov '10-DW-FB
Aug '11 – WR-BT

As of:
August 2009

October 2010
IOC

September 15 2011
FOC

Legend: Award Design Construction Outfitting Transition

On/ahead of schedule

Still some schedule risk

Minimal Construction Risk Remaining

Planning dates projected / actual dates dependent upon pending contractual action(s)

JTF CAPMED
FBCH Clinics List
February 2009

Clinic A:
Admin (Beh & Children's Health Svcs)
Children's Behavioral Health
Chiropractics
Family Advocacy
General Internal Medicine
Occupational Therapy
Outpatient Integrated Adult
Pediatric Partial Hospitalization
Pediatrics (Gen & Sub-Spec.)

Clinic B:
Allergy & Immunology
Cardiology
Cardiothoracic Surgery
Cardiovascular & Pulmonary Admin
Community Health Nursing
Family Practice
GI & Virtual Colonoscopy
Occupational Health
Orthopedics & Podiatry
Orthotics & Prosthetics
Physical Medicine & Rehabilitation
Physical Therapy
Sports Medicine

Hosp C:
Admin
Anesthesia
Behavioral Health
Blood Donor Center
Breast Care Center
Care Clinical Care ICU & IMCU
Chapel and Pastoral
Clinical Pathology & Infectious Disease Lab
Clinical Pharmacy
Emergency Ambulance Services
Environmental Health
Fast Track Clinic
General OB/GYN
Health Physics & Radiation Safety
Hematology Oncology Pharmacy
Hospital Dentistry
Industrial Hygiene
Inpatient/Outpatient Pharmacy
Investigational Research
Labor & Delivery
Main Operating Room
Main Radiology Suite
Medical Library
Medical Oncology
Medical Surgical
Multidisciplinary Interventional Imaging
Nuclear Medicine
Nursery
Pediatric Inpatient
Preventive & Consultative Services
Residential Treatment Facility, Substance Abuse
Transfusion & Aphaeresis

Clinic D:
Audiology & Speech
Breast Care Center
DVBIC
ENT Otolaryngology
General Surgery
Nephrology
Neurology
Neurosurgery
Plastic Surgery
Radiation Oncology
Urology
VA Clinic

Clinic E:
Dermatology
Endocrinology Service
Infectious Disease
Ophthalmology
Optometry
Pulmonary
Respiratory Services
Rheumatology
Vaccine Healthcare Centers

JTF CAPMED
WRNMMC Clinics List
February 2009

Bldg A:

Adolescent Medicine
Adolescent Psych/Children's Beh Health
Adult Outpatient Beh. Health
Allergy
Amputee Care
Audiology Speech
Breast Care
Chiropractics
Dermatology
Early Intervention
Endocrinology
ENT or Otolaryngology
Exceptional Family Program
Family Health
GYN Oncology
Hematology Oncology
Hematology Oncology/Cancer Center
Immunization/Vaccine Healthcare
Internal Medicine
Neurology
Occupational therapy
Optometry
Orthopedics
Orthotic Prosthetics
Outpatient Pharmacy
Partial Hospitalization
Pathology Blood Lab
Pediatric Primary Care
Pediatric Subspecialties
Physical Therapy (Outpatient)
Podiatry
Prostate Center
Radiation Oncology
Rheumatology
Satellite Radiology

Bldg B:

Cardiac Cath
Cardio Thoracic Surgery
Cardiology
Critical Care/ICU
Diagnostic Imaging
Emergency Department
Radiographic Procedures
Surgical Anesthesia
Vascular Surgery

Ren. Bldg 1-8:

3-D Medical Apps
Family Advocacy
Health Physics
Infectious Disease
Ophthalmology

Ren. Bldg 9:

Anatomical Pathology
Anesthesia Pain Clinic
APU, MOR, PACU, Women's Invitro
Cardiac
Clinical Investigations Pharmacy
Clinical Pathology
GME
Infectious Disease Lab
Nephrology/Dialysis
OB/GYN
Pulmonary
Stone Center
Surgery (Gen, Neuro & Organ Transplant, Plastic, Urology, Oral)

Ren. Bldg 10:

Beh. Health Inpatient
Med/Surg Wards
Pediatric Inpatient
Physical Therapy Inpatient
Preventive & Consultative Psych
Secure Inpatient

Planning dates projected / actual dates dependent upon pending contractual action(s)