DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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

Dear Mr. Chairman:

Section 2714(a) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010 requires the Department to develop and implement a Comprehensive Master Plan to provide sufficient world-class military medical facilities and an integrated system of healthcare delivery for the National Capital Region (NCR). Section 2714(b) of the law requires the Department to submit this plan to Congress. In addition, page 368 of the Explanatory Statement accompanying the Defense Appropriations Act for FY 2010 Committee Print requests the Department to provide the implementation status of the findings and recommendations identified by the NCR Base Realignment and Closure (BRAC) Health Systems Advisory Subcommittee of the Defense Health Board's (DHB) independent review of DoD's plans for the new Walter Reed National Military Medical Center (WRNMMC), Bethesda and Fort Belvoir Community Hospital (FBCH), provided in July 2009.

Military medicine in the NCR incorporates many of the world-class attributes and capabilities as defined in the DHB panel's recently established standard. Today, the Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC) provide an exceptional quality of care, particularly to our nation's wounded returning from war. The majority of these transit through the NCR, and the most seriously injured receive inpatient care and rehabilitation within the NCR Military Treatment Facilities (MTFs).

The Department is grateful for the DHB panel's efforts in 2009 to define the attributes of a world-class medical facility and endorsed the specific recommendations the panel made for WRNMMC, Bethesda and FBCH to achieve this newly-defined standard in its October 15, 2009 submission to Congress. With few exceptions, the DHB panel found the plans for FBCH to meet the new world-class medical facility standard and the Department has made substantial progress in addressing the panel's recommendations for WRNMMC, Bethesda.

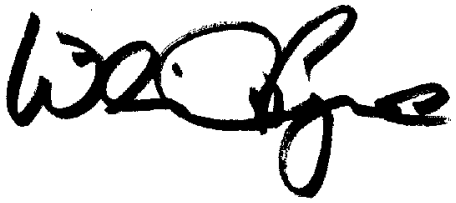
Letters sent to the Department from the Chairs and Ranking Members of the House Armed Services Committee Military Personnel and Readiness Subcommittees on January 22, 2010 and the Chair and Ranking Member of the House Appropriations Subcommittee on Defense on September 16, 2009 and November 17, 2009 expressed concern over the lack of a master plan that would achieve the standard defined in the NDAA for FY 2010. Since its October 15, 2009 submission, DoD has engaged in a Master Facilities Planning effort as part of its Comprehensive Master Plan for the National Capital Region Medical (CMP-NCRM) to refine and execute requirements to incorporate additional world-class capabilities.

The CMP-NCRM is a roadmap to achieve the additional world-class attributes the DHB panel identified, as incorporated in the NDAA for FY 2010 and Defense Appropriation Act for FY 2010 committee print. Among other items, the CMP-NCRM estimates the total cost of newly identified requirements associated with achieving the standard at Bethesda to be approximately $781M. Cost estimates have been developed by applying standard DoD construction cost factors and continue to be refined and integrated with the current NNMC Master Facility Plan.

The DHB panel identified authorities issues as "foundational" and recommended that "one official should be empowered with singular organizational and budgetary authority." The Department recognizes that it is essential to align command and control authorities, particularly as they relate to the assignment of Operational Control (OPCON) of Military Health System assets in the NCR, to allow the Commander, Joint Task Force National Capital Region Medical to effectively oversee the transformation and realignment in the region. The Department will provide OPCON of the WRAMC, NNMC and DeWitt Army Community Hospital (DACH) to the JTF CAPMED, and will provide JTF CAPMED with appropriate financial management controls. The CMP-NCRM defines the WRNMMC, Bethesda facilities and the relationship between the installation, Naval Support Activity Bethesda, and the Medical Center to ensure appropriate mission support.

The Department also provides two required certifications. It certifies that the new WRNMMC, Bethesda and FBCH construction will meet Joint Commission standards, as required by the NDAA for FY 2010. It also re-certifies that the closure of WRAMC will not result in a net loss of capacity in the NCR, as required under Section 1674(c) of the NDAA for FY 2008.

The Department expresses its appreciation to Congress for the steadfast interest and support throughout the transformation of military medicine in the NCR. Congressional oversight and actions have helped the Department with this complex process and have made immeasurable contributions to its ability to provide world-class healthcare. Next to the war itself, our Nation's wounded warfighters remain my top priority.



Enclosures
As stated

cc:
The Honorable John McCain
Ranking Member

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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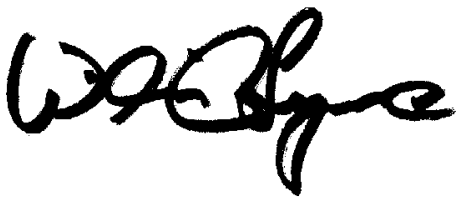

Enclosures
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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

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Enclosures
As stated

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

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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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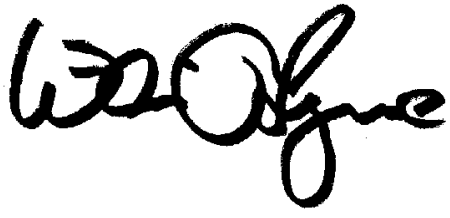

Enclosures
As stated

cc:
The Honorable Joe Wilson
Ranking Member

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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

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Enclosures
As stated

cc:
The Honorable Thad Cochran
Ranking Member

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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

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Enclosures
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

APR 23 2010

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

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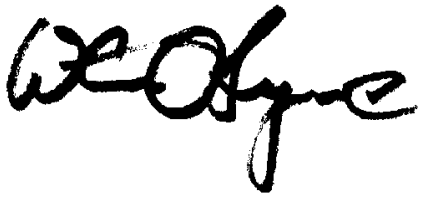
The Department also provides two required certifications. It certifies that the new WRNMMC, Bethesda and FBCH construction will meet Joint Commission standards, as required by the NDAA for FY 2010. It also re-certifies that the closure of WRAMC will not result in a net loss of capacity in the NCR, as required under Section 1674(c) of the NDAA for FY 2008.

The Department expresses its appreciation to Congress for the steadfast interest and support throughout the transformation of military medicine in the NCR. Congressional oversight and actions have helped the Department with this complex process and have made immeasurable contributions to its ability to provide world-class healthcare. Next to the war itself, our Nation's wounded warfighters remain my top priority.



Enclosures
As stated

cc:
The Honorable C.W. Bill Young
Ranking Member

ATTACHMENTS

Attachment 1:	JTF CAPMED Regional Healthcare Delivery Concept of Operation
Attachment 2:	JTF CAPMED September 2007 Establishment Document
Attachment 3:	Cultural Integration Recommendations White Paper
Attachment 4:	January 2009 Action Memo for the Personnel Structure of the NCR Medical
Attachment 5:	Operating Room Study
Attachment 6:	Emergency Room and Urgent Care Utilization and Cost Study
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20 Nov 07

JTF-CAPMED Regional Healthcare Delivery CONOPS

1. Purpose. This document provides the overarching concept for regional healthcare delivery within the Joint Operating Area (JOA) and provides the foundation for future work. It will be followed by an Execution Order (EXORD) which will drive a regional mission analysis and proposed courses of action. Collectively, this effort will chart our course as the nation's premier regional healthcare system.

2. Key Points

a. Effective 14 Sep 07, the Deputy Secretary of Defense established the Joint Task Force (National Capital Region) Medical (JTF CAPMED) and charged this organization with ensuring the effective and efficient delivery of world-class military healthcare within the National Capital Region (NCR) using all available military healthcare resources within the JOA.

b. JTF CAPMED will oversee a high quality, effective and efficient NCR healthcare delivery system dedicated to providing patient and family centered care that is convenient and accessible to our beneficiaries. The healthcare delivery system will have a strong regional perspective that prioritizes effectiveness first and then identifies efficiencies. Regional healthcare delivery will be accomplished by integrating and implementing evidenced based standards in all disciplines. This regional approach involves leveraging mutual support arrangements between adjacent and non-adjacent healthcare facilities and/or realigning JTF CAPMED resources to optimize regional capabilities.

c. Key Concepts are my published priorities:
- Casualty Care
- Caring for the Caregiver
- Be Ready Now
- Regional Healthcare Delivery
- Common Standards and Processes

3. Responsibilities

a. Leaders at all levels must understand we have a profound covenant with those entrusted to our leadership. We must view our roles and responsibilities from a holistic perspective, as well as consider what is most effective and efficient for our regional healthcare delivery system.

b. Our professional military and civilian force is now part of a regional integrated system, and their efforts impact their facility and the system as a whole.

c. Our path begins with responsible, accountable, covenant leadership supported by an informed, motivated, professional work force. I am excited about the unique opportunity before us and look forward to continuing our work as one team.

J.M. MATECZUN
Rear Admiral, U.S. Navy

Joint Task Force National Capital Region Medical
BETHESDA, MD
20 November 2007

Title: JTF CAPMED Regional Healthcare Delivery Concept of Operations

1. Situation. Effective 14 Sep 07, the Deputy Secretary of Defense established the Joint Task Force-National Capital Region/Medical (JTF CAPMED) and charged this organization with ensuring the effective and efficient delivery of world-class military healthcare within the National Capital Region (NCR) TRICARE Sub-region Joint Operation Area (JOA) using all available military healthcare resources within this JOA, and overseeing the consolidation and realignment of military healthcare within the JOA in accordance with the Base Realignment and Closure Act (BRAC) Business Plans 169 and 173E. JTF CAPMED will also conduct such other missions as may be assigned to improve the management, performance, and efficiency of the MHS.

a. Background: 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.

b. Conditions for implementation of the plan. JTF CAPMED achieved Initial Operational Capability (IOC) on 1 October 2007 and will achieve Full Operational Capability (FOC) not later than 30 September 2008.

c. Threat. The threat is a composite of ongoing or potential adversarial actions, conditions or attitudes that can reduce the effectiveness of this CONOPS.

(1) Time. We must focus our efforts, ensuring we optimize this limited commodity. We must not squander this narrow window of opportunity that has been entrusted to us to provide a model world class healthcare system for our beneficiaries and demonstrate the effectiveness of a JTF to direct regional healthcare.

(2) Stove Pipe Operations. The future of the Military Health System (MHS) lies in interoperability and cooperation among the Services, TRICARE Management Activity (TMA), and the Office of the Secretary Defense (Health Affairs). Each Service brings unique and critical capabilities, but they can only be as effective as the contribution they make to the overall mission. As members of the JTF CAPMED Team, we require an alignment of resources and processes to support the mission, vision and priorities; and an unprecedented level of teamwork aimed at giving our best for something larger than ourselves, putting aside personal ambition, ego and pride and embracing a joint view.

(3) Reluctance to Change. We must be willing to reinvent our way of doing business and center our thinking on interoperability, joint operations, and teamwork.

(4) Environment. Because of the existing and continuing possibility of the occurrence of large-scale natural, man-made, or technological disasters or emergencies within the JOA, we must be prepared to respond to, reduce vulnerability to, and recover from such emergencies or disasters. The MHS, within the JOA, must be coordinated with other local, state and federal governmental and non-governmental agencies to ensure the most effective preparation and use of manpower, resources, and facilities.

(5) Constrained Resources. Recognizing we operate in a constrained resource environment, we have an obligation to our beneficiaries and the American people to appropriately prioritize and optimally utilize our resources.

d. General tasks of friendly forces.

(1) Provide forces to create a world-class medical center at the hub of the Nation's premier regional healthcare system serving our military and our nation.

(2) Provide forces and resources to establish a fully operational Joint Task Force NCR Medical Headquarters capable of orchestrating the delivery of world-class healthcare within the JOA through a seamless integrated healthcare system supported by mission ready medical personnel.

(3) Ensure that all beneficiaries within the JOA receive world-class military healthcare services; and if called upon, the assigned forces are fully capable to command and control medical assets in support of other National Command Authority missions. The Joint Task Force Headquarters will accomplish this intent by overseeing, managing, synchronizing, distributing resources and directing all healthcare delivery, health professions education and research for military medical units within the JOA.

e. Friendly forces/relationships that will influence the plan. The following commands and organizations influence the implementation of this CONOPS. It is imperative that JTF CAPMED relationships enhance and promote coordination, instill an atmosphere of mutual support, and provide regional situational awareness.

(1) U.S. Department of Defense Health Affairs

(2) U.S. Department of Health and Human Services

(3) Veterans Health Administration

(4) U.S. Northern Command

(5) U.S. Reserve and National Guard

(6) The Office of the Surgeon General Office for each Service

(7) Bureau of Medicine and Surgery (BUMED)

(8) U.S. Army Medical Command (MEDCOM)

(9) Joint Forces HQ-National Capital Region

(10) U.S. Air Force, District of Washington (AFDW)

(11) Uniformed Services University of the Health Sciences

(12) Other federal, state and local agencies

f. Assumptions

(1) Capability for casualty care will be maintained and increased if necessary.

(2) The direct care system level of effort for delivery of services will otherwise be maintained as directed by BRAC and not increased in planning efforts.

(3) There will be centralized policy and planning and decentralized execution.

(4) Human and fiscal resources will be available to the NCR to meet the intent of this CONOPS.

(5) Services will meet staffing commitments and obligations within the NCR.

(6) JTF CAPMED will meet Full Operational Capability timelines.

(7) The Walter Reed National Military Medical Center (WRNMMC) and DeWitt Healthcare Network Transition plan will adequately address and ensure the maintenance of the current level of healthcare services throughout the transition.

(8) Healthcare services that we are not able to provide during the transition will be shifted to federal partnership facilities, private sector or network contractors.

(9) Base Realignment and Closure (BRAC) timelines will be met.

(10) JTF CAPMED will respond as part of a larger DOD and federal government response as authorized for specific types of emergencies or disasters. Medical Treatment Facility (MTF) commanders maintain authorities on local emergency response but will coordinate with the JTF.

g. Legal considerations. Frequent consultation with legal subject matter experts is critical to ensure adequate legal counsel in both the planning and execution phase on a wide variety of issues from civilian personnel law, contracting and fiscal law, environmental law, and healthcare law issues, amongst others.

(1) Authorities.

(a) Section 113, Title 10, United State Code.

(b) DOD Directive 5105.02, "Deputy Secretary of Defense," September 18, 2007.

(c) Deputy Secretary of Defense Memorandum SUBJECT: Establishing Authority for Joint Task Force - National Capital Region Medical (JTF CAPMED) and JTF CAPMED Transition Team (Unclassified), dtd 12 SEP 07.

(2) References.

(a) Deputy Secretary of Defense Memorandum SUBJECT: Implementation of the President's Commission on Care for America's Returning Wounded Warriors (The Dole/Shalala Report), dtd 29 AUG 07

(b) Joint Publication 1-02, Department of Defense Dictionary of Military and Associated Terms; dtd 12 April 2001 (As amended through 12 July 2007): OPCON (pg 391), ADCON (pg 6), TACON (pg 529).

(c) Joint Publication 3-33, Joint Task Force Headquarters, dtd16 February 2007, Chapter I, 1.a.

2. Mission: Deliver integrated healthcare in the NCR JOA, ensure readiness and disaster preparedness of the assigned forces, and execute the BRAC business plans to achieve a world-class medical center at the hub of the Nation's premier regional healthcare system serving our military and our nation.

3. Execution:

a. Who will be employed: The three Service component commands in the table of organization of JTF CAPMED are Navy Medicine National Capital Area (NMNCA) designated the Navy Component Command, 79th Medical Wing presently identified as the Air Force Component Command and North Atlantic Regional Medical Command (NARMC) presently identified as the Army Component Command.

b. Forces will be employed in the NCR JOA which includes those geographical areas and populations served by the Walter Reed Healthcare System (WRHCS), NMNCA, the 79th Medical Wing and all aligned health treatment facilities.

c. Timeline of JTF CAPMED milestones:

(1) CJTF-CAPMED will publish an EXORD that details the CONOPS Way Ahead NLT 30 working days from publication of this CONOPS.

(2) JTF-CAPMED Headquarters Full Operational Capability NLT 30 SEP 08.

(3) By 2011, in accordance with current BRAC law, the regional healthcare system will be supported by two new healthcare facilities. The current WRAMC main post is designated for closure, realigning its tertiary and complex care to NNMC Bethesda, establishing it as the Walter Reed National Military Medical Center Bethesda, MD. A new community hospital will be built on Fort Belvoir and the current DeWitt Army Hospital will be closed.

d. How forces are to be employed in the JOA:

(1) JTF CAPMED will guide a high quality, effective and efficient NCR healthcare delivery system dedicated to providing patient and family centered care which is convenient and accessible to our beneficiaries.

(2) The healthcare delivery system will have a strong regional perspective which prioritizes effectiveness first and identifies efficiencies. JTF CAPMED will be organized in such a manner to attain visibility of all regional healthcare resources. Access, capability, capacity and demand are primary considerations in maximizing our resources within the JOA.

(3) Regional healthcare delivery will be accomplished by integrating and implementing standards for clinical, operational and resource processes and procedures. Within access standards, the regional healthcare system will leverage mutual support arrangements between adjacent healthcare facilities. If these support arrangements cannot adequately address patient care needs, JTF CAPMED resources will be realigned to optimize the regional capabilities, and/or mutual support arrangements will be developed with the closest healthcare facility with the required capability. Complex care will be referred to the tertiary care facility when appropriate. Levels of care for planning purposes within the NCR are defined as:

(a) Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

(b) Secondary care is a service provided by healthcare specialists who generally do not have first contact with patients.

(c) Tertiary care is highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by healthcare specialists in a tertiary care center.

(d) A tertiary care center is a major hospital usually possessing a full complement of services such as pediatrics, general medicine, various branches of

surgery and psychiatry and where certain subspecialties could also be dedicated to specific subspecialty care such as oncology, neurosurgery, and/or trauma. Patients are often referred from smaller hospitals for major operations, consultations with sub-specialists, and when sophisticated intensive care facilities are required.

(4) JTF CAPMED headquarters staff is responsible for maintaining situational awareness, promoting effectiveness, assessing the impact of current operations on future plans and operations, implementing efficiencies within the JOA and recommending solutions to outside agencies and commands.

e. Conventional, nuclear, and other supporting operations:

(1) JTF CAPMED forces will rapidly respond in accordance with the President's and SECDEF's established priorities to assist civil authorities for domestic emergencies such as disasters and other activities that exceed the capability of civilian agencies.

(2) When directed, JTF CAPMED forces will rapidly respond to the Department of Homeland Security for domestic consequence management (CM) actions in order to maintain or restore essential services and manage and mitigate problems resulting from disasters and catastrophes, including natural, man-made, or terrorist incidents.

f. Deception: N/A

g. Tasks of each subordinate and supporting command:

(1) Provide widest dissemination of this Concept of Operations.

(2) Provide Subject Matter Experts (SMEs) to joint planning groups (JPGs) to operationalize the key concepts (specific instructions will be provided in the CONOPS Way Ahead EXORD).

h. Key concepts: See Tab A for examples of implied tasks/initiatives that may be derived from Key Concepts.

(1) Casualty Care

(a) Provide an integrated, seamless, continuum of high quality healthcare, supported by centers of knowledge and excellence, for all ill, injured or wounded service members from point of arrival in the JOA to point of departure. Included in this continuum are transition services within and external to the integrated healthcare system, while ensuring one standard of care for all Warriors in transition within the JOA.

(b) Leaders must be cognizant of the significant stressors associated with the delivery of compassionate casualty care and take appropriate measures in mitigation.

(2) Caring for the Caregiver

(a) We take care of each other as we take care of others by fostering a climate where there is a high situational awareness of the state of our fellow caregivers, in order to activate early warning systems to identify and assist those in need. We will take measures to incorporate resiliency into our daily routines.

(b) Create and maintain a productive, healthful, and caring work environment for our military, civilian and contract staff that provides opportunities for advancement, professional development and appropriate support services that promote physical, spiritual and mental well-being.

(c) Cultivate caregivers by ensuring high quality Health Professions Education (HPE) opportunities and cutting edge research that is linked and grounded with the needs of the population we serve and surrounded by a culture of cooperation and partnership with the non-military resources in our JOA.

(d) Leverage human capital through effective recruiting, retention and training programs for military and civilian personnel. Develop a mechanism to address as much as possible the employment uncertainties for the civilian workforce that may occur and mitigate/minimize the potential loss of a valuable and experienced civilian workforce.

(3) Be Ready Now

(a) Be prepared to deploy.

(b) Be poised to respond to local and national emergencies through interagency and intergovernmental coordination, planning, training, exercising, assessment, and information exchange.

(c) Develop a flexible, adaptable, competent, medically ready work force organized to meet clinical, operational and population demands across the regional healthcare system and other operational platforms.

(4) Regional Healthcare Delivery

(a) Implement regionally distributed delivery of healthcare services based on the mission and population requirements.

(b) Create a proactive patient and family centered integrated healthcare delivery system with uniform measures of quality and effectiveness across all healthcare disciplines through standardization of best practices, staff cross-utilization and information technology. This system must capitalize on the unique aspects of our military environment.

(c) Develop a proactive health promotion and prevention approach to population health based on research, health education, related organizational, social, economic, and health interventions.

(d) Create a patient centered responsive, strategic communications and customer service plan.

(e) Create a framework that addresses accountability for the JOA BRAC planning, coordination and resources.

(5) Common Standards and Processes

(a) Identify and incorporate evidence based methodologies, e.g. evidence based medicine, evidence based design and evidence based management; maximizing the regional healthcare delivery system with common standards, processes and policies centered on effectiveness with attention to patient safety and outcomes, clinical guidelines, operating rules, and quality standards.

(b) Migrate to common operating and administrative systems when feasible.

4. Administration and Logistics

a. Integrate administrative and logistical services and support within the JOA to maximize effectiveness of healthcare delivery and other critical operational requirements. The system shall implement efficiencies when identified.

5. Command and Control

a. Command relationships:

(1) JTF CAPMED is a fully functional standing Joint Task Force reporting directly to the Secretary of Defense (SECDEF) through the Deputy Secretary of Defense (DEPSECDEF)

(2) CJTF directly supervises the JTF Component Commanders within the JOA.

(3) CJTF CAPMED has Tactical Control (TACON) of the military medical units assigned or attached to the JTF (See Reference b).

(4) The Services retain operational and administrative control of the personnel assigned to JTF CAPMED (See Reference b).

b. Command and control requirements

(1) JTF CAPMED forces shall remain under military command and control in accordance with the National Response Plan (NRP) at all times during civil support operations.

TAB A – **EXAMPLES** OF IMPLIED TASKS/INITIATIVES THAT MAY BE DERIVED FROM KEY CONCEPTS AND ADMINSTRATIVE AND LOGISTIC SUPPORT

Joint Task Force National Capital Region Medical
BETHESDA, MD
20 November 2007

TAB A TO CONCEPT OF OPERATIONS
EXAMPLES OF IMPLIED TASKS/INITIATIVES THAT MAY BE DERIVED FROM KEY CONCEPTS AND ADMINSTRATIVE AND LOGISTIC SUPPORT (Not to be construed as a complete list of all tasks)

1. Casualty Care

- Distribute casualty care based on medical necessity.

- Distribute Warriors in transition and their families within the JOA based upon the needs of the Service members and their families.

- Develop a mechanism to provide total coordinated oversight of the Service member as he/she transitions through levels of care.

- Develop a coordinated MEB process.

- Capitalize on processes to evaluate and acquire new medical technology.

2. Caring for the Caregiver

- Develop, implement and sustain programs that address, prevent and/or treat "Compassion Fatigue," burnout and other assistance needs.

- Ensure the availability of sufficient support services such as childcare, counseling, nutrition, etc.

- Administer fair, equitable, predictable work schedules.

- Ensure adherence to fair labor practices.

- Ensure consistent sustainment training opportunities across all health professions to maintain currency.

- Support funding Continuing Education requirements.

- Determine and provide adequate healthcare support staff.

- Develop processes to alleviate administrative burdens.

3. Be Ready Now

- Develop a capability to monitor individual training and medical readiness across the JOA.

- Establish joint training opportunities that support readiness criteria of the Services.

- Establish and nurture partnerships between MTFs, local hospitals, and the emergency management community.

- Conduct routine coordination and exercising of contingency operations plans.

- Establish a healthcare operations center capability.

4. Regional Healthcare Delivery

- Develop a mechanism to align healthcare resources in response to population demand and HPE requirements.

- Establish the ability to monitor the same quality metrics for Inpatient and Outpatient across the JOA, whichever is applicable to the facility.

- Develop systems which allow for a seamless provider-patient encounter when practicing at any facility within the JOA.

- Establish a communication domain which will allow all authorized users within the JOA to access electronic health record information.

- Standardize the inpatient and outpatient medical records via a clinical informatics system such that one medical record is created.

- Develop common appointing and referral systems.

- Develop a strategic communications plan aimed at informing, improving, and meeting the needs of our beneficiaries.

- Develop common credentialing/privileging policies and procedures, healthcare staff development activities, and referral systems.

- Establish standardization of Centralized Credentials & Quality Assurance System (CCQAS).

- Develop a mechanism for credentialing of Reserve/National Guard providers prior to reporting for duty within the NCR.

5. Common Standards and Processes

- Establish common clinic Standing Operating Procedures (SOP), practices, and policies.

- Establish Standard Clinical Practice Guidelines.

- Establish common JOA healthcare operating rules.

- Establish common standardized research submission criteria.

6. Administrative Support

- Identify redundant support mechanisms and implement the most effective organizational structure.

- Develop an integrated business plan to support regional healthcare delivery.

- Consolidate or centrally contract the Third Party Collections (TPC) programs across MTFs.

- Develop an integrated set of manpower guidelines to facilitate staffing of the MTFs.

7. Logistic Support. Class VIII Supply Chain (SC) strategies must:

- Leverage the institutional and operational capabilities of best logistical business practices.

- Have flexibility to respond across the JOA.

- Have Joint Special Medical Augmentation Response Teams (SMART) Teams capable of rapid response and deployment supporting HLS, and other emergencies, to include support to civil authorities.

- Be capable of supporting all Service Components, and other designated government agencies.

- Facilitate standardization and interoperability of medical systems.

- Have joint equipping and acquisition strategies to optimize procurement success.

- Establish partnership with the Defense Logistics Agency (DLA) and the Defense Supply Center Philadelphia (DSCP) to obtain DLA stock fund accounts and access to standing acquisition programs.

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Attachment 8: Project Management Plan for Initial Outfitting and Transition Services for the JTF CAPMED North and South projects

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

SEP 12 2007

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
CHIEFS OF SERVICES
COMMANDERS OF THE COMBATANT COMMANDS
ASSISTANT SECRETARIES OF DEFENSE
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, ADMINISTRATION AND MANAGEMENT
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION
DIRECTORS OF THE DEFENSE AGENCIES

SUBJECT: Establishing Authority for Joint Task Force - National Capital Region/Medical (JTF CapMed) and JTF CapMed Transition Team (Unclassified)

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.

Effective 14 Sep 07, I am establishing JTF CapMed under the command of RADM John Mateczun, MC, USN, as delineated in Annex A and B. JTF CapMed will (1) ensure the effective and efficient delivery of world-class military healthcare within the NCR Tricare Sub-region (JOA) using all available military healthcare resources within this JOA, and (2) oversee the consolidation and realignment of military healthcare within the JOA in accordance with the Base Realignment and Closure Act (BRAC) Business Plan 169 and 173E. JTF CapMed will also conduct such other missions as may be assigned to improve the management, performance, and efficiency of the MHS.

Upon receipt of this memorandum, the current NCR Multiple Service Market Office (MSMO) and the NCR Medical BRAC Integration Office will merge to form the Transitional Element (TE) of JTF CapMed. RADM Mateczun will establish the Joint Table of Distribution (JTD) for the JTF Headquarters. Services will provide additional or alternate staffing as requested by the transition team or JTF.

I have tasked the Under Secretary of Defense for Personnel and Readiness and Vice Chairman, Joint Staff to oversee this effort within the Department. Tab A provides authorities, guidance, and immediate tasks to establish JTF CapMed. Tab B identifies the military units assigned to JTF CapMed.

Attachments:
As stated

TAB A

Final as of Signature Date

AUTHORITIES AND GUIDANCE FOR ESTABLISHING
JOINT TASK FORCE NATIONAL CAPITOL REGION MEDICAL (JTF CapMed)

1. **ESTABLISHMENT**. JTF CapMed will achieve Initial Operational Capable (IOC) not later than 1 October 2007 and Fully Operational Capable (FOC) not later than 30 September 2008.

a. JTF CapMed will be a fully functional Standing Joint Task Force reporting directly to the Secretary of Defense (SECDEF) through the Deputy Secretary of Defense (DEPSECDEF).

b. The commander of JTF CapMed will be an O-9 Medical Department Officer vested with appropriate authorities and reporting relationships as specified below. This position will be a position of importance and responsibility under section 601 of Title 10, United States Code.

c. The Commander of JTF CapMed will act as the senior medical officer in the JOA with responsibility for the effective and efficient delivery of world-class military healthcare in the NCR. The Commander will organize staff and reporting organizations to execute his/her mission. The Commander shall have the authority to compile budgets for the units assigned to JTF CapMed and distribute and direct resources as needed within the JOA to accomplish mission objectives. The Commander shall directly supervise the JTF Component Commanders within the JOA. The Commander shall forward risks and issues to the Co-Chairs of the Overarching Integrated Product Team for the Transition of Medical Activities in the National Capital Region (NCR OIPT) as necessary to ensure the effective execution of the JTF CapMed mission.

2. **MISSIONS AND RELATED AUTHORITIES**. The mission and authorities of JTF CapMed are as follows:

a. Oversee, manage, and direct all health care delivery by military medical units within the JOA and ensure the military medical readiness of personnel in the JOA.

b. Oversee, manage, and distribute resources to military health care assets within the JOA.

c. Develop a Joint NCR transition plan and oversee BRAC Business Plan 169 and 173E implementation and related military construction (MILCON) projects.

d. Coordinate the scheduling and funding of clinical and non-clinical work with Services, MHS BRAC Program Integration Office, US Army Corps of Engineers and NAVFAC.

e. Develop and maintain interagency and private partnerships.

f. Other tasks as assigned.

3. **JTF CAPMED LOCATION.** The Commander, National Naval Medical Center, Bethesda, Maryland shall provide or arrange for the administrative and logistic support of the headquarters of JTF CapMed.

4. **RESOURCES AND PERSONNEL.** JTF CapMed will be resourced by the Commands, Services, and MHS to ensure the successful implementation of its assigned missions, as indicated below.

a. The Commander, JTF CapMed will establish the JTD for the JTF Headquarters (HQ). Initial joint staffing will be provided by MSMO and BRAC Medical Integration Office staff. Services will take immediate steps to identify and assign military personnel to fill the JTF CapMed Headquarters Joint Table of Distribution (JTD) to meet mission requirements; Services will fill these positions prior to funding the billets.

b. The Commander, JTF CapMed will have Tactical Control (TACON) of the military medical units assigned or attached to the JTF (TAB B). The Services will retain operational and administrative control of the personnel assigned to JTF CapMed. The Services may assign and reassign personnel within the JTF CapMed JOA in support of their military medical units.

c. Operational and Maintenance funding. ASD (HA) shall identify and provide funds to support the HQ Staff of JTF CapMed and provide resources for the delivery of military health care within the JOA.

TAB B

JTF CapMed Military Medical Units

Army:

Walter Reed Army Medical Center, Washington, DC

- Dunham HC, Carlisle, PA
- Barquist AHC, FT Detrick, MD
- Kirk AHC, Aberdeen Proving Ground, MD
- Kimbrough AHC, FT Mead, MD
- Fairfax FHC, Fairfax, VA
- Woodbridge FHC, Woodbridge, VA
- Andrew/Rader FHC, FT Meyer, VA
- DeWitt ACH, FT Belvoir, VA
- Pentagon HC, Arlington, VA

Air Force:

Malcolm Grow MC, Andrews AFB, MD

- Bolling AFB 579 HC, Washington, DC
- 11th MDG Flight Medicine Clinic, Pentagon

Navy:

National Naval Medical Center, Bethesda, MD

- NHC Quantico, Quantico, VA
- Pax River HC, Patuxent River, MD
- NMC Naval Academy, Annapolis, MD
- NHC USUHS, Bethesda, MD
- NHC Carderock, Anacostia, MD
- NHC/DC Lakehurst, Lakehurst, NJ
- NHC/DC NAF Washington, DC
- NHC/DC Willow Grove, PA
- NHC Mechanicsburg, PA
- NHC/DC Dahlgren, VA
- NHC/DC Indian Head, MD
- NHC NRL, Washington, DC
- Tri-Serv Dental Clinic, Pentagon
- NHC Philadelphia Naval Bus Ctr, PA
- NHC/DC Washington Navy Yard, DC
- NHC/DC Earle, NJ
- NHC/DC Sugar Grove, WV

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CAREERSTONE group

learn today. lead tomorrow.

Cultural Integration Recommendations White Paper

Joint Task Force National Capital Region Medical

JTF CAPMED

February 2010

Prepared by

Careerstone Group, LLC

www.careerstonegroup.com

202-595-1328

Executive Summary

Cultural Integration presents a notoriously difficult organizational challenge. In order for the JTF CAPMED JOA Integrated Healthcare System to fulfill its mission and meet the expectations of multiple stakeholders, it must successfully "merge" three or more distinct cultures. Lessons from the business world bear out the difficulty of this endeavor: 50% to 80% of all mergers fail because little or no attention is paid to cultural integration. JTF CAPMED cannot make this common merger mistake.

Successful "merging" in this instance requires the careful and thoughtful integration of several delivery cultures ensuring the "best of" each culture is carried forward into the new Joint culture. Careerstone calls this the "And Story." This new culture must support the unified military health care approach that offers the best option for patients, their families, their service providers, and the American taxpayer.

Intrinsic to Cultural Integration is organizational change, which is always a challenge even when the change is desired and positive. In addition to overall change management, JTF CAPMED must also drive three important and simultaneous cultural initiatives:

1. Create Culture: Define and design a new (integrated/best of) culture
2. Integrate Culture: Integrate diverse stakeholders (who currently have strong ties to an existing culture) into new culture
3. Embed (new & integrated) Culture: Ensure that newly integrated culture is thoroughly embedded into the organization

Drivers of Cultural Integration

As a result of Careerstone Group's expertise and experience with large-scale culture integration and organizational change, we have identified five major drivers that support cultural integration:

Compelling Case for Change	Vision	Leadership & Resources	Intergrating Mechanisms	Communication
•**Needed to:** Jumpstart cooperation and overcome complacency •**Without it:** Lack of cooperation and increased resistance…"Why are we doing this?"	•**Needed to:** Pull people into the unknown of change and provide a "yardstick" to measure decisions •**Without it:** Confusion & inconsistency; mavericks and/or saboteurs	•**Needed to:** Move vision from words on paper to real commitment to the future state •**Without it:** False starts and frustration (especailly to those committed to new way)	•**Needed to:** Ensure vision is operational and supports "the way we do things here" •**Without it:** Slow and painful pace of integration, anxiety, resistance, failure of vision to take hold	•**Needed to:** Support all drivers •**Without it:** Confusion and long-term attachment to status quo

All five drivers are equally important. Lack of attention to any one driver will slow down the cultural integration effort, make it more painful, or completely derail it. Each Driver is

explained in detail with recommendations that Careerstone Group feels comfortable making at this point, with limited organizational knowledge.

N.B. These drivers align with the core elements of sustainable change identified by the Picker Institute's "Cross-Site Summary of High Performing Patient and Family-Centered Academic Medical Centers"—July 2009

Cultural Integration Management Recommendations

Careerstone realizes this is an enormously complex (and politically sensitive) undertaking. JTF CAPMED will face many internal and external challenges as it moves forward. So in addition to the strategies outlined in the body of this paper, Careerstone has also identified six high level and overarching recommendations that we feel are "must-have's" for JTF CAPMED success:

1. **Authority**—the authority question must be resolved. The military is a highly hierarchical culture, without authority it will be virtually impossible to command the respect and followership this undertaking demands.
2. **Inspiration**—Whether as a consequence of false starts or raised sensitivities that this project somehow suggests that there is "something to fix" Careerstone did not find inspiration, but rather confusion, frustration, and weariness. Inspiration must be re-discovered, re-articulated and re-communicated.
3. **Neutral/Honest Broker Support**—Due to the strong cultures of each of the military service units, JTF CAPMED should utilize outside support for many of the facilitation, training, and communication requirements of this project to ensure perception of neutrality vital to open dialogue and buy in.
4. **Coordinating Cultural Integration Mechanism**—This project will fall into distinct phases (including a potential pilot). It will have many moving parts, numerous sub-groups and functional areas to coordinate. Having a well-funded strong-core team to coordinate and liaise with all of these elements is fundamental to its success.
5. **Acknowledge, Celebrate and Leverage Work-to-Date by Internal Stakeholders**—Many working groups and highly committed and talented staff have completed significant work on this project. Good work has been done: J1, J5, J6, and J7 have begun to put together important pieces of this puzzle. Cross-service unit teams have already embraced the "And Story" and are prepared to compromise, collaborate and engage in healthy dialogue in order to deliver an integrated health care approach. Do not ignore or mitigate this work. Celebrate it, talk about it, and leverage it. Neglecting to do this will create a subset of disillusioned talent, which the Integrated Healthcare project cannot afford.
6. **The "And Story"**—JTF CAPMED will face significant resistance during integration. Some of this resistance will be the result of institutional legacy, pride, history, ego, sense of loss, etc. These are proud and accomplished institutions—in several cases institutions older than the United States itself. This sense of organizational prid must not be taken lightly. Careerstone believes—and has based its recommendations—on creating the "And Story." This simply means that cultural

integration must be framed, not as loss, but as the creation of something that incorporates and includes the best of all three institutions. This philosophy/approach must be evident in the end result as well as the integration process.

N.B. *Above recommendations are based on its brief current state audit of JTF CAPMED to-date activities including:*

- Deloitte's June 30 Cultural Integration Workshop Findings and Recommendations Report
- Col John S Murray's Military Medicine May 2009 article: "Joint Task Force National Capital Region Medical: Integration of Education, Training, and Research"
- Meetings and conversations with JTF CAPMED, Walter Reed and Bethesda Naval personnel
- JTF CAPMED Senior Leaders Conference (October 2009)

How to Use This Paper

This white paper is intended as a high-level cultural integration plan. It utilizes and is organized by the five drivers Careerstone has identified as critical to successful cultural integration: 1) Shock to the System; 2) Vision; 3) Leadership & Resources; 4) Integrating and Embedding Mechanisms; and 5) Communication

To support ease of understanding and future planning activities, recommendations are also divided into three phases:

1. **Pre-Integration Strategies & Recommendations**: Pre-Integration refers to the phase of work that precedes physical integration—i.e. the official opening of FBCH/WRNMMC. During pre-integration it is important to design and develop the integrative and embedding mechanisms for cultural adoption. These processes must be ready for implementation once physical integration occurs.

2. **Integration Strategies & Recommendations**: Integration refers to the types of activities and strategies that need attention once the integrated care delivery has begun. In other words—once FBCH/WRNMMC are online and operating.

3. **Post Integration Strategies & Recommendations**: Post-integration activities refer to the types of activities needed to sustain cultural integration after a transitional operation period has occurred. These are the strategies that will ensure the cultural integration "sticks" after the initial start-up phase.

Driving Cultural Integration: Strategies and Recommendations

Driver 1: Create a Compelling Case for Change. Instill Sense of Urgency

All organizational change and cultural transformation requires stakeholder support. Minds must be changed. Hearts must be won. JTF CAPMED faces an enormous challenge of historic proportions that will require the prolonged cooperation, support, and collaboration of thousands of diverse stakeholders—both internal and external. Overcoming complacency and resistance will be a major challenge throughout the cultural integration initiative.

Establishing a sense of urgency is critical to jumpstart needed cooperation and overcome complacency. Organizational Change expert, John Kotter, rightly points out that chang leaders should "never underestimate the magnitude of the forces that reinforce complacency and maintain the status quo." Change leaders must ensure that every level of the organization understands the sense of urgency. This is the external "push" that gets people to open their minds to the "pull" of the vision. And this push must be explicit, consistent, relevant, and compelling.

Recommended Strategies:

1. Assess current messaging: Is it urgent? Is it compelling? Does it sell the problem?
2. Increase Urgency: Identify and articulate compelling case for change
3. Communicate and embed the case for change/call to action: Are all stakeholders *really* aware of the "why"
4. Be prepared to modify the message as the culture aligns

Compelling Case for Change Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Assess current message for urgency • Articulate compelling "case for change" • Communicate "case for change"	• Continue to communicate "case for change"	• "Case for Change" message becomes part of the shared narrative and creation myth • Look out for the need to modify the "urgency" focus as the culture embeds

Recommended Action Steps:

1. Assess current messaging to test for urgency and "stickiness"
    - Is current message compelling?
    - Does it sell the problem?
    - Is it urgent?

- Is it relevant and meaningful to the stakeholders?
- Is it part of the real meta-narrative? Will it help create a compelling meta-narrative?

2. Indentify and articulate a compelling case for change. This is also known as "selling the problem." Explicitly highlight threats to the current system to ensure appropriate shock and urgency are created.
    - Leadership at the highest levels should create this message with input from all three Service branches
    - Message must be strong enough to jump-start complacency—In this case BRAC demands and the Walter Reed performance issues may no longer provide the urgency required
3. Ensure this "shock to system" stays relevant and forefront: This call to action/case for change must be heard and understood by every person in the system. Leaders must remember that they are usually further ahead on the change curve than the rest of the population so what may be obvious to them is not necessarily obvious to others. Make it obvious.
4. Communicate the case for change/call to action:
    - Communicate consistently and continually throughout the *entire* integration effort—not just once or twice at the beginning
    - The message must be relevant and real to the stakeholders
    - Every stakeholder must hear the same story
    - Multiple messengers must be identified and utilized. Messengers (change champions) are needed at all levels both horizontally (e.g. Army, Navy, Air Force) and vertically at each functional level, (e.g., doctors, nurses, civilians, administration, etc.)
    - Utilize multiple communication vehicles
    - Each messenger must deliver the same message
    - The "case for change" must be a part of every vision communication—this helps to answer the question: "why are we changing?" and "what happens if we don't change?"
    - Urgency must be inherent in message

Driver 2: Vision

The value of a clear (and compelling) vision cannot be underestimated in a Culture Creation/Integration effort. A clear and compelling vision helps "pull" people into the unknown of change. Getting people to "give up" their preferred ways of doing things (their culture) is an enormous task. Establishing and Communicating Vision is a critical and foundational step in creating and integrating culture. No serious cultural integration efforts can be implemented before Vision is articulated. Without it, there will be resistance, confusion, inconsistency, sabotage, and "wheel spinning." The Visio provides the "yardstick" against which to "test" all subsequent organizational decisions and actions, and provides individuals with a sense of a future worth working towards.

Recommended Strategies:

1. Discover the "And Story". Use this meta-narrative to ensure the Vision incorporates the values of Army, Navy, and Air Force culture and wounded warrior care.
2. Reinforce and articulate a compelling Vision
3. Communicate and embed the Vision

Vision Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Utilize and energize diverse stakeholders to "discover" important Vision elements—for both organizational vision and integrated culture vision • Create the "And Story" • Consolidate findings • Revisit and Reinforce Vision • Communicate Vision to internal stakeholders • Ensure vision is articulated through initial branding efforts and multi-media vehicles	• Ensure vision is articulated through branding and multi-media vehicles • Integrate vision into all training opportunities • Make vision central to all orientation processes • Reward stakeholders embodying vision • "Punish" stakeholders refusing to embody vision • Implement performance measurement standards and reporting	• Celebrate successes • Monitor performance measurement reporting and take performance improvement actions where relevant. • Vision becomes the cornerstone of the shared meta-narrative

Qualities of a Great Vision:

- Simplicity. Many experts argue, that if not readily understood by a 5th grader, a vision statement is too complicated
- Clearly articulates an image of a better future for the organization and its stakeholders

- Inspirational–providing the organization and its members with a purpose and a driving force for innovation, daring people to think in new ways and to pull against the status quo
- Provides a simple way to "test" operational decisions and actions—is what I am about to do, propose, develop in support of the vision?
- Wide-based and multi-level appeal
- Provides stakeholders with the opportunity for doing something new
- Calls on the skills, talents and development of all stakeholders

John F Kennedy's vision for NASA and the American people was delivered to Congress in 1961: "I believe this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to earth." This statement has all the attributes outlined above. It is short (29 words), it i inspiring, and it is unambiguous. And, it provided NASA with very simple criteria against which to measure all decisions for the next decade.

All visions embody and are developed through three elements:

1. Values—the set of beliefs people share about how to operate in conducting business. In this case the "And Story" will be key.
2. Mission—the core purpose of the organization and the contribution it makes to society and to basic human needs. It is a clear statement of the reasons for being. The mission is never completely achieved because it is a reason for existence. (Google's mission statement provides an excellent example: "Google's mission is to organize the world's information and make it universally accessible and useful.")
3. Overarching Goals—while goals will not appear in the short and simple vision statement, the identification of 5-8 high level strategic goals to determine performance measurements and success criteria are vital to make the words of the vision a reality in the day to day operations of an organization and its stakeholder groups

Communicating/Embedding the Vision

Once the mission, vision and overarching goals have been established, they must be:

- Communicated at every opportunity
- Modeled by leadership at every opportunity

There are numerous vision and mission statements, which have been created and lie on a shelf gathering dust. Vision statements must move from words on a page to living codes used by all levels of an organization to guide work, service and decision-making.

Recommended Action Steps:

1. **Acknowledge Current State: Vision, Mission, Overarching Goals**
   - Strong individual "military" cultures--each separate Service unit has ver distinct heritages and traditions, however at the June 30, 2009 Cultural

Integration workshop, leaders agreed that each Service unit "seem to share incredibly similar and underlying core values." After discussion, participants agreed that the most important core values that crossed all Service lines were: "patient-centeredness and a high quality of care."

- Mission and Authorities: JTF CAPMED is "charged with overseeing, managing and directing integrated health care delivery by military medical units within the joint operating area and ensuring the military medical readiness of assigned personnel."
- Vision: "To create a world-class medical center, (WRNMMC) at the hub of the nation's premier regional healthcare system serving the United States military and the nation."
- Overarching Goals: Casualty care, caring for caregivers, be ready now, regional health care delivery, and common standards and processes.
- Identified barriers: Integrated Healthcare Delivery Working Group Report Out JTF CAPMED Senior Leaders Conference, 28 October 2009) identified:
    - Lack of shared vision and mission as a barrier to success
    - Lack of confidence that resources will be provided to support vision
    - Lack of confidence in Integrated Healthcare System

2. Discover and Define Elements of Vision (including the "And Story")

- Develop the cultural "And Story" and the meta-narrative through facilitated sessions.
- Identify a substantial group of stakeholders (include: existing working group members, communication strategists, multi-level leadership and patients) to revisit and re-energize the vision, mission and overarching goals of JTF CAPMED.
- From this group, determine participants in a series of focus groups designed to articulate share values, vision and mission, and to ensure that these discussions are socialized (tested) throughout multi-stakeholder levels and groups. For example groups could be organized as following (all groups to include patients):
    - Uni-service, uni-level
    - Uni-service, multi-level
    - Multi-service, uni-level
    - Multi-service, multi-level
- Use single vendor (potentially non-military) seen as "honest broker" to design and facilitate sessions to establish:
    - Mission
    - Values
    - Vision
    - Strategic Goals
    - Best Practices
    - Barriers (Including cultural sensitivities)
    - Messaging template for focus groups' work

Facilitators should include both appreciative inquiry and the "And Story" approaches in the design and implementation of the sessions.

3. **Reinforce and Articulate the Vision**
    - Consolidate findings into a final summary report to articulate commonalities and shared vision, mission, values and strategic goals, barriers and best practices.
    - Ensure quick dissemination of findings through the Communications' team to ensure wide understanding of the work and to inspire next steps (including branding efforts).
    - Create/Articulate a simply defined compelling Vision Statement

4. **Communicate and Embed the Vision**
    - Ensure vision is articulated through branding and multi-media vehicles
    - Integrate vision into all training opportunities
    - Make vision central to all orientation processes
    - Reward stakeholder embodying vision
    - "Punish" stakeholders refusing to embody vision
    - Implement performance measurement standards and reporting

5. **Use Vision as "Yardstick" to measure successful integration**
    - Celebrate successes
    - Monitor performance measurement reporting and take performance improvement actions where relevant.

Driver 3: Dedicated Leadership and Resources

"Cultural cohesion is the product of senior leadership acting in concert with leaders reaching down into the organization. The process is internal, active and top down. It must begin with the clear definition of a single unifying vision, one that is attuned to the task orientation of the organization and one that all key segments of the organization can embrace. One must then actively disseminate that vision across the diverse subcultures and fractionated specialties before it can begin to take effect."

–Lt Col James M Smith USAF Retired, Building an Air and Space Force for the 21st Century

Cultural creation, integration, and cohesion of two or more separate operating units with their own unique culture is not easy and will not happen without dedicated leadership and assigned resources. Resources include: dedicated funding, full-time attention (coordinating vendor on premise), technology, messaging materials, and action and strategy planning.

It will be useful to look carefully at large-scale mergers in the for-profit space. Experts agree that the majority of mergers and acquisitions do not achieve the objectives that the parties hoped to achieve. Studies document that between 50% and 80% of all mergers fail to create their anticipated value. This failure is widely seen as a direct result of ignoring cultural integration. Leadership plays a fundamental role in the success or failure of a merger. According to the Academy of Management Executives, in mergers that really do fulfill their promise "that really make two and two equal five, leaders paid a great deal of attention to the integration process, and not surprisingly involved people at all levels of the process."

Recommended Strategies:

1. Dedicated Leadership committed to Cultural Integration
2. Aligned Action and Strategy Planning
3. Dedicated Funding & Resources

Dedicated Leadership & Resources Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Establish Guiding Coalition for Cultural Integration • Establish resources and hire or reassign full time support • Develop Cultural Integration Plan • Socialization of vision and plan • Align all plans to ensure	• Ongoing socialization of vision and cultural integration plan • Work with functional leads, e.g. communication, technology, operations, etc., to ensure cultural integration is supported in functional action planning	• Re-assess Guiding Coalition Charter • Re-assess full-time dedicated staff • Establish mechanisms t ensure cultural cohesion

cultural integration is addressed	• Implement cultural integration plan • Integrate new Guiding Coalition membership • Ensure sub cultures are integrated into broader culture • Celebrate successes • Model/champion new behaviors • Ensures cultural integration focus in training and orientation	

Recommended Action Steps:

1. Dedicated Leadership

In order for JTF CAPMED to achieve cultural integration and cohesion, Dedicated Leadership should include two elements:

- Guiding Coalition for Cultural Integration
- Full-Time Attention

These two elements are similar in their commitment to the articulated vision and their willingness to act as passionate champions for the realization of vision and cultural cohesion, however they differ in their named "job or function."

The Guiding Coalition:

- Has a fully articulated charter and purpose
- Includes formal and informal leaders from throughout JOA and should include representatives from all sub groups, e.g. physicians, nurses, patients, etc.
- Consists of members from all Services who are fully committed to the vision and cultural cohesion and willing to model desired behaviors and stand-up for articulated core values and goals
- Has a core set of members for consistency but enables new members to rotate into the coalition with quick acceptance
- Provides guidance and input to the Cultural Integration Plan
- Provides leadership and support to other cultural integration mechanisms such as Working Groups etc.
- Monitors and listens for success stories and seeks to celebrate whenever possible
- Acts as formal and informal "champions" for integration

Full-Time Attention:

Because the members of the Guiding Coalition also have "day jobs", JTF CAPMED must face the reality that a huge cultural integration project such as this one demands and deserves full-time attention. Full-time attention means staffing the cultural integration efforts with

people who whose primary function is to attend to integration efforts and processes. Full time attention could include, but is not limited to:

- A Cultural Integration leader and support staff: carefully chosen and inclusive of all three Service branches
- Outside consultants/vender support

Responsibilities of Cultural Integration staff include, but are not limited to:

- Develop the Cultural Integration Action Plan (with support from Guiding Coalition)
- Socialize the Cultural Integration Action Plan (with support from Guiding Coalition)
- Liaison with communication specialists and staff (including involvement in branding and messaging strategies and outreach)
- Liaison with all working groups
- Assist in development of process and integrative mechanisms to ensure cultural integration is supported
- Monitor technology process development to ensure such processes support not undermine or derail cultural cohesion
- Manage outside consultants/vendor support on site
- Advise and assist in development of training and orientation curricula to support skills-building sessions held for all levels of leadership and new employees
- Monitor and account for funding resources dedicated to cultural integration
- Monitor all action plans, e.g. strategic plan, communication plan, operational action plan, cultural integration plan, to ensure alignment and leveraging where possible in support of cultural cohesion
- Follow and formalize "success stories" to ensure success is reported to multi-stakeholder audiences (with support of Guiding Coalition)

An additional challenge facing JTF CAPMED is the rotational manner of deployment. Consistency of effort and leadership will greatly ease the integration efforts. JTF CAPMED leadership should consider:

- Extending deployment/assignments to support full range of integration time
- Ensuring thorough training or orientation that new personnel entering JTF CAPMED are fully prepared and oriented
- Utilizing as many internal long term resources as possible

2. Aligned Action & Strategy Planning

Bringing cultural cohesion to such a multi-stakeholder entity as that encompassed by JTF CAPMED will feel, at times, like attempting to put together a huge and complex puzzle when one is sometimes not sure who is holding which pieces. Dedicated action planning can mitigate this. This will need to be handled sensitively, so it is not seen as empire building and a push for undue control. Specific plans should and will be developed and monitored in individual functional areas. However, actions plans from all sub groups and functional areas across the NCR JOA jurisdiction should be monitored by the Full-time

Cultural Integration group to ensure that they include repeatable processes to support short-term cultural integration and long-term cultural cohesion. These plans may include:

- Strategic plan
- Facilities plan
- Operation plans (multi-level, multi functional group)
- Technology plans
- Communication plans

Action and strategy planning is essential for cultural integration. This white paper is an attempt to provide recommendations on what types of activities need to be included in a *cultural integration action plan*. Like any action plan, the cultural integration action pla provides a roadmap for cultural integration activities, strategies and tactics. We are confident in JTF CAPMED's expertise in action planning so our recommendations in this area are few and humble:

- Ensure the cultural integration action plan is in synch with operational action plans. Culture is embedded in real life organizational operations and activities so it is essential that these two plans are in alignment
- Utilize both internal and external expertise in creating the cultural integration plan
- Socialize the cultural integration plan with appropriate leadership and stakeholders to ensure buy-in
- Articulate the decision points, timelines, and decision making authority throughout the plan
- Provide as much transparency on the plan as possible
- Update plan as events warrant
- Leverage and champion the Guiding Coalition's expertise and input into the plan

3. Dedicated Funding & Resources

At this stage it is difficult to assess exact funding required to fund full-time support of the cultural integration efforts. At minimum it will require the funding of several senior level equivalent staff or vendor support. Additional funding should be set aside for print, video, web-based, etc. materials in support of cultural integration and the embedding of a clear vision as these funds may not be part of the current communications budget.

Driver 4: Integrative & Embedding Mechanisms

Integrative and Embedding mechanisms are the organizational processes and procedures to align and integrate human capital into new culture. Once the culture vision—or meta-narrative–has been established, it is essential that the mechanisms to both integrate people into the culture and embed the culture into the system are established. These mechanisms are where the cultural boots hit the operational ground. Integrating and embedding mechanisms serve two integration functions:

- Integrate stake holders at all levels into newly articulated/developed culture
- Embed values of new culture into the system

Integrative and embedding mechanisms are critical to realizing an integrated culture. These mechanisms fall into 2 main focus areas: processes and people.

1. **Organizational Processes and Procedures** (Define and Align)
    - Culture is consistently supported and embedded by formal and informal processes—SOPs, performance measurement processes, rewards, leadership commitment, stories, myths, legends, etc
    - Organizational processes and procedures must be designed/developed in alignment with the vision—both formally and informally
2. **People Enculturation: Workforce Alignment & Transition Strategies**
    - People are acculturated (integrated) into the culture through supporting mechanisms—training, communication, reward systems, etc.
    - Key positions are filled with change champions—people who both believe in and can influence the adoption of new culture
    - Resistance to change must be addressed and navigated
    - Leadership must model the "new way"
    - Feedback loops are created in order to test/refine integrative mechanisms
    - Communication is consistent and continual

1. Organizational Processes & Procedures

Organizational processes and procedures are essential to cultural development. Because processes and procedures are the nuts and bolts of organizational life ("the way we do things") they become the life-blood of organizational culture. Therefore it is essential that the SOPs are developed and aligned in accordance with values of the vision. While much of this work is being done at a technical level through the working groups, it is essential that the cultural integration group/guiding coalition be kept apprised of the work. Care should be taken to ensure that the decisions regarding processes and procedures truly support the articulated vision and values of the new system.

Organizational Processes Procedures Define and Align		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Define/establish organizational processes procedures • Ensure processes	• Review and refine processes • Involve multiple stakeholders in review	• Continue to review/refine as needed • Reward adoption of

support vision • Ensure processes represent the "best of" from all three Services	and refinement • Make timely adjustments • Utilize FBCH as a testing ground • Remember: How JTF solves operational challenges is a major influencer of culture	new processes • Measure and evaluate • Install mechanism for continual improvement • Discontinue process that don't serve values of new culture

Recommended strategies:

Processes & Procedures: (Pre-Integration Focus)

- Define processes and procedures for JTF CAPMED JOA Integrated Health Care Delivery Systems (WRNMMC & FBCH)
- Continue to utilize working groups to articulate differences in care delivery and to articulate desired processes
- Ensure working groups are manned and led by the right people: e.g. a diverse mix of Army, Navy, Air Force and civilian (including patient) expertise
- Ensure chosen processes and procedures are aligned with articulated vision
- Ensure working groups who develop processes and procedures utilize a shared decision making criteria that is consistent with the values, mission, and principles of JTF CAPMED
- Communicate new processes/procedures to appropriate stakeholders for review/feedback
- Make and finalize decisions on processes and procedures wherever possible
- Articulate why processes and procedures are chosen—make the connection between desired results and chosen procedures
- Illustrate how processes and procedures differ from existing care delivery to new integrated care delivery. Show the "And Story". This is about acknowledging and embracing the different approaches and creating one that reflects the best from each. Each Armed Service must see parts of themselves acknowledged and celebrated in the final product:
    - Consider creating posters, video, etc, that outline differences and or similarities
    - Conduct trainings, meetings, facilitated sessions that demonstrate differences and show the "And Story"

Processes & Procedures: (Integration Focus)

- Review and refine processes. Conduct multi-function AAR type meetings to determine effectiveness of processes and procedures. Use the vision and overarching goals as the "yardstick" against which to test all processes and procedures. This will help to mitigate sensitivity and "uni-service "ownership."

- Solicit recommendations and feedback from stakeholders—including patients
- Ensure that all parts of the system are represented in evaluating efficacy and effectiveness of processes and procedures.
- Make adjustments as needed in a timely and patient-centered manner
- Untimely adjustments will lead to a dysfunctional gap between "formal" and "informal" culture. Staying on top of formal organizational processes right from the beginning will help alleviate potential dysfunction found in the gap.
- Publicly reward the adoption of new processes and procedures
- Utilize FBCH as a pilot program/testing ground. Cultivate lessons learned and refine best practices. Acknowledge and communicate success stories. Acknowledge and communicate process refinements. Transparency is key.

Processes & Procedures: (Post-Integration Focus)

- Continue to review and refine processes
- Create processes to measure, assess and monitor organizational performance
- Develop organizational mechanisms to deliver continuous improvement
- Discontinue (publicly discredit) processes and procedures that don't advance the values and principles of the organization or the integrated culture

2. People Enculturation: Workforce Training and Transition

In order for the new culture to "stick" people must embrace, adopt and promote the values, assumptions and behaviors of the integration. Workforce Transition and Training strategies help stakeholders learn, adapt to, and succeed in the new culture. Enculturation requires organizational players to: a) understand the new culture; b) buy into the new culture; c) adapt to the integrated culture; d) support and promote the new culture; and, e be successful in the new culture. We recommend the following People Enculturation/Workforce Transition strategies:

a. Culture orientation, transition support, and onboarding
b. Training and skill building
c. Resistance to change management
d. Deliberate Leadership role modeling
e. Rewards & Incentives (including performance measurement and management)
f. Recruitment
g. Feedback and Communication

2a. Culture orientation: In order to promote cultural integration and adoption—people must first understand the new culture. Teaching and orienting people into the new culture is best addressed by employing a multitude of coordinated strategies—some of which JTF has already successfully begun.

A successful example of culture orientation in JTF CAPMED is the Senior Enlisted Orientation Program.

Culture Orientation Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
Culture Orientation • Assess orientation processes • Design orientation processes • Deliver as needed	**Culture Orientation** • Deliver orientation process to all relevant stakeholders • Customize where necessary for each subculture/function area • Review/refine as needed	**Culture Orientation** • Continued delivery of orientation processes • Review/refine as needed • Incorporate success stories

Recommended strategies:

- Design and develop a structured onboarding process fo JTF CAPMED, WRNMMC and FBHC. Onboarding process needs to include: JOA Integrated Health Care Delivery System mission, principles, values, systems, processes, procedures, practices and organizational expectations.
- Design and deliver in-person training and workshops that are used to both onboard new people into the system as well as to orient the existing workforce to the vision
- Ensure that each functional area/sub culture has an aligned–and where necessary–a customized orientation to address their needs
- Create multiple media orientation materials—including print materials, video and social media. Ensure all stakeholders utilize media consistently
- Ensure appropriate leadership from all Service branches have visibility in orientation processes
- Ensure leadership from all Service branches support orientation processes—both during design and delivery

2b Training and Skill Building: For culture integration to be successful people must also have the appropriate skills and sensibilities to work effectively in the new system and operate within the new processes and procedures. These training activities will range from technical training programs—e.g., how to use forms, systems, etc. to more complex behavioral training–e.g., how to provide "patient centered care."

Training and Skill Building Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Assess training needs • Determine appropriate training delivery methods • Design training • Deliver training as needed	• Deliver training as needed • Review and refine training needs and delivery • Incorporate multiple platforms for easy reference/quick guides	• Deliver training as needed • Review/refine as training needs and delivery as needed • Incorporate success stories

Recommended strategies:

- Assess training needs
- Develop training programs that help all levels of the workforce operate in the new system both technically and behaviorally
- Ensure that every subculture/function area is developing and delivering appropriate training
- Develop training and informational print materials that support skills training
- Design and utilize multiple media based training materials and support systems—including print materials, video and social media to ensure people have access to skills training.
- Create multiple platforms for people to "refresh" their learning or to provide quick reference guides

2c. Manage Resistance to Change: All change creates resistance—especially cultural change. It is essential that key leaders, managers, and influencers be trained to manage change and navigate resistance. It is also enormously helpful to provide transition support workshops to various stakeholders to help uncover resistance and to provide a framework for understanding and normalizing the sometimes painful phases of transition. Managin resistance will be an ongoing process.

Manage Resistance To Change: Phase Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Design and deliver workshops and facilitated sessions that address both transition and resistance • Incorporate "resistance data" into integration plan	• Deliver workshops and sessions as needed	• Assess and evaluate

Recommended strategies:

- Deliver change management and resistance-to-change workshops for key managers, leaders, and influencers. These workshops will focus on developing the essentials skills needed to lead change and navigate resistance
- Ensure that sub-cultures, e.g., particular functional roles or departments receive training as both intact teams and as part of cross-functional sessions
- Conduct a series of transition workshops for affected workforce. These workshops will help provide a framework for understanding the stages of transition and will provide JTF CAPMED with essential information on employee concerns, obstacles, and progress. These facilitated sessions will enable different Service branches to discuss loss, fears, resistance, hopes, needs and wants in a structured learning environment.
- Incorporate both top-down and bottom-up vehicles
- Ensure that resistance navigation strategies matches level of resistance

    - Level 1 Resistance: Cognitive (the idea itself)
    - Level 2 Resistance: Psychological/Emotional (the impact of the change on a physiological/psychological level)
    - Level 3 Resistance: Organizational & deeply embedded resistance (resisting the person or organization responsible for change due to long held grievances/mistrust/conflict)
- People accept change at different rates. Focus early on people who are early adopters, innovators and early majority
- Accept the notion that some people will not get onboard with the change, and ensure performance measures mitigate their impact

2d. Deliberate Leadership Role Modeling: Leadership alignment and role modeling of the values, norms, and behaviors is essential for cultural integration—especially at the operational level. This includes front line managers and supervisors throughout the JOA and especially at FBHC & WRNMMC. Leaders and managers must consistently model the desired norms and practices of the new culture. They must be committed to the new way of being in vision, communication and day-to-day behaviors—both explicitly and implicitly. People will follow what leaders model.

Deliberate Leadership Role Modeling Phas Focus		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Articulate and define expectations and needs of leaders and managers • Recruit/enroll formal and informal leaders • Design and deliver training as needed	• Deliver training as needed • Ensure the right leaders are in the right place • Remove leaders who do not support integration	• Assess and evaluate leadership role modeling • Reward and celebrate

Recommended strategies:

- Clearly articulate and define leadership expectations and behaviors needed at all levels throughout all functions
- Design and deliver workshops/trainings/briefings to ensure leaders/managers understand their role and the importance of their behavior
- Create a shared sense of responsibility and commitment among managers/leaders to model the values and principles of the integrated culture
- Remove leaders who do not role model the values of integrated culture/integrated delivery

2e. Rewards and Incentives

Similar to leadership role modeling, people engage in behaviors that are rewarded and incentivized. Conversely, people tend to avoid behaviors and activities that are de-incentivized and not rewarded.

The essential component here is that **both** the explicit and implicit reward systems are aligned with the values and principles of the new integrated culture. For example, if JTF wished to promote teamwork but rewarded for individual performance, then individual performance would win out and teamwork would be an uphill struggle. Similarly, if the different Service branches reward certain behaviors or performance metrics that are not in alignment with the principles and values of the integrated culture, then consistent adoption and promotion of the Integrated Culture will be undermined. *This is an ongoing process from pre-integration through post-integration.*

Recommended strategies:

- Create a shared and aligned reward and incentives system—test all reward and incentive processes against the vision "yardstick"
- Ensure that both implicit and explicit reward systems actually work to promote the values and principles of an integrated culture
- Assess the current implicit and explicit reward structure for all three medical Service branches—to see which ones need to be adopted, aligned and/or adjusted
- Address gaps and differences appropriately and definitively—ambiguity will cause integration and cultural adoption to stall
- Get agreement and buy-in at the highest levels
- Clearly communicate the reward system and performance management metrics to all employees and patients—they must have a full understanding of the types of behaviors and performance measures that will be rewarded
- Use patient surveys, etc., to check that core values are being "lived" at the patient care level
- Create new emotionally charged rituals that reward the adoption of the behaviors consistent with the new culture.
- Look for ways to publicly discredit old ways of being that will no longer serve the new culture.

2f. Recruitment

Integrating and sustaining the newly created integrated culture can be accelerated (or derailed) through recruitment policies and practices. To put it bluntly, JTF CAPMED must fill key positions with people who support the values and principles of the new culture and demonstrate the skill to be successful in living out those values. For example, JTF CAPMED should seek to staff operations and medical centers with people who believe in and will commit to an integrated care delivery philosophy and are willing to engage in "rules of the road" necessary to accomplish the integrated vision. Another way to look at this is to consider the "criteria for membership." *This is an ongoing process from pre-integration through post-integration.*

Organizations who successfully transform and sustain cultural improvements and cultural integrations take recruitment and "membership" very seriously. A handful of "non-believers" or resisters can dramatically derail integration efforts.

Admittedly, this may be a challenge due to the nature of military assignments—however recruiting the right people is essential—especially at the initial integration phase. Another challenge that we anticipate is ensuring consistency in cultural adoption due to the rotating nature of military assignments. Embedding culture takes time and energy—we highly recommend creating a stable and consistent workforce during integration efforts.

Recommended strategies:

- Align recruitment and hiring policies to support the values of the integrated culture
- Prospective employees should be recruited/hired based not only on their technical abilities but also their demonstrated experience with the values of the organization and/or their willingness to adopt the Integrated culture philosophy
- Ensure that the right people are in the right jobs and that culture integration supporters are visible at every level of the organization
- Wherever possible, support sustained assignments. Culture is not created in a vacuum—it is largely values and principles passed from worker to worker. A revolving workforce can make integration efforts very difficult as people come and go before the new cultural values have had a chance to embed into the system.

2g. Feedback and Communication

Cultural Integration will benefit from using proven organizational development strategies and techniques. One of the key tenets of organizational development is that, put simply, people will support what they help to create. Therefore it is essential to involve stakeholders wherever and whenever possible. Clearly JFT Cap Med has already embraced this principle as evidenced by its extensive use of working groups and stakeholder engagement.

We think it is just as important to get stakeholder involvement and feedback on cultural integration as well as the operational integration. This will be extremely helpful in both creating strategies for cultural integration and in identifying potential integration obstacles and resistance. While communication is addressed in depth in the next section, it bears repeating that JTF CAPMED must always be looking for opportunities to communicate and get feedback. *This is an ongoing process from pre-integration through post-integration.*

Recommended strategies:

- Create opportunities for communication and feedback
- Consider town hall type meetings and/or social media
- Provide multiple methods to solicit feedback, concerns, questions, disagreements: including but not limited to: stakeholder meetings, social media, electronic surveys, etc.
- Acknowledge feedback—let people know that they were heard, and wherever possible, what actions were taken as a result of their input
- Ensure consistent communication up, down, and across

Driver 5: Communication

Communication plays a critical role in driving cultural integration and leading change initiatives. Communication cannot be left to chance. Communication must be a focused activity tightly connected to cultural integration goals. If the communications function is not carefully considered, planned for, organized, and resourced, then the cultural integration and cultural cohesion JTF CAPMED seeks will be hard and painful to achieve.

The truth is, in the absence of information the human being "makes it up." JTF CAPMED cannot afford individuals or sub groups to "make up" anything about its drive for cultural integration. It must do whatever it can to "control" the story and the messages as they filter across and down the organization to all of its stakeholders.

By purposefully designing and empowering the communications function, the organization will be able to successfully deliver the messages, tone and information that will drive the actions needed to achieve cultural integration success. By effectively and clearly communicating what the new organization will look like and detailing how it will function, change leaders provide a culture model that can be used as a tool to ease the transition and guide activities until the desired culture and brand is adopted by employees and external audiences.

Recommended Strategies:
The key steps to ensure that JTF CAPMED communications will help manage the pending change and drive results:

1. Plan for and properly set up the communications function/department
2. Develop the overall communications strategy, which should mirror the strategic plan
3. Develop an actionable communications plan that will guide activities and each "campaign"
4. Prioritize the communication activities (using the Communication Strategy and Action Plan as a guide)
5. Begin implementation, using the Action Plan as a guidepost for each initiative and activity

Overall Communications Recommendations		
Pre-Integration Focus	**Integration Focus**	**Post Integration Focus**
• Properly set up the communication function • Develop the communication strategy • Develop actionable communication plan • Prioritize campaigns for each phase and audience • Implement Pre-	• Continue implementing strategy using the action plan as a guidepost	• Re-visit plan to ensure it is alignment with post-integration realities • Continue to implement the plan

integration communication strategies and campaigns!		

Step 1 Set up the Communication Department

Purposefully designing the communications department and its function within the organization is critical to success. This becomes crucial when facing and managing large-scale change.

Things to think about:

- How aggressive does the organization want the communications department to be? What will the existing and new culture support? Is independent action rewarded or considered insubordinate? Will the department have operational control or just tactical control of the communications output?
- What is the overall strategic plan and tactical objectives for the organization? The communications function should be set up to mirror and achieve JTF CAPMED strategy and goals.
- What phase is the organizational change/cultural integration in? In early stages of an organization's life cycle and during times of intense change, the focus is generally internal, and on influencing behavior. In later phases the focus shifts to external audiences and more of a marketing function.
- How much financial and staff resource is the organization willing to expend to ensure communications success? Are marketing, employee communications, media and Public Relations important enough to the overall strategy to staff for those functions? Financial Resources are a key factor.
- Will the organization invest primarily in full-time staff or rely heavily on outsourced agencies and freelancers, or a mix of both? This staff VS outsource ratio will determine the department configuration.

Recommended Action Steps:

1. **Define the mission, goals and objectives of the communications department:** Is it a service department that executes management's directives *after* goals are set? Or is it viewed as a partner in setting objectives and achieving organizational goals? In the first case the department's output will be measured by the success of messages and service levels to the various units. In the second case, communications has a seat at the table in making decisions and then handles implementation. The answer has implications for what the department will focus on, its role in the organization, its design and staffing. *Given the scale of this cultural integration JTF CAPMED should consider the second option, i.e. the Strategic Communications Model described below in section 2b.*
2. **Define the arrangement of the department:**
   Based on the overall mission for the department, there are several options:

a. **Service Model**: Organizational requests go to the Communications Manager, who manages the project with staff, freelance or agency support and puts the message out on the appropriate channel (internal or external). Staff must possess strong written, verbal and production skills, which will be the measures of its success. The departments' scope and influence is limited, and this setup does not provide for organized feedback or inter-departmental communications. In this configuration, staff is organized around tactical activity and not able to impact significant organizational change or direct real business results.

b. **Strategic Communications Model:** Though communication work is done for other units in this type of setup, there is more attention paid to meeting organizational goals that are set mutually with leadership. The primary goals center on assisting bi-directional communications in and outside the organization. Usually arranged into sub-groups (Employee Communications, Public Affairs, Media Relations, Patient Affairs) this model is staffed with highly experienced communications professionals, all reporting up to a functional head that is a part of the executive team and has leadership authority and operational control.

3. **Staff Appropriately:**
   Placing the right people in the right positions is critical to the successful development of the Communications function. The skills needed to hire will vary depending on the mission, organizational function, and JTF CAPMED's current blend of staff and outsourced solutions. Recommended skill sets:
   - Strong verbal, written, creative and multi-platform presentation skills
   - Understanding of external relations: PR, Marketing, Media and Public Affairs
   - Ability to influence others; Ability to deal with change and help others adapt to it
   - A strong business sense and ability to tie objectives to larger goals
   - Willingness to self-direct. Achieving results requires action. Communicators with a, ability to self-direct and take action will look for opportunities rather then wait to be told what to do.
   - Comfort and ability to effectively communicate with senior leaders (in some cases challenging superiors), outside entities and stakeholders

Real World Example:

The communications function in a similar organization can be seen at The Cleveland Clinic, which is an academic medical center that provides clinical and hospital care and is seen as a leader in research, education and health information.

- Their mission is world-class care for patients ("*Every life deserves world-class care*") and while they scored very well in terms of medical outcomes, they needed to achieve significant improvement in patient experience rankings. The communications team provided directional guidance and facilitated bi-directional communication with patients and employees. It also provided implementation assistance, messaging and creative support for each related initiative.

- Employee communications delivered core messaging around patient service. The messages centered on changing behaviors to produce the desired patient-centered results and were based on what the *patients* deemed important. Multiple platforms were used to deliver these messages to patients and employees, including training modules, fliers aimed at specific trades, newsletters upon check-in, elevator programming, interactive kiosks, monitors that showed message-specific programming, quarterly staff meetings, blogs, and a patient advocate program.
- Based on their goals and financial resources, the communications department is set up in the model of 'strategic communications' with a heavy focus on marketing activities. The department has multiple teams such as Employee Communications, Marketing and Media Relations, which all report into a department head who is part of the senior leadership team. Their marketing efforts are both patient and publicly based, but are also aimed at employees, since it has been proven that happy employees help make for happy patients.
- The department has successfully introduced and implemented multiple employee-based programs focused on meeting their needs and ensuring that their actions are focused on operational outcomes. As a result of the combined efforts, CCF was able to raise their patient satisfaction rankings in HCAHPS (*Hospital Consumer Assessment of Healthcare Providers and Systems*) and in the process, made significant improvements in employee moral and "buy-in" for the overall mission of the organization.

Step 2 Develop Overall Communication Strategy

The communication strategy should be well connected to the articulated vision and the overall strategic plan for the organization. Think of the communications strategy as a key component for delivering the strategic plan and managing change.

Things to Think about

- Organizational effectiveness and outcomes are a direct result of employee action. When coupled with clear vision, resources and dedicated leadership, well-informed and inspired employees make for a highly performing organization. This has a naturally occurring and positive impact on external audiences including stakeholders, communities and customers.
- Developing a clearly articulated Brand for the organization is a critical component and objective of the strategy
- Questions that JTF CAPMED's communications strategy needs to address:
    - What is the Brand (who you are, based on mission, values and purpose)
    - What are the objectives?
    - What is changing, and who will be affected? How? Who will lose/gain what?
    - What are the key messages? (be sure to connect them back to the Brand & Objectives)
    - What information will be communicated? When? How?
    - How will internal and external feedback be encouraged and integrated into the plan?

- The communications strategy will evolve depending o what phase the organization is in. The specific phase will determine the goals, audiences, messages and vehicles:

Communication Strategy Phases			
	Pre-Integration	**During Integration**	**Post-Integration**
Goals	• Inform, prepare, persuade & inspire employees • Facilitate the cultural integration • Address concerns and integrate feedback into process • Develop the Brand and communicate it clearly to employees	• Re-assure employees, continue to communicate benefits, explain all changes • Create early opportunities for rewarding behavior • Begin to educate external audiences and stakeholders	• Reinforce new culture by measuring and rewarding desired behaviors • Market for Brand awareness to external audiences • Shape /manage external perceptions
Audiences	• Employees, with a concentrated focus on support for mid-level management • Closely related external stakeholders	• Employees • Existing patients	• Employees • Existing and prospective patients • General Public • Congress
Messages	• TBD	• TBD	• TBD
Vehicles	• Regular staff meetings • HR, Newsletters, flyers, other employee communications • Intranet tools as a shared resource for mangers in guiding change (SharePoint) • Internet tools such as the Website, email, social media • Signage, elevator programming	• Emails, in-person meetings/WebEx, company Intranet, website, Social media for regular updates and collecting feedback • Ambassador & feedback programs, New training opportunities for employees • Rewards & incentives programs • Kiosks, monitors, signage	• Continue Internal vehicles • Add in External Vehicles: Media engagement, PR campaign, Web Campaign including blogging social media aimed at public and patients

Recommended Action Steps:

- Develop a Communications Strategy using the cultural integration strategy and the questions an guidelines provide above.

Real World Example:

Going back to the Cleveland Clinic example illustrates how a strategic communications plan should mirror the strategic plan for the organization, aligning activities and driving employee behavior. CCF's strategy as an organization is to be known for delivering world-class patient care, while being a leader in research, education and health information. Through research and gathering information, they determined where they were in relation to their goal, and adjusted the communication strategy to address the need and achieve those goals. Focusing on those overall organizational goals and using their Brand (world class patient care) as guidance helped identify who their audiences were, what messages would bring the expected results, and what channels were best to reach each of those audiences.

Step 3 Create an Actionable Communication Plan

A communications plan is the template for delivering the communications strategy, and ultimately the overall organizational strategy. It will evolve and change as progress is made or unanticipated obstacles are faced, and should be used for every "campaign" or initiative.

Things to Think about:

- For each initiative, JTF CAPMED must consider objectives, audiences, messages, and delivery vehicles.
- Keep core messages consistent, and make sure each campaign or initiative ties back to the Brand

Recommended Action Steps:

1. **Determine the Objective(s):**
   Narrow the focus and prioritize the initiatives. Be specific on what JTF CAPMED is trying to achieve and put metrics in place so it is clear and quantifiable when progress is made towards objectives.
2. **Identify and Profile the Audiences:**
   Audiences can generally be broken into two categories – Internal and External. For each, identify sub-groups that include Primary audiences (who you are directly targeting) and Secondary audiences (who can help you influence them).
3. **Determine Vehicle or Channel for Delivery:**
   What is the best way to reach intended audiences? Set each channel up to allow for a feedback loop, and pay attention to what works and what doesn't, altering the delivery method appropriately.
4. **Develop Messages:**
   Messages should provide clarity, deliver important information and inspire the audience to think, feel, or act in a certain way. They should connect back to the Brand, and be easy to remember. They can be tailored to do many things:
   - Demonstrate the urgency, relevance or importance of the issue
   - Put a "face" on the issue, Providing inspiration, motivation or persuasion
   - Bring clarity, convey facts around the issue

5. **Choose Activities and Materials**:
   What are the most effective activities, events and materials to use in selected channels? Which will be most effective in delivering the message to intended audiences?
6. **Establish Partnerships:**
   Who might help JTF CAPMED reach its goals by providing financial resources, access and credibility with audiences, support, expertise, visibility, or other resources? Who could enhance JTF CAPMED's ability to provide service?
7. **Implement the Plan:**
   There are many tools for project implementation, so JTF CAPMED should choose methods that are compatible with the organization.

Real World Example:
WJLA, ABC-7 had the organizational goal of gaining market share, and realized that community outreach was one way to do this while also offering a community benefit. Promoting volunteering was chosen, and it was decided that a re-brand of the "*7 on your side*" tagline could coincide with this effort and provide new meaning for the stations brand. A Communications Plan was developed as the guideline to roll out the initiative. It included a multi-platform delivery of messages surrounding volunteering to internal and external audiences:

- A partnership was established with the HR department, to disseminate information to employees on the initiative and on volunteering in general. The idea was to live the Brand that was verbalized in the tagline of "7 on *your* side"
- An on-air promotional campaign with talent talking about their volunteer efforts was created to drive community involvement.
- The campaign featured an on-line component, where potential volunteers could get connected with opportunities to do service through the WJLA website. The community was encouraged to share personal stories through social media and a contest was developed that highlighted the best story each week.
- A mutually beneficial strategic partnership was developed with Greater DC Cares. WJLA got the resources to manage the volunteers appropriately, and GDC got great visibility for the work it does.

Communications has a primary role in managing change, cultural integration and driving organizational results. By planning for the communications function and developing a communications strategy and actionable plan that is connected back to the organizational goals, JTF will be able to guide employee and audience actions needed to achieve success.

ATTACHMENTS

Attachment 1: JTF CAPMED Regional Healthcare Delivery Concept of Operation

Attachment 2: JTF CAPMED September 2007 Establishment Document

Attachment 3: Cultural Integration Recommendations White Paper

Attachment 4: January 2009 Action Memo for the Personnel Structure of the NCR Medical

Attachment 5: Operating Room Study

Attachment 6: Emergency Room and Urgent Care Utilization and Cost Study

Attachment 7: National Capital Region Market Analysis – Executive Summary Report

Attachment 8: Project Management Plan for Initial Outfitting and Transition Services for the JTF CAPMED North and South projects

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

450

ACTION MEMO

FOR: DEPUTY SECRETARY OF DEFENSE

FROM: David S. C. Chu, Under Secretary of Defense (Personnel and Readiness)

SUBJECT: Civilian and Military Personnel Management Structures for the Joint Task Force National Capital Region – Medical (JTF-CapMed)

- This Action Memo addresses three issues concerning JTF-CapMed: (1) approval of a civilian personnel staffing model; (2) approval of a military personnel staffing model; and (3) deferral of an ultimate governance decision.

- **Approval of Civilian Personnel Staffing Model:** On 20 October, Dr. Chu, Mr. Army, and Dr. Casscells met with you to seek your approval of our NCR OIPT Co-chairs' recommendation to adopt a DoD Civilian Model for NCR medical facilities. You approved the NCR OIPT Co-chairs' recommendation. This recommendation:

  - Is a realignment of resources, including transfer of civilian personnel authorizations, and a delegation of civilian personnel authorities to the Commander of the JTF-CapMed. This departure from current practice applicable to Joint Commands, where civilian personnel management is through Military Department support arrangements, will strengthen joint management of the CapMed organization.

  - Incorporates the policy of "guaranteed" placement of current civilian employees in the future CapMed organization. In this context, guaranteed placement means best efforts within applicable regulations to achieve placement in new positions, which efforts are expected to be fully effective.

- **Approval of a Military Personnel Staffing Model:** On 24 October, the Joint Staff Surgeon briefed the NCR OIPT on potential courses of action for military personnel manning of Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) post-BRAC. The recommendation by the NCR OIPT Co-Chairs and Joint Chiefs is the establishment of Joint Commands at WRNMMC and FBCH. This recommendation:

SD CA		DSD SA	
SD SMA		DSD SMA	
SD MA		DSD MA	
ESA		DSD CA	
ES	10nov	1140	
ESR		ESD	

- Continues the JTF-CapMed as a joint military command, establishing subordinate joint commands for WRNMMC and FBCH.
- Establishes all billets at WRNMMC and FBCH as JOINT and documented on a Joint Table of Distribution.

- Deferral of an Ultimate Governance Decision: The issue of the ultimate organizational governance of the JTF-CapMed – including consideration of potential models for organization as a defense agency or field activity or as a subordinate command under a Combatant Commander – was considered but not discussed by the NCR OIPT during the Joint Staff briefing of 24 October. However, this very important issue should be deferred to allow the new Administration to consider it. In the interim, the Commander, JTF-CapMed will continue to directly report to the Deputy Secretary of Defense.

- Attached at TAB A is the memo from the OIPT Co-chairs and the briefing slides from the 20 October meeting with you on civilian personnel (which you previously approved). Briefing slides from the 24 October OIPT are at TAB B.

RECOMMENDATION: That the Deputy Secretary of Defense: 1) confirm approval of a DoD civilian personnel model; 2) approve the establishment of Joint Commands at WRNMMC and FBCH; and 3) defer a decision on ultimate organizational governance of the JTF-CapMed.

Approve: DSD 1-15-09 Disapprove:_____

COORDINATION: TAB C

Attachments:
As stated

Regarding deferral of an Ultimate Governance Decision: These deliberations need to continue and recommendations brought forth expeditiously DSD 1-15-09

DEC 2 3 2008

Prepared by: S. Ward Casscells, MD, ASD (HA), 703-697-2111, Livelink# 159424

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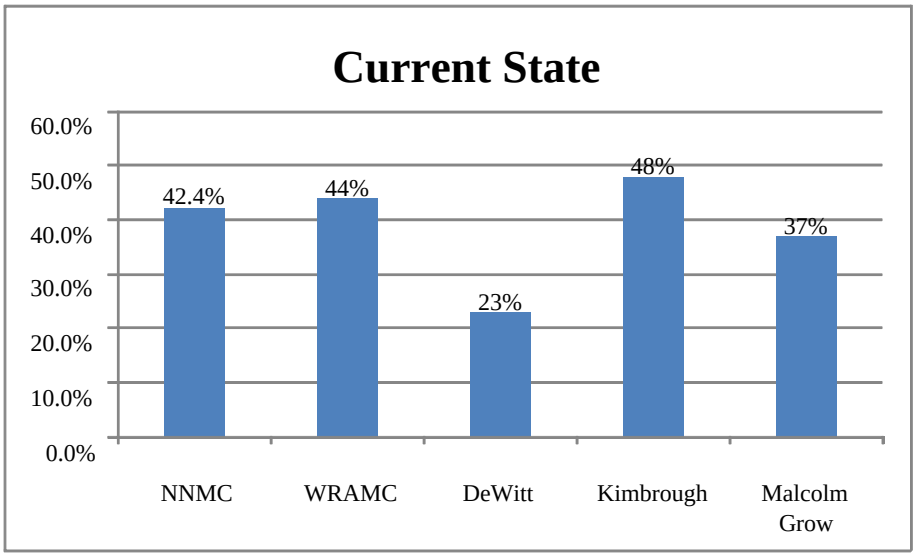
OPERATING ROOM STUDY

1.0 OVERVIEW

This document summarizes the scenarios and outcomes requested Director of J-4 Logistics. There are five scenario and comparisons developed in this report. A summary of the scenarios and outcomes are included.

2.0 CURRENT STATE

The chart below represents the average utilization across all rooms at each facility for FY09.



Location	Total Rooms
NNMC	17
WRAMC	16
DeWitt	4
Kimbrough	4
Malcolm Grow	4

3.0 SCENARIO 1

Timeframe: 10/11 to 7/12

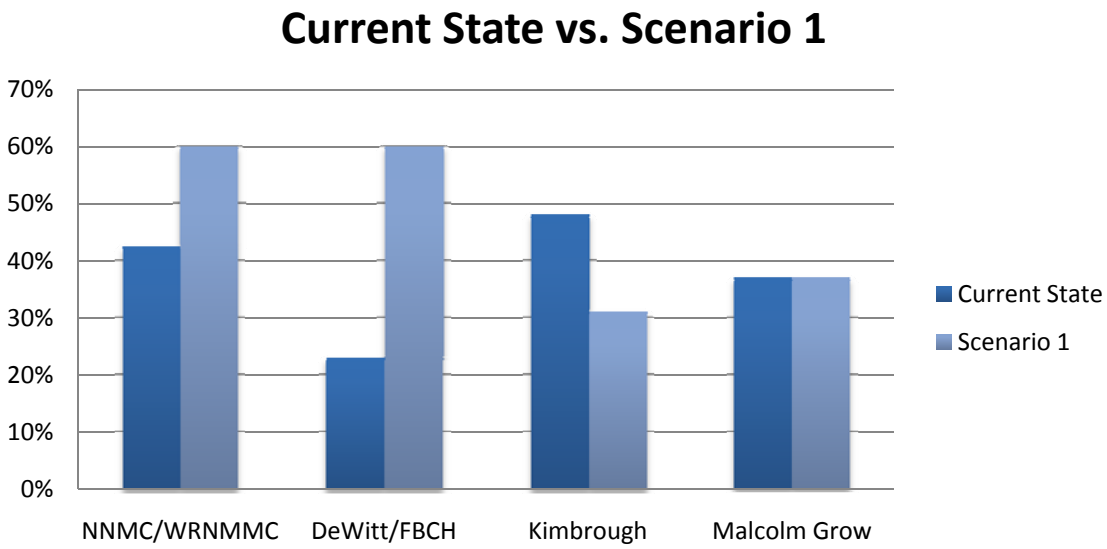
Summary:

WRNMMC: 3 Large, 10 Medium

This is the actual number of rooms available at WRNMMC post BRAC timeframe but during the final phase of construction at WRNMMC. This includes closing WRAMC and having a limited number of rooms available at WRNMMC.

Outcome:

Both WRNMMC and FBCH are at an average of 60%. Note that the current state utilization for NNMC is 42%. This is almost a 50% increase in caseload. Process changes and staff coordination improvements will be needed to operate WRNMMC and FBCH at 60%. Additionally Kimbrough and Malcolm Grow have extra capacity if needed.



Location	Current State	Scenari
NNMC/WRNMMC	17	13
WRAMC	16	0
DeWitt	4	10
Kimbrough	4	8
Malcolm Grow	4	6

4.0 SCENARIO 2

Timeframe: 7/12 to 8/13

Summary:

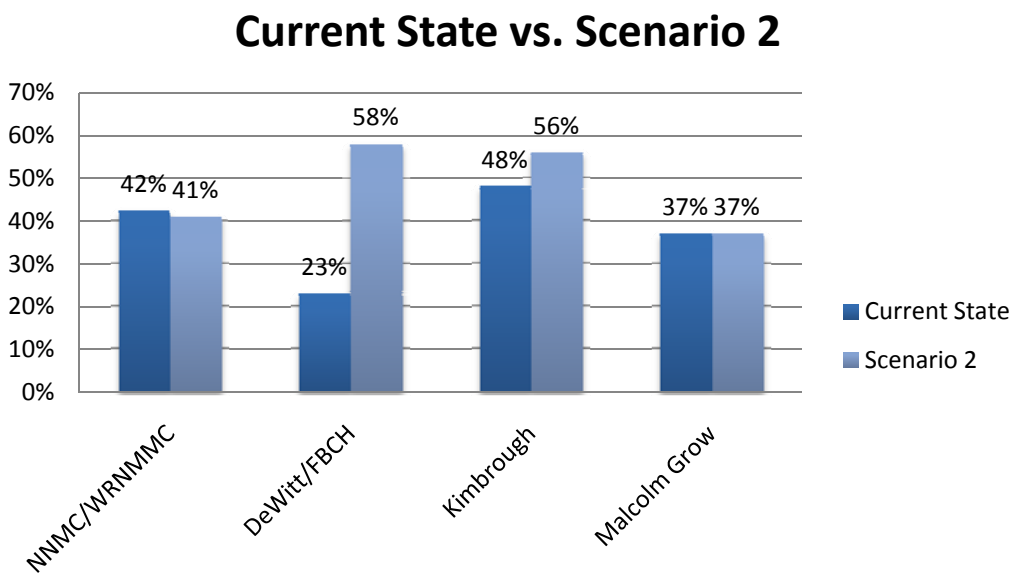
WRNMMC: 3 Large, 17 Medium

Kimbrough: 4 Medium, no Small

This is the NCR configuration post completion of WRNMMC.

Outcome:

WRNMMC is operating at close to the same utilization in the end state as the current environment. FBCH will have approximately a 50% increase in volume over WRAMC given this scenario. Kimbrough will have a 12% utilization increase and Malcolm Grow will maintain the current patient population.



Location	Current State	Scenario 2
NNMC/WRNMMC	17	20
WRAMC	16	0
DeWitt	4	10
Kimbrough	4	4
Malcolm Grow	6	6

5.0 SCENARIO 3

Timeframe: 10/11 to 7/12

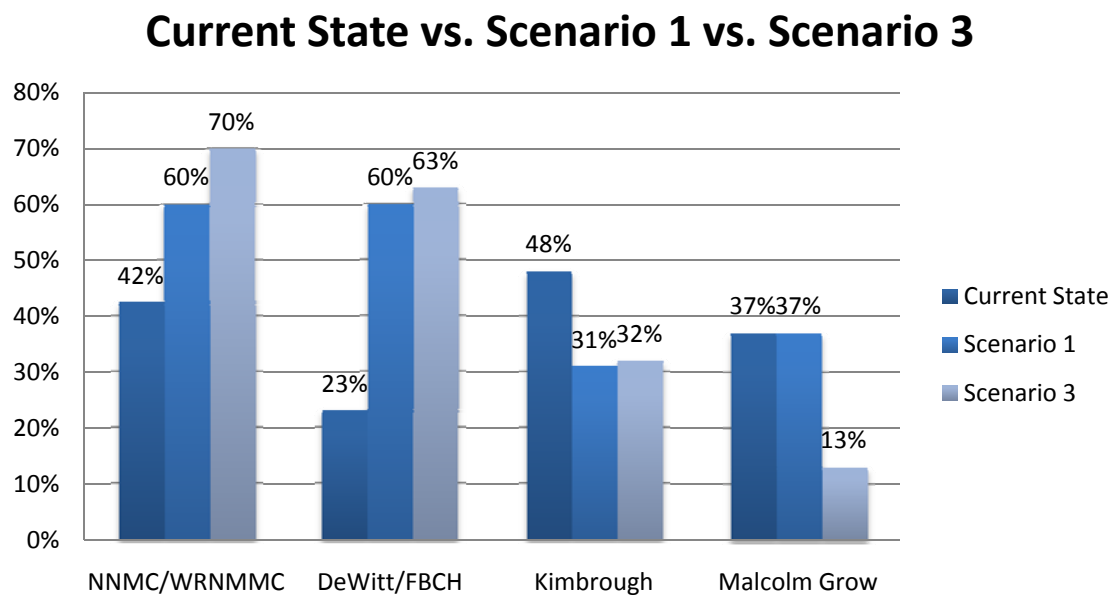
Summary:

WRNMMC: 3 Large, 10 Medium
MGMC: 6 Medium

Test 1: with IP and OP at MGMC (Scenario 1)
Test 2: with OP only (Scenario 3)
Is a waiver required for BRAC to allow inpatients (IP) to be seen at Malcolm Grow during the last phase of construction at WRNMMC?

Outcome:

The results from scenario 1 show WRNMMC and FBCH to be utilized at 60%. This is an increase of almost 50% over the current state for NNMC and WRAMC. Removing inpatient capability from Malcolm Grow spikes the average utilization for WRNMMC to 70%. This is potentially very high for this type of facility and patient mix. Additionally FBCH is already highly utilized. Any variance in patient demand and/or surge requirements may cause issues under this scenario. The recommendation is to request a BRAC waiver for Malcolm Grow until completion of construction at WRNMMC.



Location	Current State	Scenario 1	Scenario 3
NNMC/WRNMMC	17	13	13
WRAMC	16	0	0
DeWitt	4	10	10
Kimbrough	4	8	8
Malcolm Grow	6	6 (IP and OP)	6 (OP only)

6.0 SCENARIO 4

Timeframe: 7/12 to 8/13

Summary:

Scenario 2 configuration

WRNMMC: 3 Large, 17 Medium

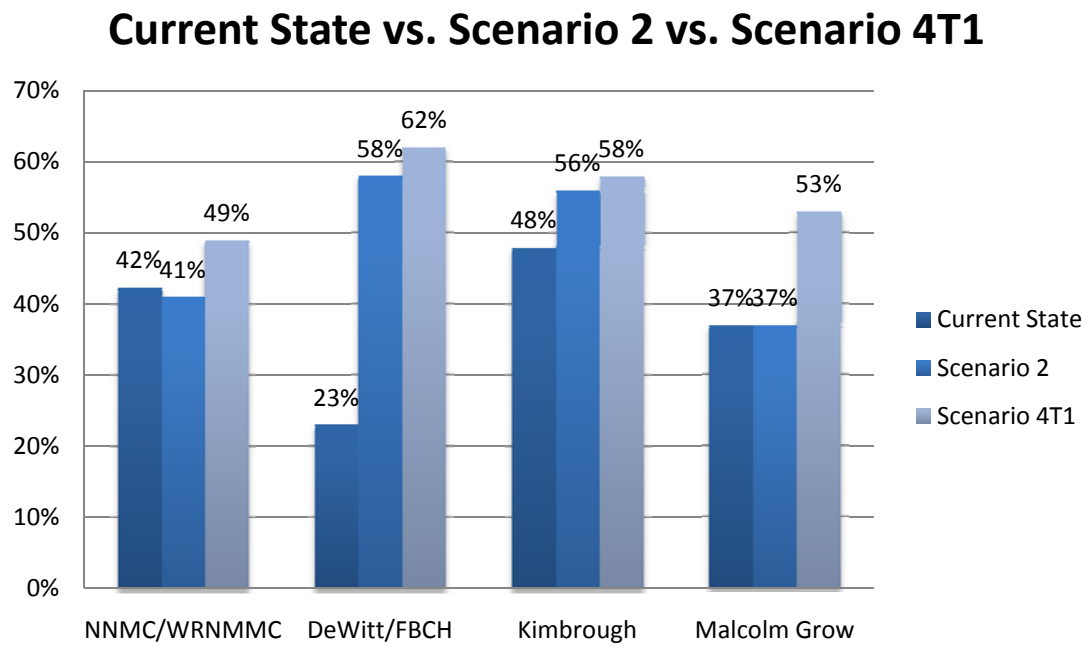
Kimbrough: 4 Medium, no Small

Test 1 (scenario 4T1): Increase caseload to FY04 levels (highest point used during BRAC planning)

This is the NCR configuration post completion of WRNMMC. Verify the OR capacity can handle increased demand and surge requirements.

Outcome:

The additional workload transfers to increased utilization at WRNMMC and Malcolm Grow. NNMC appears to still have capacity for surge requirements.



Location	Current State	Scenario 2	Scenario 4T1
NNMC/WRNMMC	17	20	20
WRAMC	16	0	0
DeWitt/FBCH	4	10	10
Kimbrough	4	4	4
Malcolm Grow	6	6 (IP and OP)	6 (IP and OP)

7.0 SCENARIO 5

Timeframe: 6/10 to 7/12

Summary:

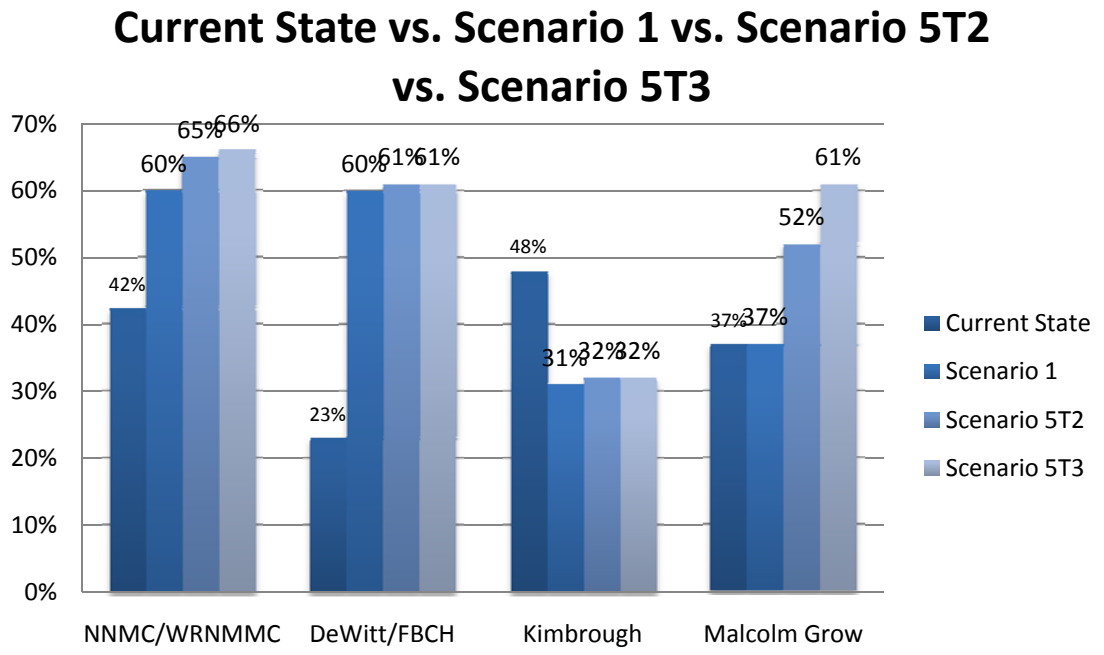
Scenario 1 configuration
WRNMMC: 3 Large, 10 Medium

Test 1: MGMC: 6 Medium (scenario 1)
Test 2: MGMC: 4 Medium
Test 3: MGMC: 3 Medium

Malcolm Grow currently operates 3 rooms. They have the ability to operate 6. How many rooms are needed during the transition phases of BRAC construction? These tests assume both IP and OP are seen at Malcolm Grow.

Outcome:

The NCR has approximately a 60% utilization of all inpatient facilities when Malcolm Grow operates 3 rooms. This potentially is of concern during surge events.



Location	Current State	Scenario 1	Scenario 5T2	Scenario 5T3
NNMC/WRNMMC	17	13	13	13
WRAMC	16	0	0	0
DeWitt/FBCH	4	10	10	10
Kimbrough	4	8	4	3
Malcolm Grow	6	6 (IP and OP)	4 (IP and OP)	4 (IP and OP)

8.0 SCENARIO 6

Timeframe: 10/11 to 7/12

Summary:

WRNMMC: 3 Large, 10 Medium

MGMC: 4 Medium, Outpatient only

Kimbrough: 4 Medium

Scenario 6 is an extension of Scenario 3 and models a fewer number of rooms at MGMC and Kimbrough and limits the types of patients going to MGMC.

The primary question for this scenario is: *Is a waiver required for BRAC to allow inpatients (IP) to be seen at Malcolm Grow during the last phase of construction at WRNMMC?*

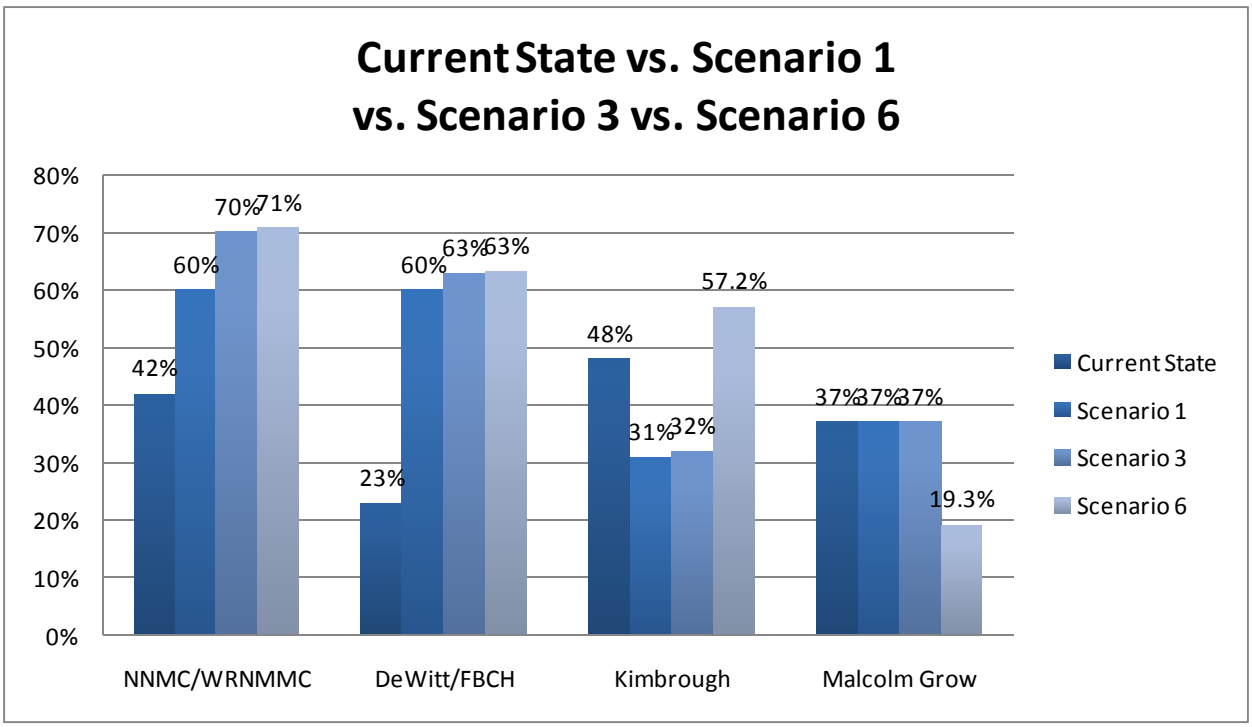
Outcome:

Scenario 3 results:

The results from scenario 1 show WRNMMC and FBCH to be utilized at 60%. This is an increase of almost 50% over the current state for NNMC and WRAMC. Removing inpatient capability from Malcolm Grow spikes the average utilization for WRNMMC to 70%. This is potentially very high for this type of facility and patient mix. Additionally FBCH is already highly utilized. Any variance in patient demand and/or surge requirements may cause issues under this scenario. The recommendation is to request a BRAC waiver for Malcolm Grow until completion of construction at WRNMMC.

Scenario 6 results:

Scenario 6 only exacerbates the situation modeled in scenario 3. WRNMMC and FBCH are still highly utilized. However the potential overflow capacity for inpatients has been removed from MGMC and even the additional outpatient capacity at Kimbrough is now being utilized because of the reduction in the number of available rooms. This situation would require creative mitigation strategies probably with private sector or other government organizations to handle patient demand variability or surges required by war.



Location	Current State	Scenario 1	Scenario 3	Scenario 6
NNMC/WRNMMC	17	13	13	13
WRAMC	16	0	0	0
DeWitt/FBCH	4	10	10	10
Kimbrough	4	8	8	4
Malcolm Grow	6	6 (IP and OP)	6 (OP)	4 (OP)

ATTACHMENTS

Attachment 1: JTF CAPMED Regional Healthcare Delivery Concept of Operation

Attachment 2: JTF CAPMED September 2007 Establishment Document

Attachment 3: Cultural Integration Recommendations White Paper

Attachment 4: January 2009 Action Memo for the Personnel Structure of the NCR Medical

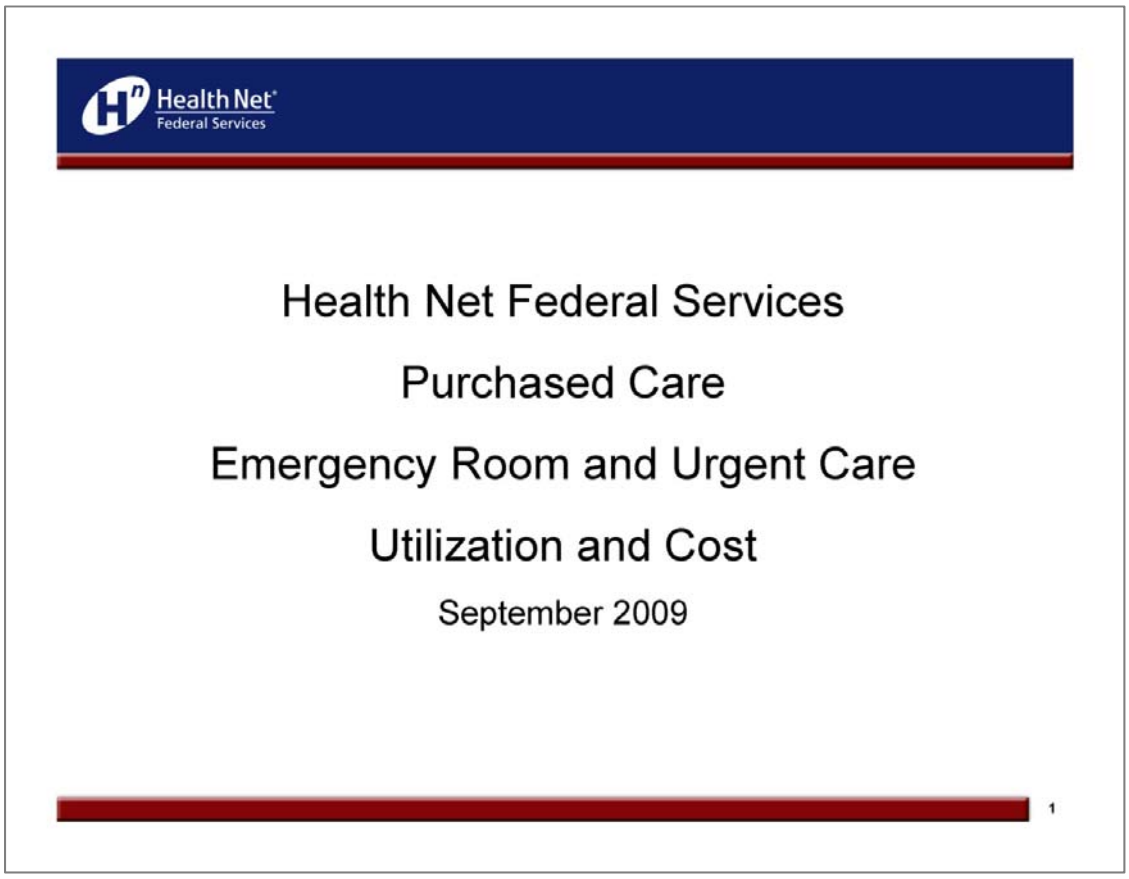
Attachment 5: Operating Room Study

Attachment 6: Emergency Room and Urgent Care Utilization and Cost Study

Attachment 7: National Capital Region Market Analysis – Executive Summary Report

Attachment 8: Project Management Plan for Initial Outfitting and Transition Services for the JTF CAPMED North and South projects

EMERGENCY ROOM AND URGENT CARE UTILIZATION AND COST STUDY



ER Usage - Commercial

Commercial – Loosely Managed*

213 annual cases per 1,000 or 17.8 per month

Commercial – Well Managed*

106 annual cases per 1,000 or 8.8 per month

- Utilization also controlled through the use of:
  - Higher cost-shares than seen in TRICARE
  - Cost differentials between ER and Urgent Care cost-shares

*Source: Milliman, 2008 Health Cost Guidelines, ER Benchmarks

North Overview

(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

- **577,000 overall ER visits or 20.5 per 1,000 eligibles per month**
  - **133% greater than a well managed commercial plan for ER utilization**
- **111,000 overall Urgent Care (UC) visits or 3.9 per 1000 eligibles per month**
- **$355 million in paid dollars or $12.60 per eligible per month**
- **ADFM utilization per 1,000 eligibles is nearly double NADFM**
- **ADFM paid per eligible per month is more than double NADFM**
- **80% of the Top 25 ER diagnosis also reported in the top 25 UC diagnosis**
- **Top 5 most common ER diagnoses make up 23% of the visits and 24% of the paid dollars**
  - **Symptoms involving respiratory system and other chest symptoms (786)**
  - **Other symptoms involving abdomen and pelvis (789)**
  - **General Symptoms (780)**
  - **Injury, other and unspecified (959)**
  - **Symptoms involving the Digestive System (787)**
- **1,576 individual had 10 or more visits in the year**
- **3,045 families had 10 or more visits in the year**

*** Source: HNFS A2D Data Warehouse Report # EO11 by PSA**

North Overview

(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

	Visits per 1,000/Month		Paid $ Millions	
	ER	UC	ER	UC
ADSM	16.7	1.8	$81.9	$1.2
ADFM				
Prime MTF Linked	24.7	4.6	$70.3	$1.9
Prime Civilian Linked	39.2	8.2	$55.7	$1.7
Non-Prime	33.9	6.8	$31.7	$0.8
Combined	30.5	6.1	$157.5	$4.3
NADFM				
Prime MTF Linked	13.8	3.2	$23.7	$0.6
Prime Civilian Linked	20.7	6.0	$38.5	$1.2
Non-Prime	13.9	2.9	$44.5	$1.1
Combined	15.3	3.6	$106.7	$2.9
Overall	20.5	4.0	$346.2	$8.3

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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NCA Overview

(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

	Visits per 1,000/Month		Paid $ Millions	
	ER	UC	ER	UC
ADSM	15.8	1.6	$10.7	$0.2
ADFM				
Prime MTF Linked	19.9	4.5	$13.5	$0.5
Prime Civilian Linked	37.3	9.6	$4.3	$0.2
Non-Prime	23.9	6.8	$2.9	$0.1
Combined	22.6	5.5	$20.8	$0.8
NADFM				
Prime MTF Linked	12.3	2.6	$7.6	$0.2
Prime Civilian Linked	19.2	8.9	$5.3	$0.2
Non-Prime	10.6	2.4	$5.8	$0.2
Combined	12.5	3.5	$18.8	$0.6
Overall	16.7	3.7	$50.9	$1.5

* Based on beneficiaries residing in the NCA

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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Health Net Federal Services

JTF Overview

(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

	Visits per 1,000/Month		Paid $ Millions	
	ER	UC	ER	UC
ADSM	12.1	1.3	$8.9	$0.1
ADFM	19.8	4.5	$13.4	$0.5
NADFM	11.9	2.6	$7.3	$0.2
Overall	14.8	2.9	$29.6	$0.8

* Based on beneficiaries enrolled to a JTF facility

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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Health Net Federal Services

Comparison - Emergency Room
Monthly Visits per 1,000 by enrollment category

(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

	North	NCA	JTF
ADSM	16.7	15.8	12.1
ADFM			
Prime MTF Linked	24.7	19.9	19.8
Prime Civilian Linked	39.2	37.3	N/A
Non-Prime	33.9	23.9	N/A
Combined	30.5	22.6	N/A
NADFM			
Prime MTF Linked	13.8	12.3	11.9
Prime Civilian Linked	20.7	19.2	N/A
Non-Prime	13.9	10.6	N/A
Combined	15.3	12.5	N/A
OVERALL	20.5	16.7	14.8

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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Health Net Federal Services

Comparison - Urgent Care
Monthly Visits per 1,000 by enrollment category
(Dates of Service 4/1/08 – 3/31/09 – Claims through 7/31/09)

	North	NCA	JTF
ADSM	1.8	1.6	1.3
ADFM			
Prime MTF Linked	4.6	4.5	4.5
Prime Civilian Linked	8.2	9.6	N/A
Non-Prime	6.8	6.8	N/A
Combined	6.1	5.5	N/A
NADFM			
Prime MTF Linked	3.2	2.6	2.6
Prime Civilian Linked	6.0	8.9	N/A
Non-Prime	2.9	2.4	N/A
Combined	3.6	3.5	N/A
OVERALL	4.0	3.7	2.9

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

Health Net Federal Services

JTF DETAIL
Emergency Room Utilization and Financial Claims Data Summary
All visits resulting in an Admission Were Excluded
Date of Service 4/1/2008 to 3/31/2009 Claims Processed Through 7/31/2009

		ADFM					NADFM					ADSM				
			Emergency					Emergency					Emergency			
Facility Name	ID	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM
Walter Reed Army Medical Center	P0037	3,106	525	13.77	$ 310,494	$ 8.15	7,359	799	8.75	$ 448,783	$ 4.91	13,396	1,224	7.77	$ 1,000,879	$ 6.35
Walter Reed Army Medical Center	C0037	3,106	525	13.78	$ 310,494	$ 8.15	7,343	799	8.77	$ 448,783	$ 4.93	3,581	380	8.95	$ 275,604	$ 6.49
DiLorenzo Tricare Health Clinic Arlington	C7298	-	-	0.00	$ -	$ -	1	-	0.00	$ -	$ -	1,076	96	7.81	$ 87,814	$ 7.20
DiLorenzo Tricare Health Clinic	C0256	-	-	0.00	$ -	$ -	15	-	0.00	$ -	$ -	8,739	748	7.27	$ 637,461	$ 6.19
McNair Army Health Clinic	C0255	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NNMC Bethesda	P0067	12,417	2,496	16.68	$ 1,389,691	$ 9.07	9,952	1,056	8.77	$ 634,265	$ 5.27	14,937	2,149	12.04	$ 1,841,237	$ 10.32
NNMC Bethesda	C0067	11,049	1,854	13.96	$ 982,018	$ 7.39	9,017	884	8.14	$ 519,938	$ 4.79	6,928	584	7.06	$ 393,397	$ 4.75
NMHC Washington Navy Yard	C0703	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	2,966	283	8.13	$ 267,482	$ 7.69
NBHC Andrews AFB	C0522	1	-	0.00	$ -	$ -	2	-	0.00	$ -	$ -	1,261	121	8.13	$ 69,727	$ 4.69
NBHC Indian Head	C0301	472	262	42.20	$ 128,183	$ 21.47	386	68	11.84	$ 26,039	$ 5.32	193	46	20.06	$ 29,062	$ 12.69
BMC Lakehurst	C0401	12	5	34.48	$ 3,025	$ 20.86	22	5	15.87	$ 4,183	$ 13.28	329	117	29.42	$ 112,207	$ 26.21
NBHC Dahlgren	C0366	876	382	35.27	$ 243,123	$ 22.45	518	109	16.83	$ 84,106	$ 12.99	770	127	13.18	$ 68,436	$ 9.18
BMC Mechanicsburg	C0348	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC Willow Grove	C0347	-	-	0.00	$ -	$ -	5	-	0.00	$ -	$ -	1,847	690	30.46	$ 725,222	$ 32.02
BMC Sugar Grove	C0404	-	-	0.00	$ -	$ -	1	-	0.00	$ -	$ -	147	52	28.73	$ 41,674	$ 23.02
Philadelphia Navy Yard	C0344	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC Colts Neck, Earle	C0322	7	3	26.55	$ 3,342	$ 29.57	1	-	0.00	$ -	$ -	477	129	22.80	$ 114,008	$ 20.15
BMC Glenbrook	C0302	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC NRL Washington	C0259	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NHC Patuxent River	P0068	4,022	2,012	41.01	$ 1,095,149	$ 22.32	2,425	659	21.85	$ 343,567	$ 11.39	2,633	634	18.89	$ 369,993	$ 11.03
Kimbrough Ambulatory Care Center	P0069	16,478	6,444	32.20	$ 3,238,446	$ 16.18	14,181	3,384	20.22	$ 1,961,620	$ 11.72	14,292	3,711	22.16	$ 2,325,284	$ 13.89
Kimbrough Ambulatory Care Center	C0069	8,193	2,851	28.31	$ 1,392,887	$ 13.83	5,466	1,023	15.68	$ 624,718	$ 9.58	8,407	2,036	20.56	$ 1,285,839	$ 12.98
Kirk AHC	C0308	3,180	1,659	43.17	$ 874,677	$ 22.76	2,586	860	27.96	$ 461,151	$ 14.99	1,657	582	30.5	$ 353,993	$ 19.09
OHC Edgewood Arsenal	C0545	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	520	140	24.36	$ 84,836	$ 14.77
TMC Aberdeen Proving Ground	C0481	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
Berquist AHC	C0309	2,155	764	30.70	$ 356,926	$ 14.34	1,553	303	17.81	$ 136,504	$ 8.02	1,600	386	20.67	$ 239,870	$ 12.78
Dunham AHC	C0352	2,950	1,170	32.42	$ 613,956	$ 17.01	4,576	1,196	22.03	$ 739,247	$ 13.59	2,108	565	22.81	$ 350,746	$ 14.16
Indiantown Gap AHC	C0350	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
New Cumberland Army Depot AHC	C0441	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
Letterkenny Army Depot AHC	C0351	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
DeWitt Army Community Hospital	P0123	35,617	5,750	13.45	$ 3,916,230	$ 9.28	31,891	3,695	9.65	$ 2,588,433	$ 6.75	11,376	1,152	8.44	$ 956,373	$ 7.17
DeWitt Army Community Hospital	C0123	16,334	1,669	8.54	$ 1,032,118	$ 5.35	6,490	497	6.50	$ 229,362	$ 4.29	6,216	415	5.61	$ 341,269	$ 4.61
Family Health Center Woodbridge	C8201	9,403	2,337	20.79	$ 1,716,207	$ 15.20	14,107	1,952	11.90	$ 1,403,888	$ 8.13	1,112	123	9.40	$ 117,832	$ 9.00
Family Health Center Fairfax	C8200	7,392	1,286	14.68	$ 858,730	$ 9.80	7,130	787	9.04	$ 528,256	$ 6.07	1,283	143	9.77	$ 103,634	$ 7.08
Andrew Rader AHC	C0390	2,488	458	16.03	$ 309,175	$ 10.82	4,164	459	9.73	$ 330,907	$ 7.02	2,766	471	14.87	$ 393,642	$ 12.43
AP Hill AHC	C0375	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NHC Annapolis	P0306	2,228	589	21.24	$ 288,403	$ 10.40	2,102	377	14.91	$ 188,415	$ 7.45	6,523	810	10.35	$ 506,782	$ 6.47
NHC Annapolis	C0306	2,228	589	21.24	$ 288,403	$ 10.40	2,102	364	14.39	$ 182,820	$ 7.23	1,546	302	16.85	$ 176,211	$ 9.83
NBHC Bancroft Hall	C0525	-	-	0.00	$ -	$ -	-	13	13,000.00	$ 5,595	$ 5,594.97	4,975	508	8.42	$ 330,572	$ 5.48
NHC Quantico	P0305	6,250	2,828	26.63	$ 2,114,521	$ 19.91	3,921	617	16.49	$ 652,596	$ 13.17	8,627	1,406	13.63	$ 1,247,944	$ 12.10
NHC Quantico	C0305	6,250	2,828	26.63	$ 2,114,521	$ 19.91	3,921	617	16.49	$ 652,596	$ 13.17	4,954	962	14.56	$ 784,014	$ 13.24
NBHC The Basic School	C1671	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	2,650	414	12.98	$ 337,422	$ 10.58
BMC OCS Brown Field	C1670	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	1,023	130	10.77	$ 126,508	$ 10.48
79th Medical Group Andrews AFB	P0066	9,270	1,484	12.86	$ 795,173	$ 6.89	8,355	721	7.19	$ 428,368	$ 4.42	7,778	578	6.19	$ 415,408	$ 4.45
579th Medical Group- Bolling AFB	P0413	3,042	414	11.01	$ 262,256	$ 6.98	887	71	6.23	$ 53,436	$ 4.69	3,396	289	6.95	$ 234,326	$ 5.64

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

Health Net Federal Services

JTF DETAIL

Urgent Care Utilization and Financial Claims Data Summary
All visits resulting in an Admission Were Excluded
Date of Service 4/1/2008 to 3/31/2009 Claims Processed Through 7/31/2009

		ADPM					NADPM					ADSM				
			Urgent Care					Urgent Care					Urgent Care			
Facility Name	ID	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM	Enrollees	Visits	Visits per 1,000	Paid $	Paid PEPM
Walter Reed Army Medical Center	P0037	3,106	69	1.81	$ 4,252	$ 0.11	7,309	121	1.32	$ 7,179	$ 0.08	13,396	119	0.73	$ 14,433	$ 0.09
Walter Reed Army Medical Center	C0037	3,106	69	1.81	$ 4,252	$ 0.11	7,343	121	1.33	$ 7,179	$ 0.08	3,581	47	1.11	$ 6,866	$ 0.14
DiLorenzo Tricare Health Clinic Arlington	C7298	-	-	0.00	$ -	$ -	1	-	0.00	$ -	$ -	1,076	9	0.74	$ 989	$ 0.06
DiLorenzo Tricare Health Clinic	C0255	-	-	0.00	$ -	$ -	15	-	0.00	$ -	$ -	8,739	59	0.57	$ 7,576	$ 0.07
McNair Army Health Clinic	C0255	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NNMC Bethesda	P0067	12,417	340	2.27	$ 29,466	$ 0.20	9,952	156	1.30	$ 8,038	$ 0.07	14,937	122	0.66	$ 15,386	$ 0.09
NNMC Bethesda	C0067	11,049	297	2.24	$ 24,482	$ 0.18	9,017	142	1.31	$ 7,405	$ 0.07	6,928	75	0.91	$ 10,340	$ 0.12
NBHC Washington Navy Yard	C0703	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	2,965	14	0.40	$ 1,557	$ 0.04
NBHC Andrews AFB	C0522	-	-	0.00	$ -	$ -	3	-	0.00	$ -	$ -	1,281	13	0.67	$ 1,459	$ 0.10
NBHC Indian Head	C0301	472	10	1.67	$ 1,681	$ 0.28	386	1	0.20	$ 20	$ 0.00	193	3	1.31	$ 294	$ 0.13
BMC Lakehurst	C0401	12	-	0.00	$ -	$ -	22	-	0.00	$ -	$ -	329	1	0.25	$ 18	$ 0.00
NBHC Dahlgren	C0386	876	33	3.05	$ 3,303	$ 0.30	518	13	2.01	$ 612	$ 0.09	770	4	0.42	$ 377	$ 0.04
BMC Mechanicsburg	C0348	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC Willow Grove	C0347	-	-	0.00	$ -	$ -	5	-	0.00	$ -	$ -	1,847	10	0.44	$ 1,105	$ 0.05
BMC Sugar Grove	C0404	-	-	0.00	$ -	$ -	1	-	0.00	$ -	$ -	147	-	0.00	$ -	$ -
Philadelphia Navy Yard	C0344	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC Cutts Neck, Earle	C0322	7	-	0.00	$ -	$ -	1	-	0.00	$ -	$ -	477	2	0.35	$ 238	$ 0.04
BMC Carderock	C0302	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
BMC NRL Washington	C0259	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NHC Patuxent River	P0066	4,022	224	4.57	$ 14,694	$ 0.30	2,425	82	2.72	$ 4,347	$ 0.14	2,633	25	0.79	$ 2,252	$ 0.07
Kimbrough Ambulatory Care Center	P0069	16,476	1,719	8.69	$ 161,735	$ 0.81	14,181	734	4.38	$ 58,603	$ 0.35	14,292	522	3.12	$ 58,915	$ 0.36
Kimbrough Ambulatory Care Center	C0069	8,193	1,149	11.41	$ 108,810	$ 1.08	5,496	333	5.11	$ 26,904	$ 0.41	8,407	216	2.18	$ 24,482	$ 0.25
Kirk AHC	C0308	3,180	445	11.58	$ 43,872	$ 1.14	2,586	342	11.12	$ 27,036	$ 0.88	1,667	226	11.85	$ 26,036	$ 1.37
OHC Edgewood Arsenal	C0545	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	520	29	4.64	$ 3,224	$ 0.56
TMC Aberdeen Proving Ground	C0481	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
Barquist AHC	C0309	2,155	97	3.90	$ 6,876	$ 0.28	1,553	43	2.53	$ 2,630	$ 0.15	1,600	39	1.92	$ 3,381	$ 0.18
Dunham AHC	C0352	2,950	28	0.78	$ 2,177	$ 0.06	4,576	16	0.29	$ 2,033	$ 0.04	2,106	15	0.61	$ 1,792	$ 0.07
Indiantown Gap AHC	C0350	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
New Cumberland Army Depot AHC	C0441	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
Letterkenny Army Depot AHC	C0351	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
DeWitt Army Community Hospital	P0123	35,617	968	2.29	$ 76,432	$ 0.18	31,891	679	1.77	$ 37,208	$ 0.10	11,376	104	0.78	$ 11,064	$ 0.08
DeWitt Army Community Hospital	C0123	16,334	209	1.08	$ 15,982	$ 0.08	6,490	66	0.86	$ 3,132	$ 0.04	6,216	44	0.59	$ 4,587	$ 0.06
Family Health Center Woodbridge	C8201	9,403	305	2.70	$ 24,443	$ 0.22	14,107	370	2.14	$ 19,777	$ 0.11	1,112	5	0.38	$ 419	$ 0.03
Family Health Center Fairfax	C8200	7,392	400	4.57	$ 32,144	$ 0.37	7,130	188	2.16	$ 11,310	$ 0.13	1,283	27	1.75	$ 2,722	$ 0.19
Andrew Rader AHC	C0390	2,488	54	1.89	$ 3,863	$ 0.14	4,164	56	1.17	$ 2,988	$ 0.06	2,765	28	0.88	$ 3,326	$ 0.10
AP Hill AHC	C0375	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -
NHC Annapolis	P0306	2,228	764	27.56	$ 74,617	$ 2.69	2,102	300	13.84	$ 28,089	$ 1.11	6,023	175	2.24	$ 21,401	$ 0.27
NHC Annapolis	C0306	2,228	764	27.56	$ 74,617	$ 2.69	2,102	349	13.80	$ 28,021	$ 1.11	1,548	106	5.91	$ 12,607	$ 0.70
NBHC Bancroft Hall	C0525	-	-	0.00	$ -	$ -	-	1	1,000.00	$ 66	$ 66.25	4,975	69	1.14	$ 6,844	$ 0.15
NHC Quantico	P0385	8,250	564	5.50	$ 37,278	$ 0.35	3,921	216	4.36	$ 10,597	$ 0.21	8,627	121	1.17	$ 11,702	$ 0.11
NHC Quantico	C0385	8,250	564	5.50	$ 37,278	$ 0.35	3,921	216	4.36	$ 10,597	$ 0.21	4,954	76	1.28	$ 7,035	$ 0.12
NBHC The Basic School	C1671	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	2,650	36	1.13	$ 3,529	$ 0.11
BMC OCS Brown Field	C1670	-	-	0.00	$ -	$ -	-	-	0.00	$ -	$ -	1,023	9	0.75	$ 1,226	$ 0.10
79th Medical Group Andrew's AFB	P0066	9,270	250	2.17	$ 19,059	$ 0.17	8,355	165	1.70	$ 11,169	$ 0.12	7,778	49	0.52	$ 5,899	$ 0.06
579th Medical Group- Bolling AFB	P0413	3,042	253	6.73	$ 30,076	$ 0.80	887	52	4.57	$ 8,035	$ 0.53	3,396	19	0.46	$ 1,814	$ 0.04

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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Health Net Federal Services

ER Purchased Care Top Diagnoses

After Hours MTF Clinic/ERHours
Dates of Service: 4/1/08 to 3/3/1/09 Claims Processed Through 7/31/09

		JTF			DeWitt			NNMC Bethesda			Walter Reed		
Code	Diagnosis	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000
786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	1	3,541	1.1	2	165	0.5	2	223	0.7	1	123	0.7
789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	3	2,439	0.8	3	100	0.3	3	157	0.5	2	91	0.5
780	GENERAL SYMPTOMS	2	2,501	0.8	1	171	0.5	1	227	0.7	3	86	0.5
959	INJURY, OTHER AND UNSPECIFIED	4	105	0.0	4	92	0.3	4	120	0.4	4	58	0.3
462	ACUTE PHARYNGITIS	5	87	0.0	8	63	0.2	6	91	0.3	5	49	0.3
787	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	6	73	0.0	11	49	0.1	7	88	0.3	6	49	0.3
719	OTHER AND UNSPECIFIED DISORDS OF JOINT	7	1,125	0.4	6	80	0.2	9	77	0.2	7	42	0.2
873	OTHER OPEN WOUND OF HEAD	8	63	0.0	9	53	0.2	10	63	0.2	8	38	0.2
599	OTHER DISORDERS OF URETHRA AND URINARY TRACT	9	57	0.0	5	85	0.2	5	117	0.4	9	37	0.2
784	SYMPTOMS INVOLVING HEAD AND NECK	10	57	0.0	10	51	0.1	19	38	0.1	10	37	0.2
465	ACUTE UPPER RESPIRATORY INFECTIONS OF MULTIPLE OR UNSPECIFIED SITES	11	56	0.0	14	48	0.1	13	48	0.1	11	37	0.2
847	SPRAINS AND STRAINS OF OTHER AND UNSPECIFIED PARTS OF BACK	12	52	0.0	7	64	0.2	8	79	0.2	12	33	0.2
724	OTHER AND UNSPECIFIED DISORDERS OF BACK	13	51	0.0	17	33	0.1	20	36	0.1	13	32	0.2
845	SPRAINS AND STRAINS OF ANKLE AND FOOT	14	51	0.0	13	48	0.1	12	48	0.1	14	28	0.2
382	SUPPURATIVE AND UNSPECIFIED OTITIS MEDIA	15	49	0.0	15	46	0.1	17	40	0.1	15	28	0.2
788	SYMPTOMS INVOLVING URINARY SYSTEM	16	39	0.0		0	0.0	18	40	0.1	16	27	0.2
592	CALCULUS OF KIDNEY AND URETER	17	38	0.0	19	29	0.1	23	35	0.1	17	27	0.2
729	OTHER DISORDERS OF SOFT TISSUES	18	37	0.0		26	0.1	0	0	0.0	18	37	0.2
692	CONTACT DERMATITIS AND OTHER ECZEMA	19	36	0.0	21	27	0.1	11	51	0.2	19	36	0.2
782	SYMPTOMS INVOLVING SKIN AND OTHER INTEGUMENTARY TISSUE	20	36	0.0		26	0.1	0	0	0.0	20	36	0.2
923	CONTUSION OF UPPER LIMB	21	35	0.0	16	40	0.1	0	0	0.0	21	35	0.2
466	ACUTE BRONCHITIS AND BRONCHIOLITIS	22	34	0.0	25	23	0.1	22	35	0.1	22	34	0.2
682	OTHER CELLULITIS AND ABSCESS	23	32	0.0	20	28	0.1	16	40	0.1	23	32	0.2
883	OPEN WOUND OF FINGER(S)	24	30	0.0	12	49	0.1	14	48	0.1	24	30	0.2
813	FRACTURE OF RADIUS AND ULNA	25	27	0.0		0	0.0			0.0	25	27	0.2
372	DISORDERS OF CONJUNCTIVA	0	0	0.0	18	29	0.1	21	35	0.1	0	0	0.0
729	OTHER DISORDERS OF SOFT TISSUES	0	0	0.0	22	26	0.1	0	0	0.0	0	0	0.0
883	OPEN WOUND OF FINGER(S)	0	0	0.0	23	26	0.1	0	0	0.0	0	0	0.0
034	STREPTOCOCCAL SORE THROAT AND SCARLET FEVER	0	0	0.0	24	24	0.1	0	0	0.0	0	0	0.0
346	MIGRAINE	0	0	0.0	0	0	0.0	15	46	0.1	0	0	0.0
388	OTHER DISORDERS OF EAR	0	0	0.0	0	0	0.0	24	34	0.1	0	0	0.0
464	ACUTE LARYNGITIS AND TRACHEITIS	0	0	0.0	0	0	0.0	25	31	0.1	0	0	0.0

MTF	Member Months		
JTF	3,108,917	NNMC	324,165
DeWitt	343,578	WRAMC	171,700

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

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Health Net Federal Services

ER Purchased Care Top Diagnoses
No After Hours MTF Clinic/ERHours
Dates of Service: 4/1/08 to 3/3/1/09 Claims Processed Through 7/31/09

		JTF			Pax River			APG/Kirk			Carlisle/Dunham		
Code	Diagnosis	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000	Rank	Visits	Per 1,000
780	GENERAL SYMPTOMS	1	3541	1.1	3	198	1.8	3	140	1.6	3	138	1.2
786	SYMPTOMS INVOLVING RESPIRATORY SYSTEM AND OTHER CHEST SYMPTOMS	3	2439	0.8	2	239	2.1	1	176	2.0	1	272	2.4
789	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS	2	2501	0.8	1	243	2.2	2	166	1.9	2	161	1.4
959	INJURY, OTHER AND UNSPECIFIED	4	92	0.0	4	132	1.2	10	71	0.8	4	105	0.9
382	SUPPURATIVE AND UNSPECIFIED OTITIS MEDIA	5	85	0.0	13	47	0.4	8	72	0.8	15	49	0.4
873	OTHER OPEN WOUND OF HEAD	6	80	0.0	10	63	0.6	12	64	0.7	8	63	0.5
465	ACUTE UPPER RESPIRATORY INFECTIONS OF MULTIPLE OR UNSPECIFIED SITES	7	1125	0.4	17	45	0.4	7	79	0.9	11	56	0.5
787	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	8	63	0.0	5	112	1.0	5	88	1.0	6	73	0.6
462	ACUTE PHARYNGITIS	9	53	0.0	12	57	0.5	6	79	0.9	5	87	0.8
724	OTHER AND UNSPECIFIED DISORDERS OF BACK	10	51	0.0	9	66	0.6	9	71	0.8	13	51	0.4
784	SYMPTOMS INVOLVING HEAD AND NECK	11	49	0.0	6	92	0.8	4	93	1.1	10	57	0.5
995	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED	12	49	0.0	24	34	0.3	8	79	0.9	12	33	0.3
599	OTHER DISORDERS OF URETHRA AND URINARY TRACT	13	48	0.0	23	36	0.3	14	49	0.6	9	57	0.5
847	SPRAINS AND STRAINS OF OTHER AND UNSPECIFIED PARTS OF BACK	14	48	0.0	19	41	0.4	11	69	0.8	12	52	0.5
682	OTHER CELLULITIS AND ABSCESS	15	46	0.0	11	62	0.5	16	45	0.5	23	32	0.3
782	SYMPTOMS INVOLVING SKIN AND OTHER INTEGUMENTARY TISSUE	16	40	0.0	15	47	0.4	26	35	0.4	20	36	0.3
719	OTHER AND UNSPECIFIED DISORDS OF JOINT	17	32	0.0	7	74	0.7	20	38	0.4	7	68	0.6
079	VIRAL AND CHLAMYDIAL INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE	20	28	0.0		26	0.2	13	54	0.6	20	28	0.2
493	ASTHMA	21	27	0.0	22	39	0.3	19	39	0.4	21	27	0.2
729	OTHER DISORDERS OF SOFT TISSUES	22	26	0.0	25	23	0.2	24	35	0.4	22	26	0.2
883	OPEN WOUND OF FINGER(S)	23	26	0.0	20	28	0.2	16	40	0.5	24	30	0.3
466	ACUTE BRONCHITIS AND BRONCHIOLITIS	26	23	0.0		0	0.0	15	77	0.9	22	34	0.3
372	DISORDERS OF CONJUNCTIVA	0	0	0.0	18	29	0.3	23	36	0.4	0	0	0.0
729	OTHER DISORDERS OF SOFT TISSUES	0	0	0.0	8	68	0.6	0	0	0.0	18	37	0.3
346	MIGRAINE	0	0	0.0	0	0	0.0	17	43	0.5	0	0	0.0
388	OTHER DISORDERS OF EAR	0	0	0.0	16	47	0.4	24	34	0.4	0	0	0.0
640	HEMMORHAGE IN EARLY PREGNANCY			0.0	14	46	0.4			0.0			0.0
648	OTHER CURRENT CONDITIOINS IN THEMOTHER CLASSIFIABLE ELSEWHERE, BUT COMPLICATING PREGNANCY			0.0	18	45	0.4			0.0			0.0
644	EARLY OR THREATENED LABOR			0.0	20	40	0.4	21	37	0.4			0.0
845	SPRAINS AND STRAINS OF ANKLE AND FOOT			0.0	21	40	0.4	18	40	0.5	14	51	0.4
486	PNEUMONIA, ORGANISM NOS			0.0	26	33	0.3			0.0			0.0
276	DISORDERS OF FLUID AND ELECTROLYTE AND ACID-BASED BALANCE			0.0			0.0	22	36	0.4			0.0
788	SYMPTOMS INVOLVING URINARY SYSTEM			0.0			0.0			0.0	16	39	0.3
592	CALCULUS OF KIDNEY URETER			0.0			0.0			0.0	17	38	0.3
692	CONTACT DERMATITIS AND OTHER ECZEMA			0.0			0.0			0.0	19	36	0.3
923	CONTUSION OF UPPER LIMB			0.0			0.0			0.0	21	35	0.3
813	FRACTURE OF RADIUS AND ULNA			0.0			0.0			0.0	26	27	0.2

MTF	Member Months		
JTF	3,108,917	APG	88,253
Pax	112,788	Carlisle	115,244

* Source: HNFS A2D Data Warehouse Report # EO11 by PSA

Health Net Federal Services

DISCUSSION POINTS

- Rich Benefit
- If you're open they will come
- ER is more costly than Urgent Care

Health Net Federal Services

QUESTIONS???

ATTACHMENTS

Attachment 1: JTF CAPMED Regional Healthcare Delivery Concept of Operation

Attachment 2: JTF CAPMED September 2007 Establishment Document

Attachment 3: Cultural Integration Recommendations White Paper

Attachment 4: January 2009 Action Memo for the Personnel Structure of the NCR Medical

Attachment 5: Operating Room Study

Attachment 6: Emergency Room and Urgent Care Utilization and Cost Study

Attachment 7: National Capital Region Market Analysis – Executive Summary Report

Attachment 8: Project Management Plan for Initial Outfitting and Transition Services for the JTF CAPMED North and South projects

Health Innovation

January 11, 2010

National Capital Region (NCR) Market Analysis – Executive Summary Report

noblis

For the best of reasons

National Capital Region (NCR) Market Analysis
Executive Summary Report

Table of Contents

The Executive Summary Report:

Background 1
Market Area Definition and Military Treatment Facilities (MTFs) in the Market 3
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Highlights of the Findings from the Market Analysis 6
Methodology, Approach, and Data Sources Overview 12
Glossary of Terms and Acronyms 13

List of Companion Documents (Provided Under Separate Cover)**:**

Informational Brief Dated November 16, 2009

Appendix A: NCR Market Profile

Appendix B: NCR MTF Profiles

Appendix C: Methodology, Approach, Glossary and Data Sources

Appendix D: Comparison of NCR findings to MHS & San Antonio Military Medical Center

Background

The Joint Task Force (JTF) charged Noblis with the task of preparing an in-depth market analysis of the National Capital Region (NCR) in FY2009. The key objectives of the market analysis as defined by the JTF included:

1. Determine the reliant population
2. Estimate workload demand
3. Understand market dynamics
4. Project future demand given current trends

This document has been produced to provide a concise executive summary report of the NCR Market Analysis.

Noblis completed relevant analyses in 2009 and the findings were presented and discussed in a briefing with JTF leadership on November 16, 2009. This briefing document was accompanied by four Appendices, which included much of the more detailed analyses. The content of these Appendices, which are referenced in this executive summary report, included the following materials.

- *Appendix A: NCR Market Profile*
  - Population – Eligible and enrolled beneficiaries residing in any zip code within the NCR, regardless of where care was delivered
  - Demand, Market Share, and Workload – Total healthcare demand from the beneficiary population in the NCR, including care delivered in the network (Purchased Care) and NCR MTFs (Direct Care), at a Clinical Service/Product Line level
  - Projected Future Demand Under the Current Trajectory – The calculation of future beneficiary populations applied to the most current utilization rates and market share trends to determine potential future direct-care workload

- *Appendix B: NCR MTF Profiles*
  - Profile of "J4 + 3" ("J4" - NNMC, WRAMC, MGMC, DeWitt and "+3" - Kimbrough, Annapolis, Quantico)

- *Appendix C: Methodology, Approach, Glossary and Data Sources*
  - Description of market area definition, product and clinical service line definitions, data sources, methodology, and a glossary

- *Appendix D: Comparison of NCR Findings to MHS & San Antonio Military Medical Center*

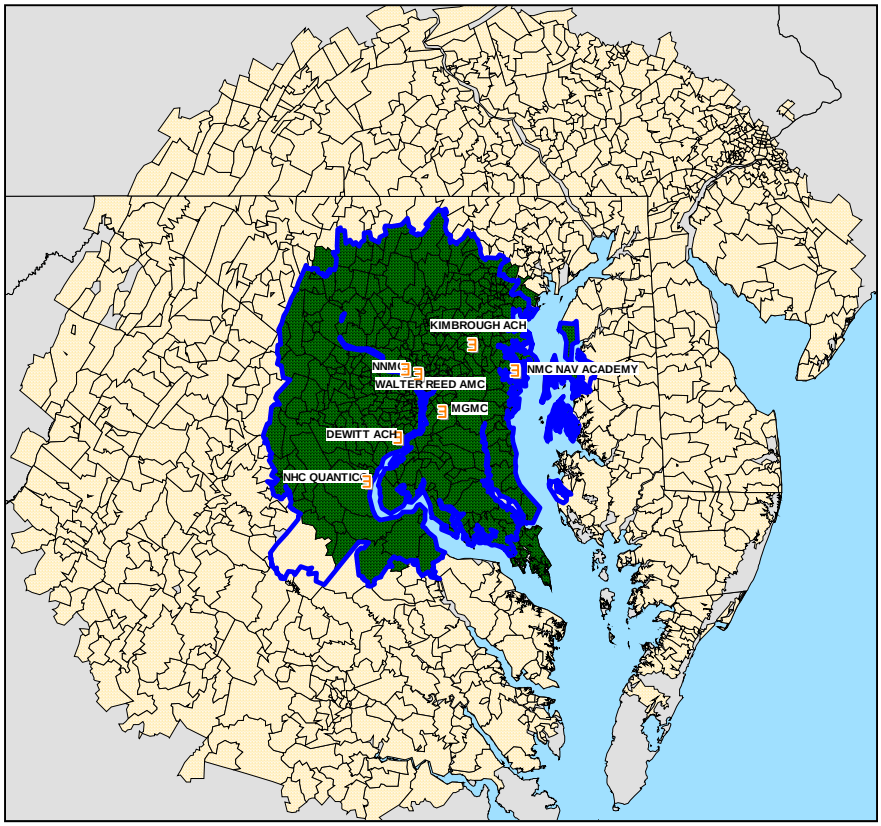
A more detailed list describing the analyses that are included in each of these Appendices is included in Table 1 of the next page.

Table 1: List of Analyses Included in the 16 Nov 09 Briefing Appendices

Appendix A *Market Profile*	**Appendix B** *MTF Profiles*	**Appendix C** *Approach, Sources*
Beneficiary population analysis • Beneficiary population trend • Beneficiary population by BenCat & ACV • Beneficiary category-ACV cross-walk **Enrolled population analysis** • Enrolled population trend • Enrollment trend by BenCat & ACV • Enrollment trend at NCR MTFs • Preferred enrollment site by BenCat and ACV **Direct & Purchased Inpatient Care Utilization** • Trends in discharges, days, ALOS, and ADC • Discharges by beneficiary category • Change in discharges by BenCat • Trends in preference of location of care • Utilization trend by Product Line • Utilization by Product Line and BenCat • Inpatient DC & PC Migration Patterns **Inpatient Direct Care Market Share** • By MDC and Clinical Service Line **Direct & Purchased Outpatient Care** • Trends in DC and PC outpatient RVU utilization • Change in outpatient RVU utilization by product line • Change in outpatient RVU utilization by Ben Cat and ACV • Purchased Care patient migration pattern • Outpt RVU DC market share by product line and for select Medical, Surgical, and Beh Health offerings **Future IP and OP workload projection**	**Profile of 7 NCR MTFs** • Map showing 30 minute drive time outline, catchment/PRISM area outline, location of MTF, location of other MHS facilities, location of private short-term acute facilities in area • Population analyses - Total enrollees (any area), enrollees within NCA market area, enrollees within c/P area, enrollees within 100 miles, enrollees within 30 minute drive time • Workload for those enrollees within 30 minute drive time • Direct OP RVUs & encounters • Direct IP dispositions, days, ALOS, ADC • Purchased IP admissions, days • Purchased OP RVUs • Pie charts comparing direct to purchased workloads • Short term acute facility in area analysis • Closest facility by drive time and distance and most used private sector facilities	• Market area definition • Data Sources • Product line, MDC, and clinical service line definitions • Future workload methodology • Glossary of terms and Acronyms **Appendix D** *Other Markets* • Comparison of JOA workload to MHS and San Antonio Military Medical Center

Market Area Definition and Military Treatment Facilities (MTFs) in the Market

The historical catchment-area rules governing TRICARE eligibility/enrollment (40 and 20 mile radius around hospitals and clinics, respectively) determined the outer boundaries of the market area. Additional "slices" of the market are available, including analysis of new access rules - e.g. 30 minute drive-time. There are a total of 23 MTFs in the NCR. Beneficiary populations and workload provided by these 23 MTFs is included in the Market Analysis. Noblis also developed detailed profiles of the "J4+3" existing facilities: "J4" (NNMC, WRAMC, MGMC, DeWitt) and "+3" (Kimbrough, Annapolis, Quantico). These seven MTFs were profiled in *Appendix B.*



DMIS	MTF	Zip
Inpatient MTFs		
0037	WRAMC	20307
0066	MGMC	20762
0067	NNMC	20889
0123	DeWitt - Belvoir	22060
Ambulatory MTFs		
0069	Kimbrough	20755
0306	Annapolis	21402
0385	Quantico (inc. 1670 & 1671)	22134

30 Minute Drive Time – Based on JTF supplied drive times for all facilities within 30 miles except for WRAMC and Annapolis. Missing data for these zips were filled in by Noblis based on zip code to zip code and not exact address to exact address. Yearly comparisons assumed zips are consistent through 2004 to 2008 (no changes to boundaries, etc.) 30 minute drive time formula: less than 31 miles.

Catchment/PRISM Area - Based on the Joint 4 + 3 zip codes (40 mile radius for WRAMC, MGMC, NNMC and DeWitt-Belvoir and the 20 mile radius for Kimbrough, Annapolis and Quantico) determined by the MapInfo Zip Point file, MapInfo Zip Boundary file and M2 listed zips for this area. Also taken into consideration are zip codes from the "*Zips Within 100 Miles.xls" file (see source notes on profile sheets).* Catchment/PRISM area formula: Less than 41 or less than 21 miles.

100 Miles Distances – Based on JTF supplied distances from the "Zip within 100

Strategic Context

Noblis developed in-depth analyses of NCR **demographic characteristics, current workload, and future workload** because they have significant impact on strategic decisions regarding care delivery and the education mission. Some of the strategic implications of the market analysis data are as follows.

- Trends in the **demographic characteristics** (size and age mix) of both the eligible and enrolled patient populations in the NCR are strategically significant for the JTF because:
  - The size and age mix of the population to be served in the future are the primary determinants of the scope of nature of clinical services that they will required and the demand for care resources.
  - The older age cohorts of the service population will have greater and more clinically complex medical and surgical care needs than the younger cohorts of the populations.
  - It is the future enrolled portion of the total eligible population, who receive their care from the MHS system - either through direct care resources at military treatment facilities (MTFs) or through other non-MHS providers in the TRICARE contract network – that will determine the total future clinical workloads to which the integrated system of healthcare delivery's capacity will need to be sized.
  - It is the future utilization of the enrolled portion of the eligible population of the system's direct care resources (MTFs) that will determine the future workloads to which the capacity of the system's direct care resources (facilities, staff, equipment) will need to be right sized.
- Trends in the **current clinical workload demand** generated by the enrolled patient populations in the NCR utilizing the direct care system capacity are strategically significant for the JTF because:
  - The total annual volume of workload demand in each clinical service that are produced by the populations using the direct care system resources will impact the extent to which a critical mass of activity exists at an individual MTF to support a both a clinically-effective and cost-effective service or program (clinical care, training and/or research).
- Trends in the **market share** of the Direct Care System significantly influence **projections for future workload** and are strategically significant for the JTF because:
  - The critical mass of inpatient and specialty care workload is particularly important in order to attract and retain clinical providers and staff who are necessary for GME/Health Profession Education, training and research.
  - Once patients leave the direct care system, it becomes increasingly harder to "recapture" the workload generated by these patients.
  - Additional future losses in market presence become inevitable as providers and others shift to where the patients are seeking care.

Strategic Conclusions and Implications

1. The NCR population and overall demand for medical care services is significant, and will support robust inpatient and outpatient health delivery initiatives for the foreseeable future.

2. The NCR direct care system has experienced a substantial loss of "market share" to network providers; a pattern, which if continued, could threaten the viability of the academic programs, might result in excess capacity of facilities already in construction, and may have an overall negative impact on fulfillment of a host of medical military missions.

3. JTF CAPMED confronts a classic set of "marketing" challenges – how to steer or influence eligible beneficiaries into the NCR direct care system or alternatively, choose to partner in new and different ways.

4. Fortunately, the NCR already possesses the component attributes –people, infrastructure, technology, knowledge systems, etc. - to attack and resolve these challenges.

Recommendations for Next Steps

The market analysis is the first step in an assessment of the MHS NCR. Key findings from the market analysis indicate additional analyses are required within an aggressive time-frame for strategic decision making:

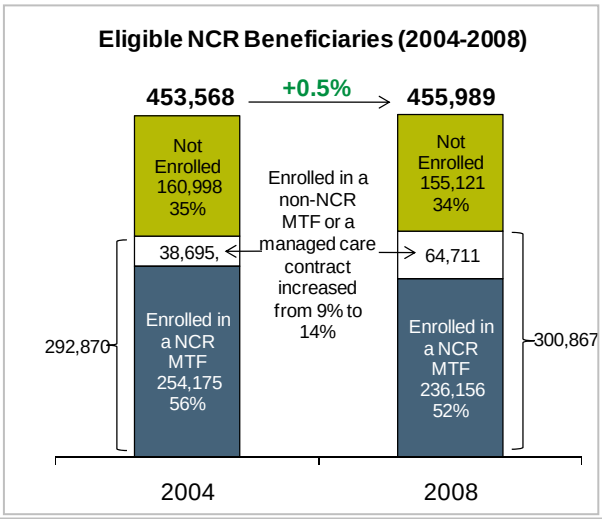
- A comprehensive assessment of:
  - Financial implications of patient migration and market share changes
  - Operational implications (scheduling/appointing, template management, staffing, etc.)
  - Marketing/additional market planning requirements
  - Impact of changes in approaches to care management (e.g., medical home models, chronic disease management programs, telemedicine visits/consults, etc.) and changes in approaches to care delivery models and processes (e.g., extended hours, flexible staffing, pre-registration, new technologies, etc.)
- Creative development and rapid implementation of a comprehensive master plan for the NCR
  - The need has already been ostensibly recognized and the charge has been made by Congress (NDAA FY10)
  - This is a formidable and system-wide undertaking which draws upon all elements of the organization
  - It is both an intellectual and interactive process which must be quickly shaped but will evolve over time
  - There will need to be multiple component plans and initiatives that are integrally related such as: plans for marketing, clinical care, medical training and research, finance, governance and operations, managed care, staffing, technology, and facilities

The next few pages of this executive summary report provide an overview of some of the highlights of the NCR's demographic characteristics, current direct care and network care workloads, and a projection of future workloads within the NCR if current trends continue.

Highlights of the Findings from the Market Analysis

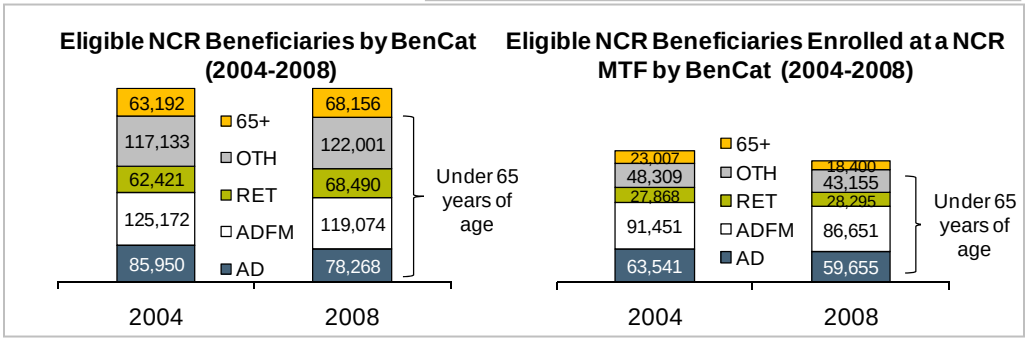
Trends in the size and age mix of the eligible and enrolled patient population in the NCR[1]

The eligible beneficiary population in the NCR increased by 0.5 percent (453,568 to 455,989) and the enrolled population increased by 3 percent (292,870 to 300,867) between 2004 and 2008. Even though the percentage of population enrolled increased overall, the likelihood of a NCR beneficiary being enrolled in a NCR MTF declined.

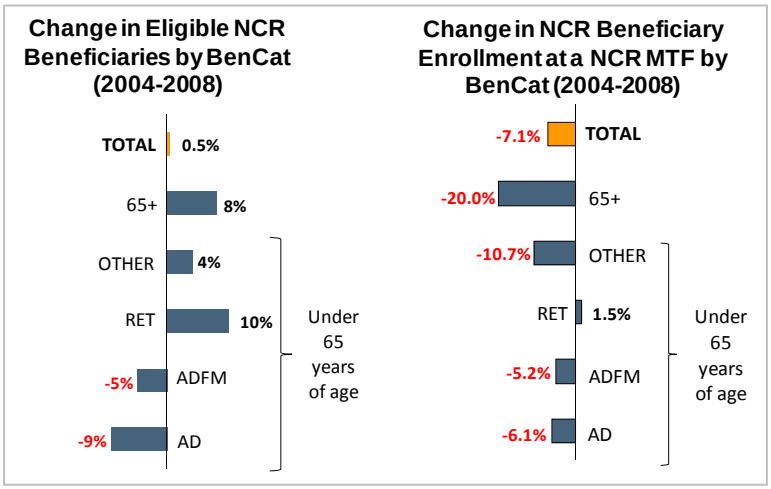


45 percent of the beneficiaries enrolled in non-NCR MTF or managed care contract were enrolled with the Region 17 managed care contractor and 30 percent were enrolled with Johns Hopkins in 2008.

The under 65 AD and ADFM population comprise 45 percent of the NCR beneficiary population and are most likely to enroll in a NCR MTF (63 percent are enrolled in a NCR MTF).

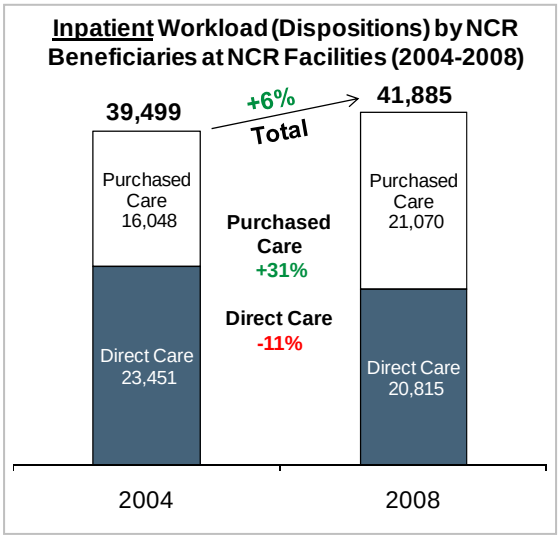


15 percent of the eligible population is older than 65 years of age and the 65+ age group is growing (8% growth between 2004 and 2008). The 65+ population is the least likely to be enrolled, they comprise 8 percent of the NCR beneficiaries enrolled in a NCR MTF, and their numbers have declined by 20 percent between 2004 and 2008.



[1] *Please refer to* Appendix A *for more detailed analyses and to* Appendix C *for methodology, approach, and sources.*

Trends in the clinical workload and market share for the patient population in the NCR[2]



Inpatient workload of NCR beneficiaries at NCR facilities (direct and purchased care combined) increased by 6 percent between 2004 and 2008.

While there is an overall increase in NCR inpatient workload; direct care declined by 11 percent and purchased care increased by 31 percent.

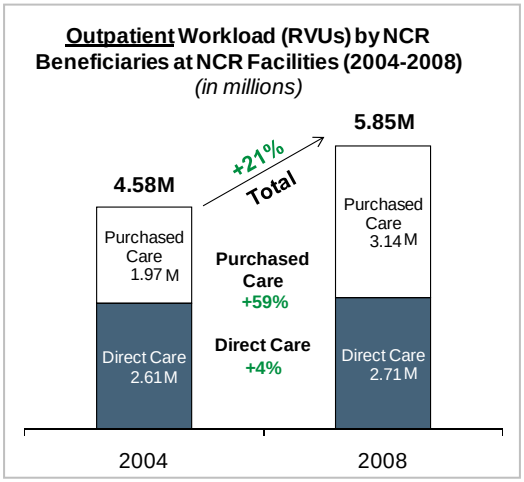
The decline in direct care workload was across all beneficiary categories except AD between 2004 and 2008. On the other hand, NCR beneficiary inpatient purchased care workload increased for all beneficiary categories between 2004 and 2008.

Change in Inpatient Direct Care Share for NCR Beneficiaries at NCR MTFs by *Select* Clinical Service Line (2004-2008)

Service Line	Change in Market Size	Change in DC Mkt. Share
Cardiology	0%	-7% points
GI	-2%	-14% points
Respiratory	-3%	-13% points
Neonatology	24%	-3% points
OB	-2%	-6% points
Orthopedics	27%	-3% points
Gen Surgery	6%	-10% points
Urology	12%	-1% points
Psychiatry	6%	-11% points
Substance Abuse	12%	-20% points

The overall direct care market share of NCR inpatient discharges has decreased by 9 points between 2004 and 2008.

When evaluated at a product line-level (medical surgical, OB, newborns, and behavioral health), the decline in direct care inpatient discharges was across all product lines. When evaluated at a clinical service line level, the decline in direct care discharges is across all clinical service lines except Rehab. The table shows decline in market share for the largest medical, surgical, and other service lines.



Outpatient workload of NCR beneficiaries (direct and purchased care combined) increased by 21 percent between 2004 and 2008. While there is overall increase in outpatient workload; direct care RVUs increased by a smaller percentage compared to purchased care.

NCR beneficiary outpatient direct care workload decreased for all beneficiary categories except AD and RET and the increase in outpatient workload is across all seven major product lines (Primary Care, Medical Specialties, OB/Gyn, Surgical Specialties, ER, Behavioral Health, and Other).

[2] *Please refer to* Appendix A *for more detailed analyses and to* Appendix C *for methodology, approach, and sources.*

The overall direct care market share of NCR outpatient RVUs has decreased by 10 points between 2004 and 2008.

When evaluated at a product line-level (primary care, medical specialties, surgical specialties, OB, ER, behavioral health, and other), the decline in direct care outpatient RVUs was across all product lines except "Other".

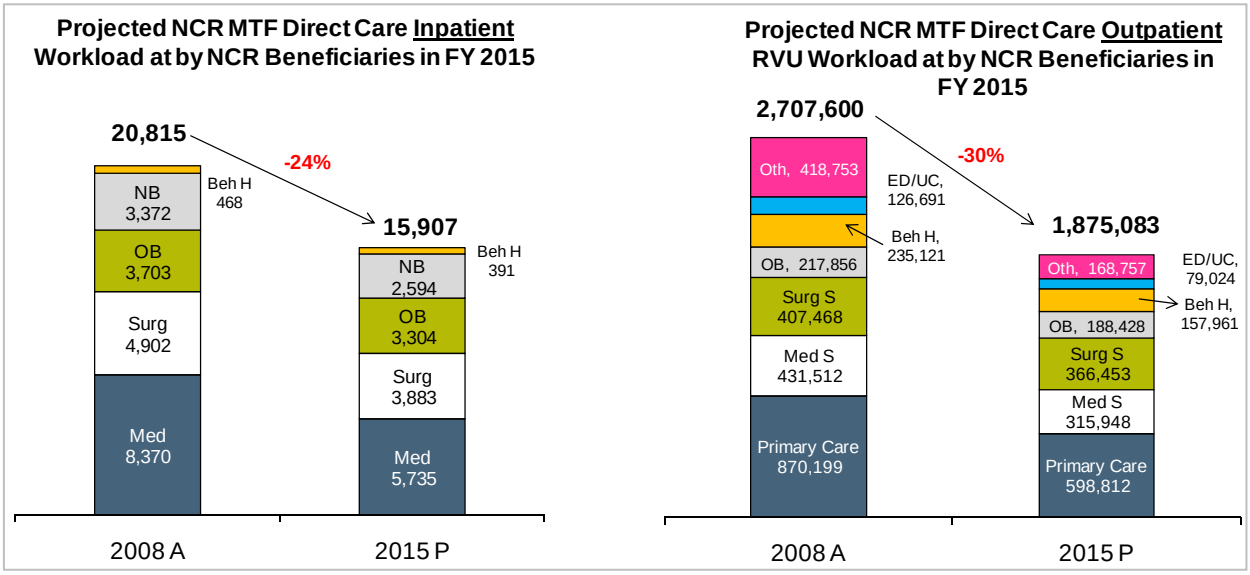
When evaluated at a clinical service line level, outpatient direct care workload:

Change in Outpatient Direct Care Share for NCR Beneficiaries at NCR Facilities by Product Line (2004-2008)

Service Line	Change in Market Size	Change in DC Mkt. Share
Primary Care	51%	-13% points
Medical Specialties	31%	-8% points
Surgical Specialties	4%	-4% points
OB	28%	-4% points
Beh Health	-5%	-16% points
Urgent/Emergent	59%	-14% points
Other	4%	1% points

- Increased for Cardio/Pulm, General Surgery, Urology, and Vascular Surgery, GI, General Internal Medicine, ID, Hem/Onc, and Pulmonary
- Declined for Ortho, Cardiac and all other medical and surgical specialties combined
- Decreased for all Behavioral Health specialties (Child Guidance, Mental Health, Psychiatry, Psychology, Social Work, and Substance Abuse)

Results of modeling future population, market share and direct care workload, based upon current utilization rates and the current trajectory in market share trends[3]



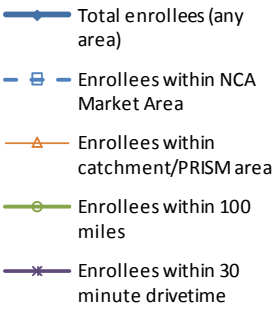
If current trends were to continue, the total inpatient demand by NCR beneficiaries is expected to increase by 3 percent to 45,453 dispositions but the NCR MTF direct care inpatient workload is expected to decline by 24 percent between 2008 and 2015 to 15,907. The total outpatient RVU demand by NCR beneficiaries is expected to increase by 1.5 percent to 5.97 RVUs but the NCR MTF direct care outpatient workload is expected to decline by 30 percent between 2008 and 2015 to 1.6M RVUs.

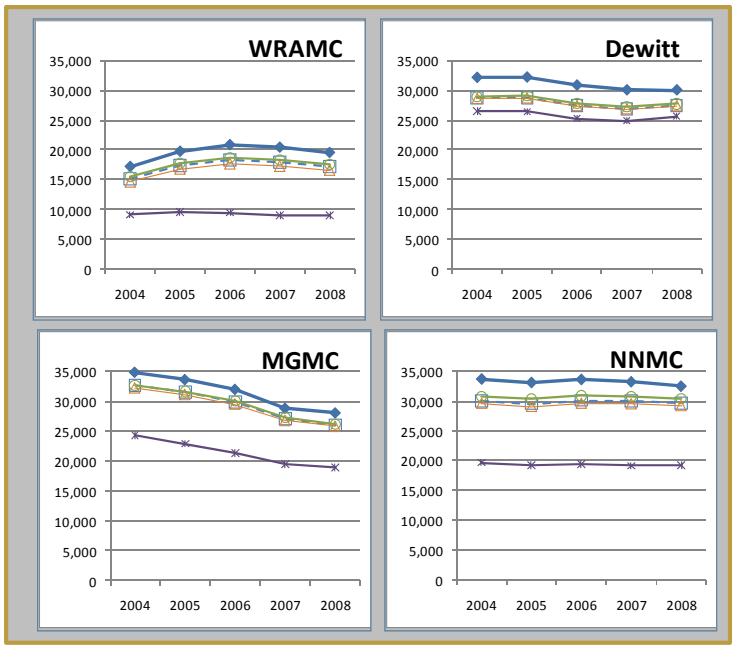
[3] *Please refer to* Appendix A *for more detailed analyses and to* Appendix C *for methodology, approach, and sources.*

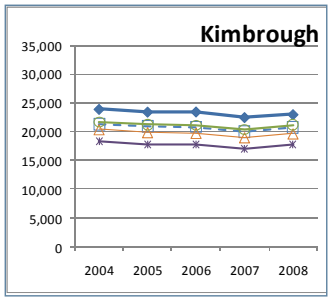
(Assumptions: Beneficiary population declines slightly by 2 percent between 2008 and 2015, current utilization rates, and the current trajectory in market share trends).

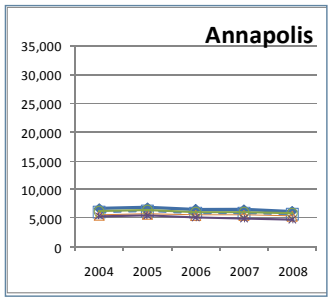
Trends in size and age mix of the enrolled patient population and clinical workload at NCR Military Treatment Facilities (MTFs)[4]

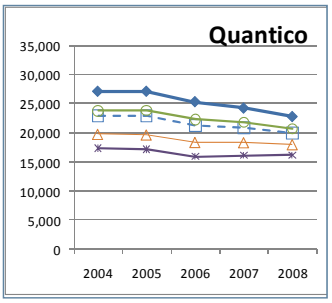
The enrolled population was stable or declined at all NCR MTFs except WRAMC between 2004 and 2008 under all market definitions (within NCA market area, within PRISM/catchment area, and within 30-minute drive-time area).











[4] *Please refer to* Appendix B *for more detailed analyses and to* Appendix C *for methodology, approach, and sources.*

Change in direct care workload within 30 minute drive-time of each profiled NCR MTF was variable but mostly declined between 2004 and 2008. Inpatient direct care workload declined within 30-minute drive-time of all MTFs except NNMC.

Outpatient direct care encounters declined within 30-minute drive-time of all MTFs except Dewitt and WRAMC.

Change in Direct Care Workload within 30-minute Drive-time Zips (2004-2008)

MTF	Change in IP Dispositions	Change in OP Encounters	Change in OP RVUs
Dewitt	-7%	2%	19%
WRAMC	-6%	14%	-2%
MGMC	-69%	-40%	-27%
NNMC	1%	-1%	5%
Kimbrough	NA	-10%	5%
Annapolis	NA	-48%	-31%
Quantico	NA	-6%	23%

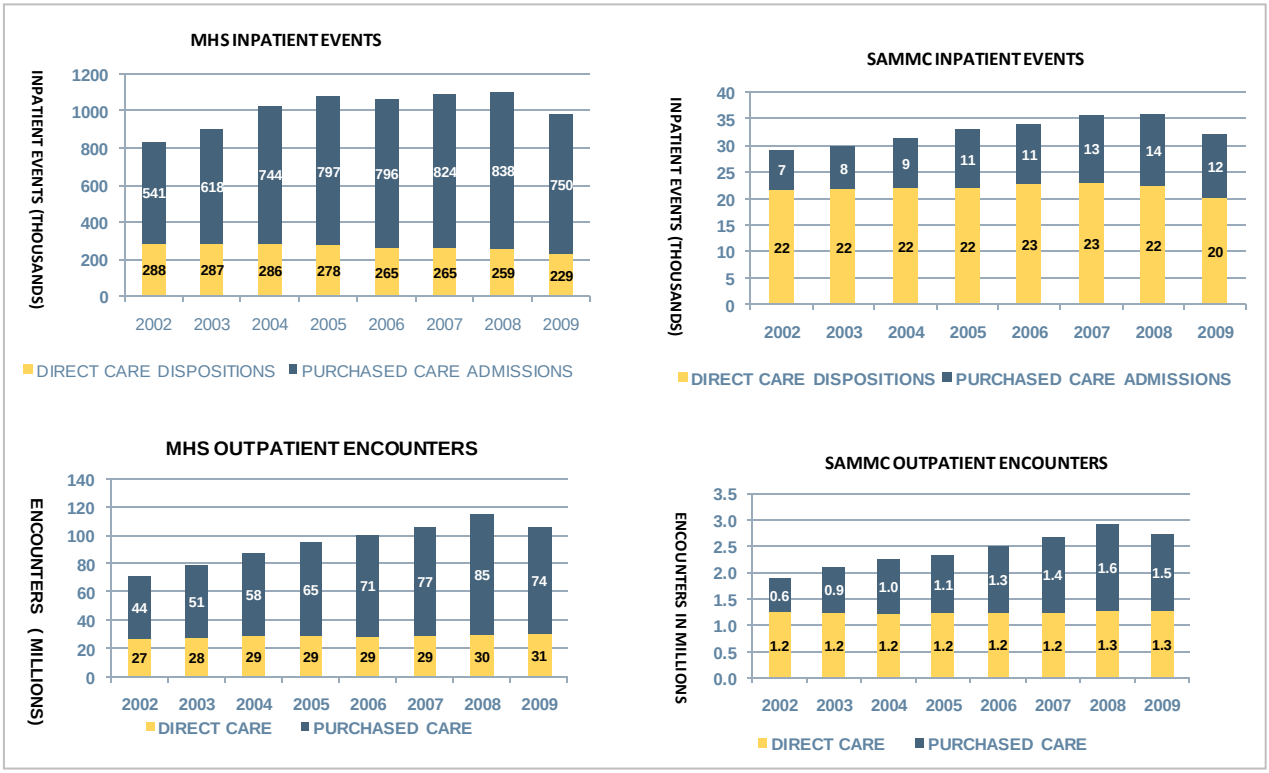
Change in Purchased Care Workload within 30-minute Drive-time Zips (2004-2008)

MTF	Change in IP Dispositions	Change in OP RVUs
Dewitt	29%	51%
WRAMC	18%	31%
MGMC	30%	44%
NNMC	23%	36%
Kimbrough	24%	42%
Annapolis	20%	37%
Quantico	38%	73%

Purchased care inpatient and outpatient workload within 30 minute drive-time of each profiled NCR MTF increased between 2004 and 2008.

Trends in workload in the MHS and at San Antonio Military Medical Center (SAMMC)[5]

Increase in inpatient and outpatient purchased care workload is not restricted to the NCR – it is happening MHS-wide and in SAMMC; suggesting that the trend is generalized to the system rather than to the National Capital Region (NCR) alone.



[5] *Please refer to* Appendix D *for more detailed findings. Direct Care inpatient events equal number of dispositions. Purchase Care Inpatient events equal number of admissions. MHS encounters include all catchment areas within the MHS (OCONUS and CONUS). SAMMC encounters include encounters in WHMC and BAMC catchment areas. Source is M2.*

Methodology, Approach, and Data Sources Overview

Please refer to *Appendix C* for methodology, approach, market area and service line definitions.

Data and Information Sources

- All data was pulled for the past 5 complete years (FY04-08). The primary source for population data is the DEERS file in the MHS MART (M2). This data includes beneficiary demographics and eligibility as well as enrollment status. Future population projections come from the DEERS/MCFAS file and approximate eligible population through 2015.
- The workload data in this market overview and the MTF profile reports primarily comes from the multiple detailed workload data files in M2. These include: for Direct Care, the SIDR (standard inpatient data record) and SADR (standard ambulatory data record) Detail records; for Indirect Care, the MERCHF and TED files for Institutional and Non-Institutional Care.
- The original data pulls were based upon an extended market area, and included data for all the ZIPs within Maryland, Virginia and Washington, DC. As the market area was better defined, the list of ZIPs shrank. The deep dive data was pulled using a filter to provide information for the 938 beneficiary ZIPs. An extensive process was undergone to identify the location of each ZIP code, its characteristics, the distance to each MTF from within it, and the drive time boundaries of each MTF service area.
- The original data pulls were based upon an extended market area, and included data for all the ZIPs within Maryland, Virginia and Washington, DC. As the market area was better defined, the list of ZIPs shrank. The deep dive data was pulled using a filter to provide information for the 938 beneficiary ZIPs. These ZIPs provide the basis for the market analysis. In addition to the market analysis, a ZIP table was created to identify each zip within current access standards. To do this, added to the original 942 (?) ZIPs were all ZIPs identified to be within 100 miles. These additional ZIPs were based on drive times and distances supplied by Donald Kerr in a file called "ZIPs Within 100 Miles.xls" emailed to Doug Wilson on 21SEPT09. This email states that "MTFs used are those that are listed in CHCS 1 with enrollees from all JOA MTFs." An extensive process was undergone to identify the location of each ZIP code, its characteristics, the distance to each MTF from within it, and the drive time boundaries of each MTF service area. Population and workload information was then added, by ZIP, to the table. These were added on a market-wide basis and broken down by MTF as well. Noblis was then able to determine which ZIPs fall within the current access standards for each J4+3 facility (Dewitt, MGMC, NNMC, WRAMC, Kimbrough, Annapolis, and Quantico). For our analysis, we looked at current access standards in three ways: within 30 minute drive time, within catchment/PRISM area (40 miles/20 miles) and within 100 miles distances.

Data	Source	Date Pulled
Population - Eligibility and Enrollment	DEERS Person Details	21 September 2009
Direct Care Inpatient	SIDR (Inpatient admissions detail)	21 September 2009
Direct Care Outpatient	SADR (Professional encounters)	21 September 2009 to 2 October 2009
Purchased Care Inpatient	Purchased Care Institutional	21 September 2009
Purchased Care Outpatient	Purchased Care non-institutional	21 September 2009

Glossary of Terms and Acronyms

- ACV – alternate care value – A code indicating type of enrollment of beneficiary at the time of the extract (ACVs of A, D, E represent TRICARE Prime).
- AD – Active Duty – A beneficiary category that includes all active duty soldiers, marines, sailors and airmen as well as active duty national guard. In this analysis, AD refers only to beneficiaries under the age of 65.
- ADFM – active duty family members – A beneficiary category that includes all dependents (families) of Active Duty and Guard beneficiaries. In this analysis, ADFM refers to beneficiaries under the age of 65.
- Age 65+ – Any beneficiary over the age of 65. (In this analysis, these beneficiaries may belong to any of the preceding BenCats.)
- BenCat – Beneficiary Category *(see AD, ADFM, RET, RETFM, Age 65+)*
- Beneficiary – anyone who is eligible to receive care within the MHS
- Clinical Service Line – the subspecialty-level at which workload can be measured. In the direct care system, MEPRS3 Codes are often used to delineate clinical services.
- Demand – The amount of healthcare that is required to meet the needs of the beneficiaries within the market area.
- DRG - Diagnosis Related Group - An inpatient classification system that relates demographic, diagnostic and therapeutic characteristics of patients to LOS and amount of resources consumed.
- Market Area – The geographic area in which healthcare service is provided to the beneficiary population. Also, the Catchment or PRISM area of a given MTF.
- MDC – Major diagnostic category – A set of 31 category codes that indicate which body parts or systems were affected and required healthcare services.
- MEPRS Codes – Medical Expense and Performance Reporting System codes – lettered codes that range from one to four letters and represent the units of service (equivalent to cost centers in the private sector). MEPRS3 and MEPRS4 Codes are used to indicate clinical services or subspecialties; MEPRS2 codes are broader categories of services; MEPRS1 Codes represent the type of service provided (A=Inpatient, B=Ambulatory, C=Dental, D=Ancillary, etc.).
- Other – A beneficiary category that includes survivors of AD or RET beneficiaries, dependents of Guard and Reserve troops, local nationals, RETFM, and all other non-specified BenCats. In this analysis, Other refers only to beneficiaries under the age of 65.
- Product Line – An aggregation of clinical service lines into broader similar categories.
- RET – Retirees – a beneficiary category that includes all those soldiers, marines, sailors and airmen who have retired from active duty but are still eligible to receive care within the MHS. In this analysis, RET refers to beneficiaries under the age of 65.
- RETFM – Retiree Family Members – A beneficiary category that includes the familial dependents of military Retirees. This BenCat is not delineated in this analysis.
- TRICARE Overseas Remote – Includes TRICARE Global Remote Overseas Prime AD and TRICARE Global Remote Overseas Prime ADFM
- TRICARE Plus - Tricare Plus allows military beneficiaries who are not in an HMO to enroll at a military clinic or hospital for primary care only. They do not pay a fee and cannot be guaranteed specialty care, but they are seen according to the same access standards as Prime patients.
- TRICARE Prime – Those enrolled beneficiaries with the first priority access to care in the MHS; AD are usually Prime.
- TRICARE Reliant – Includes AD not reported as enrolled and Active Duty enrolled to Op Forces

ATTACHMENTS

Attachment 1: JTF CAPMED Regional Healthcare Delivery Concept of Operation

Attachment 2: JTF CAPMED September 2007 Establishment Document

Attachment 3: Cultural Integration Recommendations White Paper

Attachment 4: January 2009 Action Memo for the Personnel Structure of the NCR Medical

Attachment 5: Operating Room Study

Attachment 6: Emergency Room and Urgent Care Utilization and Cost Study

Attachment 7: National Capital Region Market Analysis – Executive Summary Report

Attachment 8: Project Management Plan for Initial Outfitting and Transition Services for the JTF CAPMED North and South projects

Project Management Plan
for the
Initial Outfitting and Transition (IO&T) Services
for
Joint Task Force National Capital Region Medical (JTF CAPMED)
North and South Projects

December 31, 2009

NOTE: This first version Project Management Plan (PMP) provides the foundation for our management approach for the JTF CAPMED IO&T Project. In continuous improvement actions and successive submissions, the Project Management Plan will grow and improve to reflect the most current processes being developed or perfected, and the actions underway to support the project. The plan will also be adjusted as necessary based on current construction milestones, clinical integration and transition schedules, and/or other JTF CAPMED policy and program changes that affect General Dynamics project management and execution. The PMP will closely monitor any revisions and updates to the JTF CAPMED's Master Transition Plan and Integrated Master Schedule (IMS). One of our project management team's senior Project Management Professionals, Mr. Robert (Bob) Case (robert.case@gdit.com) will serve as the General Dynamics' Project Manager's primary action officer for maintaining changes to, and the currency of, the PMP. Mr. Case will serve as the General Dynamics lead on implementing PMP changes and updates, and preparing subsequent submissions in accordance with the project deliverable schedule. These actions will also include continuous improvement and currency to all attached plans that together comprise the complete PMP. Mr. Case will ensure that the PMP complies with best industry practices as defined by the Project Management Institute's "Project Management Book of Knowledge (PMBOK).

Approvals:

Stuart Mervis

31 December 2009

Project Manager **Date**

Patsy Hubbard

December 31, 2009

Contracting Officer **Date**

1.0 Overview

1.1 Project Summary

This project provides Initial Outfitting and Transition (IO&T) services to support the JTF CAPMED in their program to establish the new Walter Reed National Military Medical Center (WRNMMC) at Bethesda, MD; and to build and open the new Fort Belvoir Community Hospital at Fort Belvoir, VA. The JTF CAPMED actions reflect the historic developments resulting from the 2005 Defense Base Closure and Realignment Commission (BRAC) final report. These actions cause a significant restructuring of military health activities in the National Capital Region (NCR). The new WRNMMC involves significant construction and renovation to the existing National Naval Medical Center (NNMC) at Bethesda and the closure of the existing Walter Reed Army Medical Center (WRAMC). Several clinical services and operations currently at WRAMC will integrate with current services at the NNMC. The new Fort Belvoir Community Hospital (FBCH) is a major, new facility construction project that will replace the existing Dewitt Army Community Hospital and provide operating space for elements of the existing WRAMC that are designated to transition to the new community hospital.

Initial Outfitting is the process to equip and provision both new hospital operations in order to open and operate these new facilities. General Dynamics, in performance of its initial outfitting task, will receive equipment and provisioning requirements from the Government and perform the sourcing, purchasing, delivery, installation, and related actions (e.g. training, calibration, property accountability, etc.) leading to the acceptance and ownership of all items by the Government. The broad categories of equipment and provisioning include medical, non-medical, information technology, and furniture items. In addition, General Dynamics will support reuse and relocation of the Government's designated items by performing or managing the dis-installation, movement, placement, and/or reinstallation of these specified items. The entire initial outfitting process will be conducted in close coordination with WRNNMC and These action will also lead to the Government with equipment and materiel required to conduct FBCH project team to ensure adherence to complex construction, renovation, and transition schedules.

Transition is the process to move staff, clinical operations, and administrative functions as prescribed by the JTF CAPMED to the WRNMMC and to the FBCH. The BRAC actions and the accompanying major facility projects create a significant restructuring of healthcare activities within the NCR and as such necessitate a complex series of transition actions. General Dynamics will support the development and implementation of necessary plans and actions to accomplish this transition of healthcare operations. The General Dynamics project team will provide this support under the direction of the JTF CAPMED's overarching transition strategy and direction, and in concert with and the tactical direction of integration and transition support offices at the NNMC, WRAMC, and the Fort Belvoir office of the US Army Health Facility. The specific support provided will encompass elements of transition design, operations and occupancy planning, and preoccupancy and post-occupancy implementation and execution actions. Examples of these broad areas may include transition assessment and structure, concepts of operations for clinical services and processes, hospital logistics management, occupancy readiness planning, movement planning, "Day in the Life" exercises, and post-

occupancy evaluations. The specific array of transition services may be tailored to the specific requirements and needs at each of the affected activities.

Overarching project management, information management, quality assurance, and risk management functions and activities will envelop the initial outfitting and transition services. These activities will shape the structure and direction of the performed tasks, and the continuous communication and evaluation with Government officials required to ensure compliance with qualitative, quantitative, and timeframe objectives. A continuous series of in-process reviews with Government officials, and updates to this PMP (capturing specific enhancements and changes to process and practice) will shape the essential coordination and public-private partnering required in a project of this size and scope; and ensure appropriate records for lessons learned and historical documentation of project outcomes.

1.2 Project Purpose, Scope, and Objectives

The purpose of this project is to provide Initial Outfitting and Transition (IO&T) services to support the JTF CAPMED in their program to establish the new Walter Reed National Military Medical Center (WRNMMC) at Bethesda, MD; and to build and open the new Fort Belvoir Community Hospital at Fort Belvoir, VA.

The scope of this project is detailed in the Performance Work Summary (Pages 20 and 21 of the PWS) and details several sub-activities and functions that combine to form the complete IO&T services. The scope of the project extends across the multiple organizations comprising the JTF CAPMED and the specific healthcare operations directly affected by the BRAC actions. This principally includes the following organizations and activities:

- Headquarters, JTF CAPMED, and its staff elements
- The National Naval Medical Center and the BRAC Project Office at the NNMC, Bethesda, MD
- Walter Reed Army Medical Center and the BRAC Transition Office at WRAMC
- DeWitt Army Community and the US Army Health Facility Planning Agency Office at Fort Belvoir, VA
- Malcolm Grow Medical Center, Andrews Air Force Base, MD

The objective of this project is to achieve the "overall goal" as prescribed by the PWS Paragraph C.1.1 which states the following:

> "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."

The objectives of this project are further characterized by the "project requirements" stated in PWS Paragraph C.2.1. These requirements are summarized as follows:

- Provide hospital transition and activation services, project management services, and provisioning of medical and non-medical equipment, data processing equipment (IT), furniture and furnishings, consistent with the Government-provided architectural and engineering requirements of the facilities being supported with this work.
- Document a realistic Project Management Plan that shall serve as the management guideline for the project and its tasks.
- Provision and range for the installation of required medical equipment (Attachment 1 to the PWS).
- Provision and schedule for the installation of the required non-medical equipment (Attachment 2 to the PWS)
- Provision and arrange for the installation of the required IT equipment (Attachment 3 to the PWS) in compliance with Defense Information Assurance Certifications and Accreditation (DIACAP) requirements.
- Provision the required furniture and furnishings identified in Attachment 4 to the PWS and install them in accordance with the Comprehensive Interior Design Package to be provided by the Government as GFI.
- Implement standardization decisions when provisioning and equipping the North (WRNMMC) and South (FBCH) project.
- Coordinate with the Government to prevent delivery conflicts with construction schedules and Other Contractor Provisioned and Installed Equipment (OCPIE) provided as Attachment 5 to the PWS.
- Arrange for the removal, packing, relocation, unpacking, and reinstallation of reuse equipment (Attachment 6 to the PWS).
- 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.
- Apply NFPA, OSHA, ASHRAE, ADA, other health and safety codes, and medical standard to fully identify, integrate, and apply requirements to all provided services.
- Provide the appropriate transitioning of official Government records/files, including patient records and sensitive protected information. Abide by all applicable Health Insurance Portability and Accountability (HIPAA) privacy and security requirements regarding health information as defined in the contract.

The General Dynamics Project Team objectives embrace the Government's overall goal and project requirements and add to them the following goals:

- Achieve the overall goal and project requirements established by the Government for IO&T Services to support the new WRNMMC and the new FBCH.
- Provide IO&T Services that truly enable the successful opening and operation of the new WRNMMC and the new FBCH.

- Achieve, through the provision of IO&T Services, a clearly visible and measureable impact on the quality of healthcare services provided by the JTF CAPMED to the military community that it serves.
- Establish state-of-the-art, best practices and capabilities in the IO&T functional area that are demanded by subsequent projects within the Military Health System, other federal healthcare organizations, and the broader realm of private sector and international health enterprises.

1.3 Project Deliverables

This plan complies with all requirements of the RFP including Section C.3.0 Deliverable. The following Table lists required deliverables and their scheduled due dates.

Item	RFP	Title	Initial	Subsequent
Deliverable 1	C.3.2	Project Management Plan	12/31/2009	2/26/2009 Every 6 MACA* (Updates)
Deliverable 1-A	C.3.2	Movement Plan	1/7/2010	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 1-B	C.3.2	Warranty Management Plan	1/15/2010	Every 6 MACA (Updates)
Deliverable 1-C	C.3.2	Staffing Plan	12/31/2009	120 DACA (Final) As Required (Updates)
Deliverable 1-D	C.3.2	Subcontract Management Plan	12/31/2009	75 DACA (Final) As Required (Updates)
Deliverable 1-E	C.3.2	Risk Management Plan	12/31/2009	90 DACA (Final) As Required (Updates)
Deliverable 2	C.3.3	Standardization Plan	1/2/2010	120 DACA (Final) As Required (Updates)
Deliverable 3	C.3.4	Equipment Reuse Plan	1/2/2010	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 4	C.3.5	Test and Calibration Plan	2/21/2010	120 DACA (Final)
Deliverable 5	C.3.6	Training Plan	1/17/2010	120 DACA (Final) Every 6 MACA (Updates)
Deliverable 6	C.3.7	Tracking Tool User Manual	12/31/2009	Every 6 MACA (Updates)
Deliverable 7	C.3.8	Quality Control Plan	12/30/2009	90 DACA (Final) Every 6 MACA (Updates)
Deliverable 8	C.3.9	Integrated Master Schedule (IMS)	1/7/2010	Every 6 MACA (Updates)
Deliverable 9	C.3.10	Monthly Progress Report	12/14/2009	Monthly by the 8th day of the following month
Deliverable 10	C.3.11	Subcontract Expenditures Report	12/31/2009	Monthly by the 8th day of the following month
Deliverable 11	C.3.12	Tracking Tool Report	12/31/2009	Monthly by the 8th day of the following month
Deliverable 12	H.9	Data Use Agreement Plan	As required	Update as Required
			*DACA Days After Contract Award *MACA Months After Contract Award	

2.0 Reference Documents

Applicable Regulations and Manuals
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/TIA/EIA 606 - Admin Standard for Telecomm Infrastructure of Commercial Buildings
AR 735-11 Accounting for Lost, Damaged, and Destroyed Property
AR 735-5. Policies and Procedures for Property Accountability
AR 40-61 Medical Logistics
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
MIL-HDBK-419/2A - Grounding, Bonding and Shielding for Electronic Equipment and Facilities, Volume 2 of 2
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
UFC 4-510-01 Design: Medical Military Facilities
UFC 4-021-01 Design and O&M: Mass Notification Systems

General Dynamics Reference Documentation
AAALAC Guide for the Care and Use of Laboratory Animals (NRC1996)
Guidelines for construction and equipment of hospital and medical facilities. AIA Press, 1993
CLIA regulations Part 493, Laboratory Regulations Subpart A - T
Status of Forces Agreement(SOFA)/ Republic of Korea
ADA383511: Performance of External Quality Control Reviews by Military Department Audit Agencies
ASQC Q90 Quality Management and Quality Assurance Standards – Guidelines for Selection and Use
ASQC Q91 Quality Systems - Model for Quality Assurance in Design/Development, Production, Installation, and Servicing
ASQC Q93 Quality Systems - Model for Quality Assurance
ASQC Q94 Quality Management and Quality System Elements – Guidelines
ISO 9000 Quality management and quality assurance standards – Guidelines for selection and
ISO 9001 Quality systems - Model for quality assurance in design, development, production, installation, servicing
ISO 9002 Quality systems - Model for quality assurance in production and installation
PMI Project Management Book of Knowledge (PMBOK) – Quality Planning, Assurance, and Control
GDIT Policy #s: SBP-PRO-5.1 through 5.9

3.0 Acronyms

ACL	Access Control List	**JSN**	Joint Service Number
AMEDD	Army Medical Department	**JTF**	Joint Task Force
BIO	Belvoir Integration Office		
BMET	Biomedical Equipment Technician	**KO**	Contracting Officer
CAD	Computer-Aided Design	**LNO**	Liaison Office
CapMed	Capital Medical	**MC4**	Medical Communications for Combat Casualty Care
CEO	Chief Executive Officer	**MHS**	Military Health System
CoE	Center of Excellence	**MPR**	Monthly Progress Report
CJTF	Commander, JTF	**NAD**	North Atlantic Division
CONOPS	Concept of Operations	**NAVFAC**	Naval Facilities Engineering Command
COOP	Continuity of Operations Program	**NCR**	National Capital Region
COR	Contracting Officer Representative	**NISPOM**	National Industrial Security Program Operating Manual
COTR	Contracting Officer Technical Representative	**NIST**	National Institute of Standards and Technology
DCAA	Defense Contract Audit Agency	**NNMC**	National Naval Medical Center
DCID	Director of Central Intelligence Directives	**OICC**	Officer in Charge of Construction
DMLSS	Defense Medical Logistics Standard Support	**PA&E**	Program Analysis and Evaluation
DCJTF	Deputy Commander, JTF	**PAO**	Public Affairs Officer
DoD	Department of Defense	**PenRen**	Pentagon Renovation
DSCP	Defense Supply Center Philadelphia	**PKI**	Program Knowledge Institute
ES&H	Environmental, Safety and Health	**PM**	Project Manager
FBCH	Fort Belvoir Community Hospital	**PMBOK**	Program Management Book of Knowledge
FSS	Federal Supply Service	**PMIS**	Program Management Information System
GDIT	General Dynamics Information Technology	**PMO**	Program Management Office
GFP	Government Furnished Property	**POC**	Point of Contact
GRSi	Grove Resource Services Inc.	**PPS**	Ports Protocols and Services
GSA	Government Services Administration	**PMP**	Program Management Professional
HCR	Health Care Relocations	**QASP**	Quality Assurance Surveillance Plan
		QCC	Quality Control Checklists
HCT	Health Care Transitions Services	**QCP**	Quality Control Plan
HFPA	Health Facility Planning Agency	**QRM**	Quality Risk Manager
HFS	Health Facility Solutions Company	**RFID**	Radio Frequency Identification
HIMSS	Healthcare Information and Management Systems Society	**RFP**	Request for Proposal
HIPAA	Health Insurance Portability and Accountability Act	**RSNA**	Radiological Society of North America
HSG	Health Services Group	**SME**	Subject Matter Expert
IA	Information Assurance	**SO**	Security Officer
IAVB	Information Assurance Vulnerability Bulletins	**SOP**	Standard Operating Procedure
IAVM	Information Assurance Vulnerability	**STO**	Site Transition Office
IAW	In Accordance With	**TARA**	Technology Assessment and Requirements Analysis
IDS	Intrusion Detection System	**TMA**	Tri-care Management Activity

IESNA	Illuminating Engineering Society of North America	**TPO**	Transition Planning Office
IM	Information Management	**USACE**	US Army Corps of Engineers
IMIT	Information Management/ Information Technology	**USAMMA**	United States Army Medical Materiel Agency
IMS	Integrated Master Schedule	**VCE**	Vision Center of Excellence
IO&T	Initial Outfitting and Transition	**VMS**	Vulnerability Management System
IPS	Intrusion Protection System	**WBS**	Work Breakdown Structure
IT	Information Technology	**WRAMC**	Walter Reed National Military Medical Center
		WRNMMC	Walter Reed National Military Medical Center

4.0 Project Organization

4.1 Organization Structure and Capabilities

The General Dynamics Project Team contains key persons and core capabilities from the General Dynamics Information Technology (GDIT) operating component of the parent corporation; and the functional expertise, capabilities, and supporting staff from our ten partner subcontractor firms. The entire team forms a thoughtfully crafted and highly capable organizational structure to accomplish the comprehensive planning, control of activities, performance monitoring, and execution and implementation of IO&T services required to support project objectives. General Dynamics will establish its project management office at 8601 Georgia Avenue, Silver Spring, MD; and maintain site transition support elements at the NNMC, WRAMC, and within the Fort Belvoir HFPA Office. The organizational structure, to include the effective application of all partners, achieves the following three essential dimensions to project performance:

- ***Project Management***: the overarching management and control of the project is accomplished by the following structural and staffing assets:
  - General Dynamics provides project management leadership and expertise to lead and manage the project. This includes Stuart Mervis, Senior Director within the General Dynamics Health Services Group as the Project Manager; Ginger Boston, Senior Director within the General Dynamics Army Infrastructure Group as Deputy Project Manager; Site Lead Managers at both Bethesda and Fort Belvoir; and several other key managers and technical experts as described below.
  - M&R Facility Concepts provides its principal, Nathan Chong, as the team lead for quality assurance and risk management.
  - SFW, LLC provides information technology support in the form of their Accendo, web-based mapping and visualization application which will be a key part of the project tracking and information management program.
  - AMI Environmental provides one of its technical experts, Larry Owens, to serve as the project team's environment and safety staff expert and resource.
- ***Operational Capability***: the project team contains operational capability to perform the functions of transition support and services, equipping and provisioning, and hospital relocation services. This operational capability is represented in the following organizational assets:
  - Transition Services
    - Health Care Transitions (HCT) provides highly experienced, strategic hospital transition experts that will shape the transition planning model and the introduction, completion, and application of specific transition plans. HCT staff will include Sandra Hamper, Tom Van Hook, Nancy Bowen, and Kevin

Mettler. Each will deploy to specific JTF CAPMED activities to link with the activity's senior clinical integration and transition official.

- Health Facility Solutions (HFS) provides operational staff that will perform transition support tasks at each of the affected activities, i.e. NNMC, WRAMC, and Fort Belvoir. These staff members will form Site Transition Teams that will work in direct support of the activity's integration and transition unit.

- VW International (VWI) provides selected experts to support specific transition support functions. Pat Saulsberry will directly support transition activities at WRAMC and within the WRAMC to Fort Belvoir transition "lane."

- Equipping and provisioning as the essential functions within the initial outfitting component of project work:

  - RTKL provides the equipment sourcing, purchasing, delivery, and installation required to support the extensive array of initial outfitting requirements. RTKL will provide support for all medical, non-medical, and furniture items. RTKL will oversee warranty provisions for all equipment within their support requirement. RTKL will operate its primary support functions from its Dallas, TX base with on-site project staff at the project management office (Silver Spring, MD) and designated project site leads for Bethesda and Fort Belvoir.

  - General Dynamics Army Infrastructure provides the equipment sourcing, purchasing, delivery, and installation required for all information technology (IT) equipment. This unit will oversee all warranty provisions for all equipment within their support requirement. This unit will operate from the Silver Spring, MD project management office, its Rosslyn, VA core offices, and provide on-site lead staff at both Bethesda and Fort Belvoir.

  - GRSi provides biomedical equipment specialists to support the equipping and provisioning processes. GRSi will create an organic Technical Assessment Requirements Analysis (TARA) capability within the team and provides biomedical technician staff members to support assessment, installation, relocation, and other required functions within the project.

  - Interstate International provides logistics capabilities to include warehousing, transportation, selected installation services, and logistics support staffing to support the initial outfitting component of the project. Interstate assets will be deployed within the project in accordance with the project team's logistics concept of operations. For example, several high density items will be routed to Interstate's interim storage facility for unpacking, assembly, and staging for delivery to hospital locations.

- Hospital Relocation Services to support movement of reuse and relocated equipment, and all ancillary items required to achieve full operational capability in the new facilities.

    - Health Care Relocations (HCR) provides the primary relocation capability with the project team. HCR will perform the highly detailed planning for all items designated by the Government for relocation to new facilities. HCR will produce move "books" and transferrable equipment reports that document the precise relocated item and all information required to assure movement to the prescribed location within the new facility. HCR provides tote boxes and carts for movement of ancillary items from offices and clinical areas of the transitioning elements to the new facility locations. HCR planners will operate from the Silver Spring, MD project management office and on-site at WRAMC, NNMC, and DeWitt Army Community Hospital to plan and facilitate relocation actions.

    - GRSi provides biomedical equipment technician support in the relocation process.

    - Interstate International provides logistics support to complement HCR in the relocation process.

- ***Project Infrastructure:*** these are the essential support capabilities and processes that are instrumental to performance of the IO&T Services and include the following functions:

    - Purchasing: General Dynamics will provide purchasing center support to execute the numerous purchase orders required to perform the initial outfitting component of the project. General Dynamics will apply purchasing capabilities from both its Fairfax, VA and Needham, MA purchasing centers. Purchasing functions will be conducted in accordance with contract and FAR guidelines and be fully subjected to continuous DCAA monitoring. The purchasing methodology will closely align RTKL's sourcing, competitive analysis, and order/delivery tracking with General Dynamics' purchasing techniques. This will ensure efficient transaction of purchase orders in full compliance with contract purchasing guidelines.

    - Financial Management: General Dynamics will provide the financial management processes and practices to support the initial outfitting component of the project. This includes the precise financial accounting of all purchase orders. All purchase orders will enter the General Dynamics financial management system – creating a financial record for each transaction – and required tracking through invoicing, vendor payment, Government reimbursement, and closure. General Dynamics' financial management specialists are assigned to the project team structure with monitoring and reporting responsibilities to the appropriate senior financial management official (i.e. VP for Finance, Army Solutions Division).

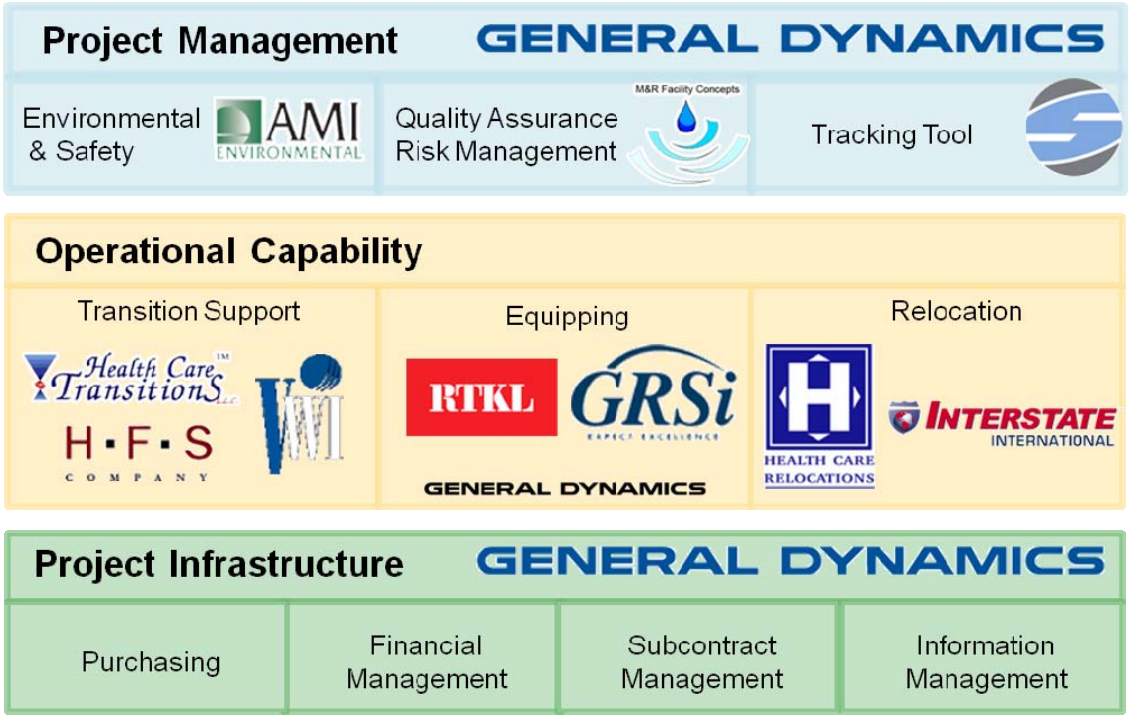
    - Subcontractor Management: General Dynamics will establish specified subcontractor management staff members to oversee the contractual, financial, and reporting requirements associated with the contract. Two designated subcontract managers will

engage the ten subcontractor firms. Each subcontractor is required to provide financial reports and contract performance reports in accordance with General Dynamics and Government provisions.

- Information Management: General Dynamics will provide the overarching information management support to the project team. Dr. Michelle Strah has been designated the Information Management Lead for the Project Team and she will orchestrate and manage all aspects of project information. This will include the tracking tool process and product to meet contract requirements. The information management structure is described in Section 7 of the PMP as the Project Management Information System (PMIS).

The Project Team will achieve its objectives by the collective performance and accomplishments of the prime contractor and its partner-subcontractors working across the dimensions of project management, operational capability, and project infrastructure. As a comprehensive and cohesive organization, the entire team will cause each of these dimensions to be interwoven to manage, deliver, and support the IO&T Services.

Figure 4-1Project Dimensions. *The General Dynamics Team works across the dimensions of project management, operational capability, and project infrastructure.*



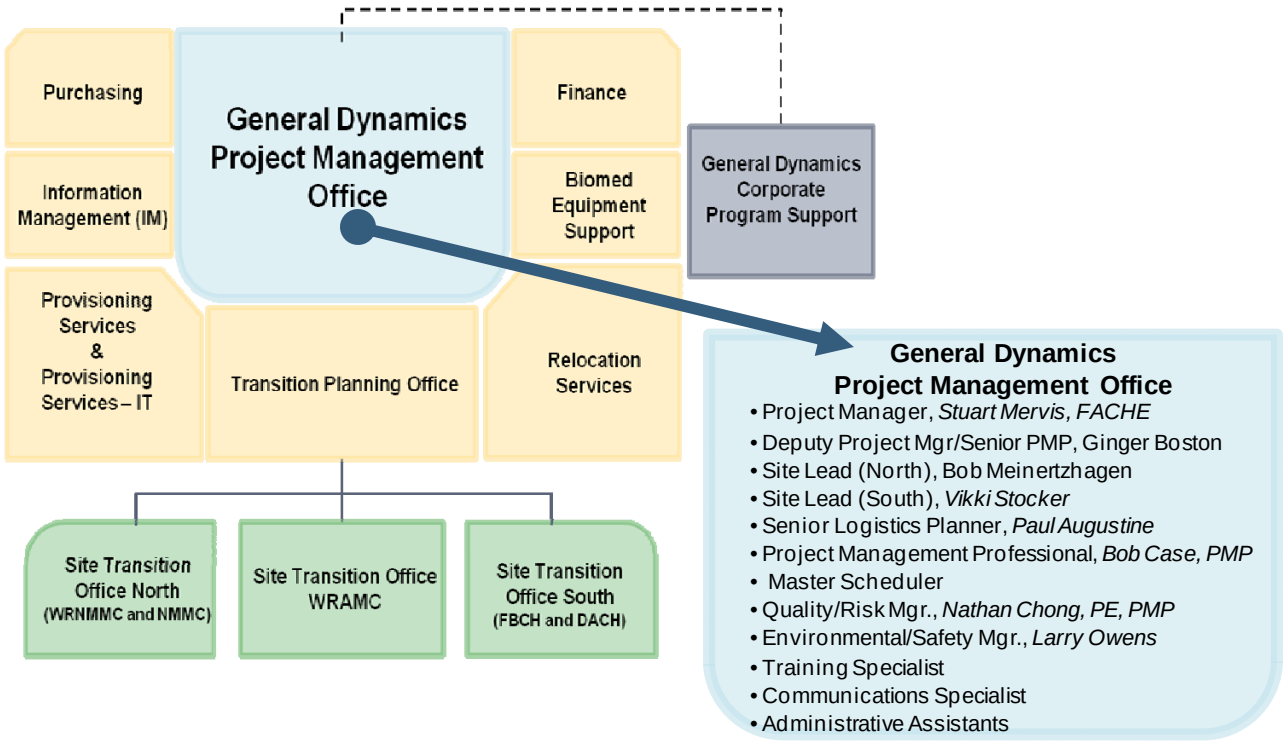
4.1.1 Project Team Organization

The design of our IO&T Project Team Organization brings together the three project dimensions that we discuss above. Our objective is to effectively organize our project management capability to orchestrate the operational capabilities and apply the necessary project infrastructure that is essential to support the project. Therefore there are three elements to our project team organization:

- The Project Management Office contains the key staff members that will lead and direct the project team and its performance.
- The Project Team Infrastructure Elements include key supporting elements in purchasing, financial management, subcontract management, and information management that provide integral support to the project. These elements are both co-located with the project management office, work from selected General Dynamics corporate offices, and/or may be positioned at the activity level for various time intervals in order to support project operations.
- The Project Team Operational Capabilities represent the project team elements that perform direct support to the Government activities in the areas of transition, equipping, and relocation. These elements may have selected staff members located in the project management office, at the activity level primarily working out of site transition offices, or at their respective home offices in order to carry out required functions and tasks.

Figure 4-2. displays the project team's organizational structure.

Figure 4-2 General Dynamics' JTF CAPMED IO&T Project Management Organization. *We have designed our organization to provide effective planning, management and control of JTF CAPMED IO&T activities.*



Project Management Office. The project management office directs all functions contain in project performance. The project management office is located at 8601 Georgia Avenue, Silver Spring, MD. This office contains the Project Manager, Deputy Project Manager and other key staff members that are required to direct and manage project operations.

The information below in Figure 4-3contains a description of the roles and responsibilities of the each member of the project management staff.

Figure 4-3 Project Management Roles and Responsibilities. *The Project Management Office contains the key staff members that will lead and direct the project team and its performance.*

Position	Name	Roles and Responsibilities
Project Manager	*Stuart Mervis*	Responsible for overall contract performance and has the associated authority to commit company resources. Strategist and architect of technical and management processes to support the JTF CAPMED IO&T project. Recognized expert in medical materiel acquisition and logistics, and former senior military official directing medical materiel programs. Will apply this expertise to assure full effectiveness of the initial outfitting process. Oversees quality control an risk management. Primary General Dynamics representative in all in-process reviews and other direct engagement with Government contract and program officials.
Deputy Project Manager/Senior PMP	*Ginger Boston*	Reports to the Project Manager and acts in his behalf during any absences of the PM. Primary developer and manager for project team's internal operating processes to include the logistical and purchasing concept of operations, financial management processes, staffing, and performance reviews. Maintains a full range of contract performance measurements and prepares status and reporting information for all in-process reviews and other official responses to Government officials.
Site Lead North	*Bob Meinertzhagen*	Primary representative of the Project Team located on-site at the NNMC North Project. Oversees all contract performance activities to include initial outfitting, transition support, and relocation services as they apply in the North Project. Provides project performance status and reports to NNMC and North Project officials. Maintains reporting channel to the project team through the Deputy Project Manager.
Site Lead South	*Vikki Stocker*	Primary representative of the Project Team located on-site at Fort Belvoir and South Project. Oversees all contract performance activities to include initial outfitting, transition support, and relocation services as they apply in the South Project. Provides project performance status and reports to Fort Belvoir and South Project officials. Maintains reporting channel to the project team through the Deputy Project Manager.
Senior Logistics Planner	*Paul Augustine*	Performs overall logistics planning to support the project objectives. Role spans the initial outfitting dimension to include validation of equipment requirements, construction of the requirements data base, sourcing and purchasing of item requirements, delivery, storage, and installation management, and final government acceptance criteria and completion. Maintain initial outfitting status across both North and South projects and provides information, status, and report to internal and external review processes.
Project Management Professional	*Robert Case*	Performs project management functions in support of the project team and the project objectives. Maintains the Project Management Plan and the Integrated Master Schedule. Continuously updates the PMP with process and results information. Oversees the master scheduler's construction and application of the IMS, conducts continuous review and reporting of IMS events and provides notification of all schedule issues and/or accomplishment to the project leadership. Maintain the library of essential project documents via the Sharepoint site.

Position	Name	Roles and Responsibilities
Master Scheduler	*TBD*	Performs the primary development and management of the Integrated Master Schedule. Serves as the Project Team's expert on project timeliness in accordance with the IMS events and activities. Closely coordinates with Government schedulers at the JTF and activity levels. Provides required periodic reports and assessments related to adherence to schedules.
Quality Control/Risk Manager	*Nathan Chong*	Primary project team official for development and management of the Quality Control Plan and the Risk Management Plan. Develops quality control activities list in synchronization with the Government's QASP. Provides periodic monitoring and reporting of quality and risk indicators in accordance with internal and external reporting schedules. Conducts the quality control and risk management assessments in accordance with respective plans.
Environmental/ Safety	*Larry Owens*	Primary project team official for development and management of environmental and safety plans related to project performance. Conducts surveys to assess environmental and safety risks and assures project team compliance with Governmental guidance in this area (e.g. NFPA, OSHA, and others as cited in the PWS).
Training Specialist	*TBD*	Primary project team official for development and management of internal and external training plans. Performs planning and implementation actions to conduct training to support team processes and functions, and coordinate external training requirements to support project requirements (e.g. development and implementation of the new equipment training program)
Communications Specialist	*TBD*	Primary project team staff member to support the full range of communications matters to include public affairs, project informational briefings, project literature, and project representation at Government sponsored planning meetings and conference events.
Administrative Assistants	*Michael Davis*	Performs a full range of administrative duties to support the project team.

Project Team Infrastructure. These elements provide essential support to project objectives and functions. Each of these supporting infrastructure elements is vital to project. Each of these supporting components provides specific expertise and capability. These organizational components include:

- **Purchasing:** Our large provisioning effort necessitates a carefully crafted purchase control and financial management system. RTKL will perform all equipment planning, market research, sourcing, competition review, and other tasks necessary to plan and execute the procurement action. Procurement transactions will operate with the support and oversight of the General Dynamics purchasing centers in accordance with the project team's logistics concept of operations and document/transaction flow model. General Dynamics through this process will maintain full control of purchasing transactions and ensure compliance with DCAA requirements. In accordance with invoicing procedures defined in our pricing proposal, General Dynamics purchasing agents will process invoice and reimbursement actions through the Government's supporting finance and accounting office. This entire process will be performed in a precise and efficient manner in order to

ensure prompt payment to equipment suppliers and timely cost data for the Government. Our experience in procurement support on behalf of Government requirements, coupled with our proven methods and procedures for invoice management will significantly enhance overall project performance and reduce the risk of that procurement issues will cause cost or schedule impact.

- **Financial Management:** All purchasing actions will enter the General Dynamics financial management system to ensure proper accounting leading to accurate invoice processing and Government reimbursement. A senior financial management official will work directly in the project management office to oversee the financial management process. Other dedicated financial management technicians will work in the General Dynamics financial management center to directly manage, control, and monitor all project transactions. The financial management element will provide continuous status and reports on transaction and overall financial management status.
- **Subcontractor Management.** The General Dynamics contracts department will contain subcontractor management specialists who will track subcontractor work, invoices, and payment. The objective is very precise management of subcontractors, assurance of their appropriate performance levels, and equally efficient management between GDIT and subcontracted team members.
- **Information Management Unit.** The Project Team's information management (IM) element focuses on the integration of project data and information to meet internal project management requirements and support all informational and reporting requirements to the Government. For the IO&T project, our Project Management Information System (PMIS) takes advantage of several outstanding information tools being used by our specialized team partners. For example, RTKL uses Attainia (a provisioning system that specializes in healthcare equipment) to provide very detailed tracking and item information on all equipment provisioning actions. HCR uses a customized spreadsheet to capture every item that is moving and tracks the item's status throughout the project. Our project management staff will employ Microsoft Project for the IO&T IMS to track all events, tasks, and activities as well as synchronize resource requirements with the work breakdown structure for the project. Our IM unit will organize and coordinate all data and information to meet all reporting requirements. They will also deploy, train, and sustain our Accendo® application. This capability will apply web based mapping to visualize all item information. Finally, the entire information dimension will be brought together on a JTF CAPMED web portal that will serve as the primary source for our project information. The information management element also includes a DMLSS support team. Full integration with DMLSS is imperative, and our technical approach completely recognizes this element as critical to the project's success and has applied our DMLSS experts in support of the project team. We will ensure that all equipment transactions enter the DMLSS property accounting/equipment management module, and that all appropriate DMLSS-Facility Management (FM) transactions are properly processed.
- **Biomedical Equipment Support Unit.** One of the most critical supporting elements of the project team is our Biomedical Equipment Support unit. There is an extensive array of biomedical equipment technical actions required to support the IO&T project. Biomedical equipment support is a factor in provisioning and relocation; it plays a key role in capturing item information for property accountability and warranty management. We

have structured our biomedical equipment support unit as an organic resource that will complement any manufacturer support in the provisioning process. Our biomedical team members also provide significant support to Health Care Relocations (HCR) move teams for reuse equipment. It is imperative that sufficient biomedical equipment support resources are available to support an efficient transition, provisioning, and relocation of medical equipment. Lack of proper biomedical equipment support for the IO&T project is major risk factor for the overall success of the NCR program. Our overall biomedical equipment support has two dimensions. First, we are replicating the highly effective Technical Assessment Requirements Analysis (TARA) processes used by the US Army Medical Materiel Agency in the medical equipment requirements determination program. GRSi, our biomedical equipment support contractor, is the current USAMMA TARA contractor. We will use this capability in equipment identification, sourcing, and in any scenario where analysis of equipment systems, and/or determination of clinical engineering and information technology intersections are required. Secondly, GRSi staff members will provide our biomedical technician (BMET) workforce to support condition coding, removal, installation, inventory verification, equipment training, and DMLSS data entry. This BMET team will also lead our test and calibration program. This approach to biomedical equipment support allows our PM and Senior Logistics Planner to apply BMETs in multiple configurations and scenarios to dramatically improve project performance.

Operational Capabilities Our organizational structure establishes three operational components in the areas of transition, equipping/provisioning, and relocation. The project manager and staff in our Project Management Office (PMO) provide management direction and control of these elements. The range of the operational capabilities is further detailed in the Technical Processes, Section 6 of the PMP.

4.2 External Interfaces

General Dynamics envisions extensive interfaces with all JTF CAPMED elements and project stakeholders. Our coordination and interface practices will follow these imperative guidelines:

- The Contracting Officer, Ms. Laurie Hovermale, USAMRAA, will be informed and advised on all tangible actions related to the project. This includes scheduling of meetings and in-process reviews related to performance assessment or evaluation; events focused on major program processes and/or procedures; announcement of major project results; and/or determination of project area clarifications and/or project issues and/or concerns. In general, the General Dynamics Project Manager will notify or provide copy furnished information to the Contracting Officer on all significant events or developments in the project. The General Dynamics Project Manager will make all contacts to the Contracting Officer through the General Dynamics Contracts Department official, Ms. Patsy Hubbard, responsible for contract support to this project.
- Interface coordination will be managed through the COR, CAPT Russell Pendergrass, JTF CAPMED, Director of Acquisition and Contracting; and the Project Program Manager, and Ms. Janice McCreary-Watson, Deputy Director of Logistics Acquisition Program Management. The General Dynamics Project Team will continuously recognize the command and control responsibilities of the JTF CAPMED and as such will ensure that all major events and actions are coordinated through these project officials. Proper

notification will be made of all secondary actions resulting from initially coordinated events and actions.

- All events and actions at site level will be coordinated through the appropriate integration and transition elements at NNMC, WRAMC, and Fort Belvoir respectively. These direct contacts presuppose coordination through the JTF CAPMED and approval for continuing action at the site level. General Dynamics Project Team Site Leads at Bethesda and Fort Belvoir will maintain continuing coordination with the respective project managers and transition management officials at these sites.
- The following JTF CAPMED officials and elements constitute the primary coordination and contact points for all external interfaces:
    - JTF CAPMED Contracting Officer Representative (CAPT Pendergrass)
    - JTF CAPMED Project Manager (Ms. McCreary-Watson)
    - JTF CAPMED J-4 (COL Bulick)
    - JTF CAPMED Transition Project Manager (CAPT Myhre)
    - NNMC BRAC Project Office (Mr. Oliveria)
    - NNMC Deputy Commander for Integration and Transition (CAPT Bitonti)
    - NNMC NAVFAC and Building A and B Project Officials
    - WRAMC Clinical Integration and Transition Officials (COL Joilissaint and COL Edinger)
    - WRAME Directorate of Logistics (COL Gardner, LTC Harper, CW4 Dunham)
    - Fort Belvoir Health Facility Planning Office (Mr. Fortune, Dr. Repeta, CDR Johnson)
    - DeWitt Army Community Hospital Logistics Division (MAJ Kellen)
    - Malcolm Grove Air Force Medical Center (LTC Seese)

(*Note: complete roster for all JTF staff being engaged in the project is being prepared and will be added to subsequent PMP versions)*

5.0 Management Processes

General Dynamics has a comprehensive set of processes to manage the IO&T Project from initial contract award through final turnover and close out. We have adapted the General Dynamics' ISO 9001-2008 management processes to the JTF CAPMED IO&T Project and have included features specifically designed to manage major health care facility transitions and the special consideration of integrating tri-service military medical operations into a single joint operation. As a whole, our management processes provide the foundation for a successful JTF CAPMED transition by clearly defining IO&T project objectives, goals, and most important, the methods for accomplishing those goals. We present our management processes in terms of the project stage.

5.1 Start-up Stage

The transition of WRNMMC and FBCH is on an aggressive schedule that is driven by BRAC requirements. This demands we start engage all project initiation matters in a highly aggressive manner. Key personnel and other staffing requirements have been in active management for several weeks prior to notification of contract award, and have set the stage to move quickly to fully staff the project team. Other matters such as establishing necessary office work areas, achieving information systems connectivity, and development of initial plans have also had preparatory actions to ensure their readiness upon contract award. Our approach to start-up features:

Pre-Award Processes. During the development of our proposal, and continuing until contract award we initiate several processes that facilitate a smooth start-up.

- **Key Personnel Recruiting Process.** Our recruiting process for this project targeted personnel with specific qualifications and experience aligned to the JTF CAPMED IO&T Project. As we discuss in our Staffing Plan (Appendix C) General Dynamics has been able to assemble a management team of highly qualified health care professionals that have significant experience managing major transitions but also have a genuine understanding of the military healthcare community, and commercial best-practices that will underpin contract performance. All but one of our proposed personnel are current employees of General Dynamics or our team and all have made a commitment to this project. This fact will allow us to have our entire management team assembled and working within a week. All key personnel identified in the proposal have been assigned to the project team as forecast. All are now fully engaged in the project team's start-up phase. Mr. Stuart Mervis, the designated Project Manager in the proposal, is in fact leading project team operations from the immediate notification of contract award. Other key persons have been added to the team, in addition to those originally identified in the proposal, to quickly expand the full level of experience and expertise being brought to the project. These persons are identified in the Staffing Plan.
- **Start-Up Schedule and Milestones.** As part of our IO&T IMS we have included activities associated with the Start-up of the IO&T Project. Commencing upon Contract Award Our Project Manger (PM) will initiate this schedule and begin tracking performance to ensure we stay on schedule to meet the overall IO&T requirements.

- **Monitor JTF CAPMED Progress.** During the period between proposal submittal and contract award our PM, Mr. Stuart Mervis, has actively monitored the JTF CAPMED website and other information sources to detect anything that may affect our proposed approach or our ability to carry out IO&T services within the required specifications. Upon contract award, immediate interaction with the COR and the JTF's IO&T Program Manager, as well as other officials, has rapidly eleveated the project team's understanding of immediate developments affecting the JTF and ultimately the performance of the IO&T support.

Post-Award Processes. Immediately following contract award notification on 23 November 2009 the following events were scheduled and executed to begin the rapid immersion of the project team into the contract requirements and performance:

1 Dec 09: Kick-off Meeting

3 Dec 09: Site visit to Fort Belvoir

7 Dec 09: Site visit to NNMC

8 Dec 09: Site visit to Fort Belvoir, return visit for additional project team members.

9 Dec 09: Government-Contractor Coordination Meeting, conducted at Fort Belvoir and including participation of approximately 100 persons from all activities supported in the project. General Dynamics team introductions and capability briefings were provided.

10-31 Dec 09: Multiple counterpart meetings and work sessions conducted resulting from initial introductions at the 9 Dec coordination event. These meetings have provided considerable insight in current JTF CAPMED programs and processes related to the performance of the IO&T project. These events have also shaped elements of the initial deliverables being provided on 30 Dec and 31 Dec 2009.

31 December 2009: Submission of initial deliverables: The post-award phase is concluding on 31 Dec with the submission of Version 1.0 of the Project Management Plan. This initial plan represents the project team's original concept of operations with immediate adjustments resulting from interaction with multiple Government elements during this post-award phase. Subsequent versions will capture planning stage and execution stage developments and direct task performance.

5.2 Planning Stage

Key planning events are now rapidly unfolding and will shape the execution of the IO&T project. Project performance and the key events currently underway should be viewed in the following structure of project management, initial outfitting, relocation services, transition support, information management, and quality control/risk management. This structure will characterize the performance of IO&T support and also provide the reporting framework of project progress in future in-process reviews and engagements with key JTF CAPMED officials.

- Project Management:

  - Project team staffing is the primary project management objective in the planning phase. The project management team is already largely place. Virtually all key positions have been filled. The staffing plan articulates the specific staffing requirements and action to date. Senior project management officials have immediately moved to the project team to include the Project Manager and the Deputy Project Manager/Senior Project Management Professional. In addition, Site Leads for the North and South Projects have been selected and start project performance on 4 January. Additional key positions have been filled to include the senior financial management staff member, senior logistics planner, information management lead, and others. Any remaining vacancies are projected to be filled not later than 15 January. Project management team staffing is viewed as the first critical step in providing the structure and direction to the overall project. Staffing actions will continue to ensure that the project management team at full strength to engage all requirements.

  - Project management office and work areas: Offices for the project management team and selected members of the operational capability partners have been established at 8601 Georgia Avenue, Silver Spring, MD. Use of existing General Dynamics office space at this location and expansion to adjacent space will ultimately accommodate the complete project management team and selected members of the equipping, relocation, biomedical technician, and transition planning staff. Project team members will work at their current General Dynamics office area until Monday, 4 January 10. With arrival and setup of computer and telecommunications assets, the project management team is scheduled to mass at the Silver Spring location during the week of 4 January. Site leads at Bethesda and Fort Belvoir will go into place NLT 11 January. Additional staff at the site transition offices will also go on-site NLT the week of 11 January. Work space has been identified at Fort Belvoir in Building 701 which houses the Transition Coordinator and staff. Space at Bethesda and at Walter Reed is schedule to be examined during the week of 4 January. Planning stage actions will continue with expectation that all office and all staff will be on-site as required between 15 and 30 January.

  - Project team processes and operating procedures: While the overarching concept of operations for the project team is already in place, many specific operating processes and procedures will largely go into place during January, 2010. The project team leadership is aggressively reviewing all coordination, financial management, logistics concepts, and other underpinning processes that are paramount to project success. Each process will be documented during the planning phase and added to the PMP.

- Initial Outfitting: Planning phase actions related to initial outfitting include the following:

  - Analysis of master schedules and work sessions with project delivery teams: The project management team received the JTF CAPMED's IMS (as GFI) on 23 Dec 09, and is beginning its full review of this essential information. The first full work session with the Fort Belvoir Project Delivery Team is scheduled for 6 January 2010.

This session involves the COE, HFPA, construction contractor, architect and engineering firm, interior design team, and others. This key event will provide initial information and insight to the project planning milestones and key events, and will be significant in beginning the scheduling to support the IO&T program. A similar event is expected to be conducted at NNMC is early January.

- Receipt of Equipment Lists: The initial outfitting component of the project is largely impacted by the declaration and validation of Government requirements as provided on designated equipment lists. The COR advised during the week of 21 Dec 09 that the lists would be provided as GFI via official contract modification. The expected delivery of this modification is early January, 2010. As part of the 23 Dec 09 GFI, the project team did receive interior design package information which does contain advance information on the furniture and furnishings component of the initial outfitting. It is anticipated that this information will be confirmed on the Furniture Equipment List (Attachment 4 to the PWS). Equipment planning work sessions are also being convened during this stage of the project and counterpart relationships are clearly unfolding.

- Initial outfitting data base: The project team's most important action in the planning stage is the construction of the initial outfitting or equipping data base. This product is developed by RTKL, the project team's lead equipment planner, in their Attainia information system. The data base lists and tracks every item and aligns each item by the hospital location in which the item will be delivered to and placed or installed. This is a vital component of project performance and drives all subsequent procurement planning, sourcing, purchasing, delivery, and installation.

- Relocation Services: The project team's relocation component commences its planning stage during the first week of January, 2010. Several events are planned and will begin the extensive process to identify, validate (match to Attachment 6 of the PWS), catalog and characterize (all details about the item move), and conduct detailed planning in preparation for the physical relocation. This is an extensive planning stage process. Initial planning events will shape projections on timeline completion dates for this part of the planning stage. As these dates are calculated they will entered to the PMP and IMS. These initial events are already planned:

  - 5 January 10: Relocation planners will conduct their first survey of Dewitt Army Community Hospital and work with Logistics Division staff on concept of operations and planning for movement of items from Dewitt to the new FBCH.

  - 7 January 10: Relocation planner will conduct an extensive work session with Directorate of Logistics officials at Walter Reed Army Medical Center. Multiple issues will be addressed to include scheduling of the complete reuse/relocation item survey, preparation of the transferrable equipment reports, preparation of the 'move" book, determination of JTARA versus Non-JTARA status of items, and other important matters. The extensive survey process with then unfold with timeframes and targeted completion dates provided in subsequent PMP and IMS documents.

- Relocation planning at NNMC: Specific date for the initial event is to be determined. Project team officials will meet with the BRAC Transition Management Team on 6 January 10 to begin formulation of all planning stage events as they relate to the NNMC. Likely timeframe for the initial relocation planning work session is during the week of 11 January.

- Multiple events and on-site actions will continue in the relocation services planning stage. Detailed activities will be recorded in the IMS. Progress will be reported in in-process reviews and subsequent versions of the PMP will capture the extensive array of events and activities in this area.

- Transition Support: Extensive interaction across the JTF characterizes the development of the project's transition planning model. The following sequence of planning events is already unfolding:

  - Coordination with the JTF CAPMED's senior transition project management official. Initial meetings have been conducted with CAPT Elizabeth Myhre to ensure that the transition planning model is fully consistent with the JTF's transition strategy and guidance. Continuing meetings and work sessions are planned to commence on 6 January to expand the detailed nature of this planning effort. Additional J-staff elements that are supporting the transition effort are expected to join these work sessions. The senior official from Health Care Transitions, Ms. Sandra Hamper, will begin her direct interaction and support to CAPT Myhre during the week of 4 January. Ms. Hamper will provide senior level subject matter expertise to the JTF related to transition design and specific components of the planning model.

  - Coordination at activity level. The project team's transition support element began in December, 09 to engage activity level transition coordinators to understand the transition planning model, strategy, and tactics applied to date. Several meetings and work sessions have already been conducted at Fort Belvoir. Initial work sessions have also been conducted at Bethesda and at Walter Reed. These events have led to increasing discussion about the HCT planning model. The model is being introduced and activities are applying their perspectives to its application. A key Fort Belvoir event is planned for 8 January which involves all the "transition chiefs" and consideration of adoption and/or adaptation of the HCT model. This type of event is pivotal to definitizing the precise project team support role related to transition plans. It is expected that with this events and others closely related and scheduled during January, 2010, the final planning model will be determined and specific plan development actions prescribed.

  - Establishment of the site transition offices. Project team staffing is now moving into place to support detailed transition planning and implementation at each of the three activities: NNMC, WRAMC, and Fort Belvoir. The staffing concept for these offices is undergoing a final review in the coordination events cited above. These offices will perform the tactical transition plan support required in the project. Subsequent PMP versions will detail the exact planning components – several of which will derive from the transition planning framework described in Section 6, Technical Processes.

- Transition planning will extend for several months. Development and approval of specific plans will be noted in the IMS and reported in subsequent PMP versions. The planning process will lead to a specific set of plans at each activity detailing elements of transition design, operations planning, and implementation of transition plans.

- Information Management: The Project Team has begun the full development of a Project Management Information System (PMIS) that will envelop the entire project management effort. The PMIS incorporates the tracking tool and provides the system design and implementation to achieve effective information, status, and reporting support for the project. The PMIS is further described in Section 7 and is characterized by the tracking tool manual and sample report also provided as deliverable products.

- Quality Control and Risk Management: The Project Team has begun the full development of a Quality Control Plan and a Risk Management Plan. Development of these products is reported upon in separate deliverable products that are attachments to the PMP. In the planning stage, both products will undergo detailed review with the JTF staff. The JTF's Quality Assurance Surveillance Plan will be received in January, 2010, and form the basis for adjustment and finalization of the QCP. The Risk Management Plan will also undergo further review with the JTF to in order to finalize reporting metrics and specific in-process review subject areas.

5.3 Execution Stage

The actual performance of the IO&T services (including transition support, equipment provisioning, and relocation services) is formed by our Technical Processes as contained in Section 6 of the PMP. Our management processes are designed to facilitate the execution of IO&T services and will include:

Coordination Processes: We will apply a high level of continuous coordination and interaction across the JTF to ensure effective receipt of JTF guidance and direction, and to ensure achievement of all project objectives. Multiple forums will be used to ensure continuous, effective engagement. Project management office senior officials and site leads will maintain active, open coordination with all supported elements. We expect a vigorous level of interaction that forges a highly dynamic and effective partnership and working relationship.

Communications Processes. We will reinforce our coordination processes with formal communications methods that provide tangible representation of the effective working relationship, and provide essential and timely information to support planning and implementation actions. We will use a wide variety of formal and informal communications processes in place including the PMP, IMS, PMIS, in-process reviews, project updates and newsletters, and other web-based communications to support the communications process.

Technical Processes. We will apply technical processes in the primary support areas of transition, equipping, and relocation. These technical processes begin to be explained in Section 6 of this PMP. The overall information and description of these processes will grow dramatically as the project team engages all dimensions of the project work. Our operational capabilities will continuously expand and be documented for subsequent PMP versions.

Training Processes. We will continuously apply training across our project team and across the JTF to ensure that all processes and products are effective and clearly understandable to the user groups. Training will also extend to many detailed elements of the project such as the receipt, acceptance, and use of new equipment; the conveyance of new operating procedures in the new facilities; and the use of specialized exercises such as "Day in the Life" to prepare operational and administrative staffs to function within new facilities. A formal training plan will underpin this component of our execution stage.

5.4 Monitoring and Controlling

Monitoring and controlling is the most important aspect of our management approach. For the most part our monitoring and control processes are documented in formal plans and procedures. Examples of these are: Financial Management Procedures, Quality Control Plan, Risk Management Plan, Subcontract Management Plan, Staffing Plan, Tracking Tool Report, and the Integrated Master Schedule (IMS). Each of these documents provide guidance on monitoring and controlling performance. Our PMIS provides a real-time tool for monitoring performance and will be used to automatically alert managers when deficiencies in cost, schedule or quality are detected. The following paragraphs discuss our monitoring and control processes.

Cost Monitoring and Control. IO&T Project costs (labor, material, ODCS and fee) are captured in our Deltek CostPoint financial management system. We will set up this system to monitor cost versus budget in various ways:

- **Cost by CLIN**. We capture actual cost by CLIN and monitor the totals against budgeted burn rates as well as total CLIN budget. At a minimum we notify the KO when costs for any CLIN reach 80% of the budgeted cost. In addition, we will develop algorithms that are able to spot abnormal trends (e.g., high burn rates) and anomalies (e.g., excessive expense) and alert our managers to investigate the cause.
- **Cost by WBS**. As we develop our IMS we assign resources according to WBS number. We then collect and report on cost to provide real time cost of services to our managers as well as Government monitors. This will give managers and planners the information they need to make any required adjustments to the project work effort.
- **Other**. CostPoint is a powerful financial management tool and has a number of features that allow custom and ad hoc inquiries and reporting for authorized users.

Schedule Monitoring and Control. GDIT has developed an initial IO&T IMS which we will fully populate shortly after contract award. This MSProject based schedule will provide a dynamic tool for monitoring schedule performance. Our Professional Project Manager, Mr. Robert Case, will be responsible for the IMS and be supported by a Master Scheduler and resources from our Information Management unit. The schedule will be updated each day and queries run to determine any actual or potential schedule conflicts or deficiencies. Upon discovering any deficiencies our Master Scheduler will contact the appropriate manager and develop mitigation plans. We will record every schedule deficiency on our IO&T web page to give visibility to all IO&T stakeholders, contractor and Government.

Inventory Monitoring and Control. With more than $200M worth of equipment to track inventory monitoring and control is a high priority. Our inventory control processes include:

- **Property Management Procedures.** GDIT accounts for, maintains, and dispositions and manage Government-Furnished Property (GFP) in full compliance with FAR Part 45 and FAR 52.245-1. Our Property Management Plan will describe the disciplined methods we use for keeping track of GFP, and our property custodians will ensure that the property inventory lists are kept up-to-date and that required inventory inspections occur.
- **Inventory Tracking Tool.** GDIT's tracking tool consists of a suite of proven commercial-off-the-shelf (COTS) applications that are fully compatible with DMLSS. We provide details of these applications in Section 7 - Project Management Information System (PMIS) and Attachment 2 - Tracking Tool User Manual (deliverable 6). As equipment is procured or relocated GDIT will update inventory records including RFID and barcode information. Once an item has been installed (including testing, calibration and user/maintainer training) we will update inventory data. During the turnover and close out phase we will transfer all inventory data to DMLSS.

Quality Monitoring and Control. Our approach to monitoring and controlling quality and performance is provided in Appendix F - Quality Control Plan.

Environmental/Safety Monitoring and Control. GDIT's Environmental/Safety Manager will implement GDIT's comprehensive Environmental, Safety and Health (ES&H) Plan for the NCR IO&T Project. He will provide training to all employees and monitor any activities that involve environmental risk or unusual personnel safety risk.

5.5 Close Out Stage

Extensive post-occupancy actions will be developed in the planning phase and executed at the end of the project. The post-occupancy and close-out stage will extend over several weeks following the full relocation of services and commencement of operations in the new facilities. There will be multiple dimensions to the close out and post-occupancy period. Some will include but are limited to:

- Facilitation of turnover of all applicable documents
- Verification of DMLSS property accounting and equipment management actions.
- Verification of equipment training and subsequent training as required.
- Verification of equipment operational readiness and satisfactory operating condition.
- Review of concept of operation and operational planning within the new facilities.
- Review of policies and procedures affecting operations in the new facilities.
- Formal post-occupancy evaluations in accordance with the PWS.

6.0 Technical Process

6.1 Project Team Approach for Technical Processes

The General Dynamics Project Team will perform initial outfitting and transition support functions in support of the opening and operation of the WRNMMC and the FBCH. While

closely related in terms of the overall success of the total project, each of these two major project functions requires distinct technical expertise and technical processes. The expertise and the processes that support these functions come from the major operational capabilities contained in the project team. The three operational capabilities are transition support, equipping/provisioning, and relocation services. In this part of the PMP we provide an increasingly detailed description of how each of the operational capabilities will be applied to achieve project objectives. The operational capabilities are enveloped by a comprehensive project management, information management, quality assurance, and risk management structure to assure continuous evaluation and improvement, and measurement of operational performance. In this regard, the PMP will be continuously viewed as a "living document" in which changes, adaptations, and improvements are captured to ensure the current state of capabilities and performance is accurately described.

6.2 Transition Support

The JTF CAPMED faces an immense transition challenge. In fact, the process of hospital transition actually involves several dimensions to include the integration of clinical services at new healthcare facilities (WRNMMC and FBCH), the transition of staff and services to new operating locations, and in many cases the actual transformation of services to a new state-of-the-art for military medicine. The JTF objectives to achieve "world-class medical facilities" places an extremely high premium on the ability to successfully integrate, transition, and transform clinical and support services across the JTF.

The Project Team's approach to transition support is centered in the planning model developed by Health Care Transitions (HCT) in over 20 years of work supporting healthcare organization transitions to new hospital facilities. This is a highly detailed model that is tailored to the specific structure, culture, and operational requirements of the activity supported. In the case of this project, a carefully designed review period commences immediately at the outset of the project to determine the specific application of the model. The Health Care Transitions experts are teamed with staff from Health Facility Solutions (HFS) to forge the specific plan of action for each of the activities engaged in the transition. From the outset of this project the transition support team will work directly with the following lead elements engaged in the JTF CAPMED transition process:

- JTF CAPMED Transition Project Management Office: This office is led by CAPT Elizabeth Myhre and contains a support staff to oversee transition strategy and operations.
- NNMC Deputy Commander for Integration and Transition: This office is led by CAPT David Bitonti and contains a support staff to direct transition activities affecting the NNMC as it transforms to the WRNMMC.
- WRAMC Deputy Commander for Integration and Transition: This office is led by COL Jolissaint and COL Edinger and contains a support staff to direct the transition activities affecting the closure of WRAMC and the relocation of activities to the new WRNMMC and the FBCH.
- Fort Belvoir Health Facility Planning Office Transition Coordinator: This office is led by CDR Scott Johnson and contains a support staff to direct the integration, transition, and transformation of healthcare operations at Fort Belvoir leading to occupancy and operation within the new FBCH.

The Project Team structure and alignment is designed to support these four elements. The project management office will maintain direct and continuous coordination with the JTF Transition Project Management Office. This will be led by the Senior Transition Planner and the senior Subject Matter Expert from Health Care Transitions, Ms. Sandra Hamper. Site Transition Offices will operate at each of three operational activities with HCT and HFS staff providing support. The complete transition support process then extends to management and staff levels throughout the respective organizations as they become an active participant in the transition planning and implementation phases.

The transition support program will be executed in three phases; each successively applied to form the transition approach, to prepare the required specific plans, and then to perform the actual transition operations culminating in the movement of staff and operations to the new facilities. These three phases include:

- Transition Design Phase
- Transition Planning Phase
- Transition Implementation Phase

6.2.1 Transition Design Phase:

This initial phase has commenced with the contract award and involves a critical review of several aspects of transition support. Specifically, the HCT and HFS teams will perform the following:

- Transition Assessment: review and validate essential requirements in the transition support program and process.
- Transition Structure: determine the responsibility and impact of all Government transition activities and confirm the best application of Project Team transition staff and resources to support the transition requirements.
- Transition Plan and Documentation: determine the specific planning components essential to project success and begin formulation of the Transition Activity and Event Model and Timeline.
- Transition Budget: review budget requirements to support transition planning and activities with Government counterparts to ensure adequate readiness for major transition events such as “Day in the Life” exercises and other transition support requirements.
- Transition Process Guiding Documents: assure that all required documents are available and appropriately reviewed to support transition plans.

The Transition Design Phase requires detailed consultation with each of the JTF transition support elements and culminates with context and direction to engage the Transition Planning Phase.

6.2.2 Transition Planning Phase:

This phase involves very detailed work to prepare specific plans that support the transition process. The planning phase will be completed over a several month timeframe in advance of actual transition of operations. The planning phase is structured in three planning components: operations planning, occupancy planning, and human component planning.

- Operations Planning: this component of the planning phase focuses on the processes and practices that will underpin the new hospital operations. Working in close coordination with the transition support elements and the actual clinical and administrative departments the objective is to provide a series of plans addresses multiple operational aspects of the new facility operations. In many cases this project will require consultation and ultimately decisions by the Government as convergence of processes and practices from potentially activities is shaped as a process/practice for the new hospital operation. Direct interaction with activity "transition chiefs" and 'integrated service chief" will be necessary to finalize specific operational plans. The operations planning component addresses the following types of plans:
    - Concepts of Operations
    - Special Studies
    - Staffing/Human Resources
    - Business Plan Interface
    - Medical Staff Readiness
    - Hospital Wide Programs
    - Policies/Procedures
    - Operational Budget

Each of these above plans applies a structured event and action template designed by HCT. These templates will be introduced in the transition design phase as discussion and determination of specific plan requirements is finalized. As templates are adopted they will be added to the PMP.

- Occupancy Planning: this component of the planning phase focuses directly on the physical movement of staff, patients, and operations to the new facility. This phase contains a close alignment with the Relocation Services element of the Project Team's operational capability. The specific elements with the Occupancy Planning component include:
    - Hospital Logistics Management
    - "Low Voltage" Planning (information systems/telecommunications)
    - Space Management
    - Legal/Regulatory Guidelines
    - Occupancy Readiness Plan
    - Department Movement Plans
    - Occupancy Master Plan
    - Patient Move Plan

During the transition design phase there is direct discussion with the transition elements to determine the current strategy and depth of occupancy planning. From this discussion and evaluation, the final planning components for occupancy planning are determined. Each of the above components contains a HCT event and major activity template which is then put into place to guide development of the specific plan. As final components of occupancy planning are determined the specific templates will be added to the PMP.

- Human Component Planning: this component of the Planning Phase addresses the range of individuals that are directly involved in the transition. This includes staff, patients, and families. The objective of this component is to fully prepare all individuals for the

significant operational transition that will occur and the impact that it will have on their daily role and task performance. This planning component is also designed to ensure that on an individual level, all elements are ready for the transition and are able to effectively perform their duties in the new hospital facility. This planning component culminates with the "Day in the Life" exercise which is designed to simulate everyday hospital operations in the new facility. The exercise takes place in the new facility. The specific planning elements in this component include:

- The Patient and Family Experience
- Facility Tours and Site Visitations
- Change Management
- Project Communications and Public Affairs
- Education and Orientation
- "Day in the Life" Exercises

Each of the above planning elements contains a HCT designed events and activities template. The specific structure of these templates will be reviewed with the activity's transition officials and then added to the PMP. The "Day in the Life" exercise involves an extensive planning process and the preparation of multiple scenarios that portray actual hospital operations. As the transition process moves into this planning component – this is several months away and much closer to actual new facility occupancy – the actual exercise plan will also be added to the PMP

6.2.3 Transition Implementation Phase:

This phase executes the plans developed in the planning phase. There is both a pre-occupancy and post-occupancy component of this phase. In the center of these two components is the actual patient move which truly commences operations in the new facility.

- Preoccupancy represents the execution of occupancy readiness and movement plans. "Day in the Life" exercises immediately precede the occupancy phase as the staff undergoes final preparations to move to the new facility. Public relations and public affairs events provide required announcements and communications to the supported community. Command center type operations go into effect as all hospital elements prepare for relocation.
- Post-occupancy represents the period following the patient move and includes an extensive evaluation process to determine transition effectiveness and determine areas of the transition that require additional reinforcement in terms of program or procedure clarification and/or reconsideration.

The implementation phase also contains HCT templates to define key events and activities. Final templates will be added to the PMP as developed during the design and planning phases. The post-occupancy template will be applied to guide post-occupancy evaluations in accordance with the PWS.

6.2.4 Development of the Key Activities Timeline.

There are a multitude of activities and tasks that must be accomplished to achieve the transition objectives. The framework for this area is established by the Key Activities Timeline. We present this extremely important part of our project management plan in Figure 6-1 below. The

timeline is the work of Health Care Transitions (HCT) and their functional expert team led by Sandra Hamper. The timeline reflects HCT's experience in the transition of hospital operations into new or renovated facilities. The Key Activities Timeline is the basis for our transition plan and becomes the principal means to manage and control all transition activities. Several steps are followed in which we introduce, imbed, and then apply and control the timeline within the total project performance. In effect, what starts as the overarching timeline becomes the definitive plan for hospital transition and the activation services.

- Step 1: ***Timeline entry to Microsoft Project application***: We capture all timeline events, tasks, and activities in our IMS (Microsoft Project). HCT has timeline iterations already captured in MS Project, each has been adapted and modified to the specific nature and factors in the respective project. The date of contract award drives timeframes and begins to shape the entire timeline from start to finish. We load and adjust all timeline events based on the starting date of the contract. This allows for an initial timeline structure to be available in the first series of meetings with Government staff. Timeline events are clearly adjusted as the Government and GDIT staff work in unison.
- Step 2: ***Transition Process Management, solidifying the initial timeline, crafting and finalizing the Transition Plan:*** In the earliest stages of the project there are very important meetings and work sessions that occur between key Government staff and the project team. Several critical interactions will take place to tackle major elements in the transition process. In fact, in the timeline we note these activities in red. These activities solidify our understanding of the JTF CapMed transition strategy. The initial exchange between JTF and project team also confirms many details regarding the transition approach. Because of our work in Step 1, we are able to enter these meetings with our "first cut" on the key activities timeline and the transition process. We expect considerable dialog to exchange ideas and views. But, from our standpoint an essential management tool and approach has been brought forward. The timeline is a vital part of this process. It immediately contributes to the structure of the transition planning phase. There may be Government versions, in varying level of detail, addressing the same or similar events, and they will certainly also shape the discussion. But, the imperative objective is that we arrive at a consensus on the events, tasks, and schedule for the timeline and prepare to build and finalize the transition plan. This step will set the pace for the project. We expect changes and adjustments, but the transition course of action will be initiated and it will have a guiding timeframe for multiple component events and tasks. We conclude this phase with the finalization of the transition plan. We have now taken our initial timeline and worked through a critical step with the entire Government and project team to arrive at a plan that will guide and control the multitude of following events and actions.
- Step 3: ***Timeline Management:*** As the Transition Plan goes into place it becomes the guiding force in the overall project management. The events within the plan are visualized in MS Project. The two tools are now inextricably linked. Timeline management therefore uses MS Project to organize and track actions, but the project team's strategic understanding of how events are connected, and the daily focus on tactical actions, forms the basis for substantive timeline and plan management. As we move deeper into the timeline/plan the continuity of key staff is critical. The project team is now operating at a highly synchronized level and the importance of moving as a unit

through to project completion becomes critical. (In this regard, GDIT has sought strong commitments from key staff, and pursued partners in which company principals are engaged versus project-only hires). The plan is now the driving structure for Operations Planning, Human Component Planning, and Occupancy Planning. Our project team will apply the following actions to implement and report on all events, tasks, and activities occurring within the plan:

- ***Daily Summary***: this report extracts MS Project events, tasks, and activities and is aligned along the primary areas of operations planning, human component planning, and occupancy planning. The daily summary advises on the specific actions along each line and the status of the ongoing action. The daily summary becomes a very detailed accounting of all project actions. The daily summary is also used to identify project issues and track resolution. The format for the daily summary is implemented by the Central Project Management Office's project management professional and supported by the information management staff and the master scheduler. The report is compiled electronically and organized by the project management professional to reflect events at specific sites and cross –over events to specific functional areas. The summaries are completed by transition assistants supporting specific elements within the site transition plan, by the site transition leads, and moving upward to the central transition office. Examples of specific areas in the daily summary will include but are not limited to:
    - Operations Planning: Project goals and measures, current status; policy document status; civilian and military position status and recruitment; operational set-up by patient care area.
    - Human Component Planning: Education and orientation participation; training exercises; day in the life training; systems and equipment readiness; vendor training; patient and family interaction and orientation.
    - Occupancy Planning: Provisioning status; relocation plan and status; movement plan and sequencing; occupancy readiness.
- ***Monthly Progress Report***: this is a deliverable report that will also be tied to the transition plan, the resulting daily summaries, and the addition of any other critical issues and/or accomplishments. The important connection between the daily summary and the monthly progress report is that there is a clear history of events and the capture of facts and perspectives that can be transferred from one or several daily summaries to the monthly report. The monthly progress report will also tie to specific project milestones and report on specific area transitions. The Central Project Office's Project Management Professional, and Quality Control/Risk Manager will have important roles in formation of the monthly progress report.
- ***Strategic Objective Analysis*** (monthly): this monthly statement will be made by the Project Manager. The statement will contain a reflection of the monthly progress report in terms of analysis and supporting data/information to define the overall project status and the expectation for strategic objective accomplishment. Specific transition objectives related to clinics, departments, and major facility will be assessed and reported upon. This constitutes a critical review by the Project Manager on a monthly basis, and his statement is expected to have wide visibility across the

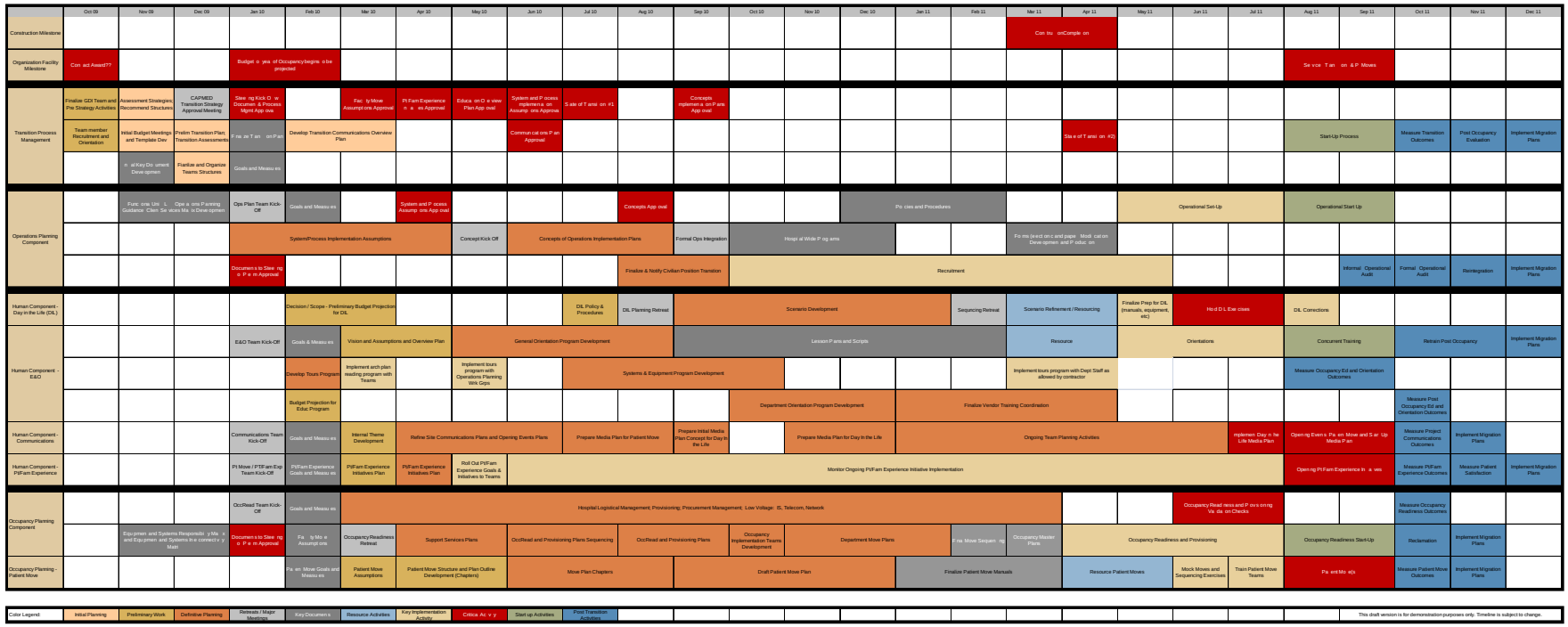
Government and project management teams. Selected dashboard indicators showing rates of equipment provisioning, finalization of relocation plans and then actual receipts and moves are types of performance measurement information that will be used.

- ***Incentive Award Report*** (monthly): this monthly statement will be made by the Project Manager, and contain specific reference to the two components within the Incentive Award Plan; achieving transition milestone and obtaining equipment provisioning cost savings.

- Step 4: ***Transition Evaluation and Analysis, tactical and strategic adjustment, lessons learned:*** The timeline development process, followed by capture and execution via the transition plan, provides the basis for measuring milestone accomplishment and other management objectives; e.g. rates of provisioning and relocation actions. The entire process from daily summaries to monthly reports provides substantial information on events, tasks, and accomplishments that must be subjected to overall evaluation and analysis. Linkages between event timing and results from specific activities to transition accomplishments can be traced and evaluated for future operations. Important information and perspectives are gained related to the integration of services and the supporting equipment requirements. The project team gains significant understanding of the functional implications of the facility design and can convey these perspectives to the hospital operating staff as it completes its full occupancy and commences operations in the new facility. If transition results in larger than anticipated new staff recruitment the transition team can be a valuable contributor to new staff training and orientation. These and other dimensions form the basis to provide a complete evaluation and analysis of the transition, and the lessons learned that impact current and future operations within the new facility.

This process culminates with the design of the activity timeline for the project. Pictured below is a sample of this product. The actual model for this specific project will be initially provided within the transition planning phase, and upon completion will be added to the PMP. This product will then serve as a vital tool in the project and be a primary factor in guiding the performance of all transition events.

Figure 6-1 The Key Activities Timeline *This is the basis for our transition plan and becomes the principal means to manage and control all transition activities.*



6.3 Initial Outfitting Support

A substantial component of the project is the initial outfitting of the new hospital facilities. This involves both the acquisition of new equipment and the relocation of existing equipment. A critical underpinning principle in this support is that the Project Team will respond and support the initial outfitting decisions made and requirements established by the Government. The Government's equipment planners determine the item requirements. These requirements are conveyed to the Project Team via the "attachments" to the PWS, or the "equipment lists" as they will become to be known as the project unfolds. Government and Project Team staff will work together to assure conveyance of the best possible equipment information, starting with JSN identification and proceeding to specific location and delivery timeframe within the initial outfitting schedule.

The General Dynamics Project Team is structured with operational capability to support both the acquisition of new equipment and the relocation of equipment designated for reuse. RTKL is the primary partner-subcontractor designated to perform the sourcing and purchasing for all medical, non-medical, and furniture items. The General Dynamics Army Infrastructure element, as a project team member, will perform the same functions to support information technology items. Health Care Relocations will perform all the specific management and execution functions required to relocate items designated for reuse. These respective roles will be performed in accordance with the following planning guidance.

6.3.1 New Equipment Provisioning

New equipment provisioning falls along four lines or types of equipment that are to be procured, delivered, installed, trained, and accepted by the Government. These types include medical, non-medical, furniture, and data processing/information technology equipment. A fifth category of equipment involves items that are provisioned by other contractors/sources; this is largely high-cost items that are expected to be obtained via the Defense Logistics Agency or other sources and the role in this project is to ensure coordination and avoidance of conflicts during delivery and installation. In the project management process there are clear, essential steps that must be taken to ensure synchronization with the transition plan and specifically the occupancy planning and readiness component. These steps are designed to manage, monitor, and track the provisioning process through the course of the project. Each step contains specific performance measures and reports that wrap up to the overall daily summary and monthly progress reports identified in project management of the hospital transition and activation services.

- Step 1 - ***Equipment Requirements Identification and Validation and Construction of the Supporting Requirements Data Base:*** Action has commenced to obtain the Government's equipment requirements and to begin the identification and validation process. This action is closely tied to the construction of the supporting equipment requirements data base. All equipment requirements will be entered to the Attainia data management system used by RTKL to support the provisioning process. This action is essential to also build the tracking system for *every* item to be provisioned in the initial outfitting process. There are very tangible reporting factors for this step. The project management office through the PM and the Senior Logistics Planner will lead the implementation of this initial step in close coordination with RTKL and the Gerneral

Dynamics Army Infrastructure element. The specific actions in this step include the following:

- Equipment Lists are received from the Government as GFI.
- Department and room locations are received from the Government as GFI. Facility design and space allocation information is vital to matching equipment requirements to specific room location.
- Equipment planning work sessions are conducted with the JTF, NNMC, Fort Belvoir, and Walter Reed equipment planning and reuse/relocation teams to ensure counterpart designations, establish necessary working relationships, and confirm validation, purchasing approval, and other operating procedures.
- Project delivery team work sessions are conducted to include COE/NAVFAC, Service health facility planners, construction contractors, interior design teams, architects, and other principles to provide and clarify all construction and initial outfitting planning schedules.
- Integrated master schedules are prepared to definitize initial outfitting timeframes for each facility.
- RTKL and General Dynamics equipment planning specialists move on-site at NNMC and Fort Belvoir to engage the equipment requirements and validation process.
- Equipment data base construction begins at RTKL.
- Equipment requirements validation work sessions are scheduled.
- Equipment approval procedures are put into place. All subsequent equipment purchasing actions are predicated on clear authorization by Government officials.
- Equipment data capture process is completed and tracking tool model established via Attainia data transfer to the Accendo web based mapping and visualization tool.
- Equipment requirements process, validation, and approval process is finalized and details added to the PMP.
- Data capture completed – equipment lines in tracking tool
- Reconciliation of equipment lists is completed.
- Item standardization process is operational.
- Equipment "blocks" or detailed equipment requirements matched to specific space and room locations and synchronized to initial outfitting schedule per facility are established. These blocks of equipment acquisition form the basis for procurement planning and purchasing actions.
- First cut "door reports" summarize all validated equipment by specific hospital department, area, or room. Reports are distributed to Government project elements for placement and application as the initial outfitting process continues.

The goal in Step 1 is the complete capture of all equipment requirements, their validation, and approval, and authorization to commence equipment procurement planning.

- Step 2 – ***Equipment Procurement Planning:*** The actions and objectives in this step involve two critical elements of the project. First, the alignment of all items with the initial outfitting and transition plans, and specifically the occupancy plan so that equipment is provisioned in accordance with the movement of clinical operations and commencement of medical care in the new facility. This element is largely influenced by the close coordination with project delivery teams to include COE/NAVFAC, site project management teams, and transition teams. This coordination results in precise scheduling of the delivery of initial outfitting equipment. The second element involves the detailed market research and sourcing to ensure product availability at appropriate pricing. This element engages the sourcing capabilities at RTKL and General Dynamics as the full range of procurement requirements are finalized. Across this step the Project Team and particularly the Senior Logistics Planner closely monitor the procurement planning actions. The following information is reported and analyzed on a continuous basis. Tracking tool access and summary reports will be used daily and monthly to intimately characterize provisioning progress. This is intended to be a very intensively and highly detailed level of management – it is not designed for general summary status – it is implemented to know the status of *every* item. The Provisioning Service elements will perform and report the following:
    - Prepare equipment summaries by department, clinic, room, or any operational area defined by the Government.
    - Ensure all items enter the Attainia data base housed by RTKL to track every item to be procured.
    - Conduct market research and sourcing actions – determination of prescribed (Government make and model directed), optional (qualified vendors or pricing vehicles), or open (no sourcing factor predetermined) courses of procurement action.
    - Project pricing and analyze related to JSN and other government information provided on equipment lists.
    - Assess delivery date, installation, and operational readiness date factors.
    - Determine lead time implications, conduct long lead time planning and advise on any items affected by product availability problems.
    - Establish item groupings and develop standardization approach in each group. Apply the Project Team's standardization plan and Standardization SME to determine sourcing actions to support this requirement.
    - Assure continuous data feed to the tracking tool update and summary
    - Obtain all necessary COTR/COR approval and authorization to execute procurement actions.

The goal in Step 2 is to align all items along the procurement track and to have all procurement factors to include approval and authorization resolved. The reporting process maintains a continuous status on procurement readiness and the preparation to execute. The Project Team has several tangible data elements to analyze and evaluate, and will apply additional resources or align priorities in accordance with compliance with the transition plan milestones and objectives. Most critically, the Project Manager will be able to ensure that procurement readiness is aligned with specific transition dates for all clinical areas.

- Step 3 – ***Execute Procurement Action:*** As procurement planning culminates in approved and authorized procurement requirements, the Project Team begins to implement the direct procurement/purchasing of the required items. This action is characterized by the preparation and release of the purchase order by the General Dynamics purchasing center. Simultaneously, the Project Team opens the financial management file associated with the purchasing action. This step therefore involves the management of the following actions:
    - Purchase files are opened for each transaction. On-line purchase order document is completed by the provisioning element and released to the General Dynamics purchasing center. In accordance with DCAA prerequisites, the authorization for federal pricing and acceptability of the sourcing decision are confirmed. The purchasing file, an on-line, electronic file, is annotated accordingly. The purchase audit trail is initiated. Purchase submission is processed; normally this is an on-line transmission.
    - Finance files opened for each transaction. The on-line financial management file is opened and the account payable status is established. Each finance file is now opened congruently with the purchase file and is a trackable and reportable factor for the project management team. Daily summary of open and closed files will now be viewed daily, reported not less than monthly, and featured in strategic objective and incentive award reports.
    - Incentive fee status. Pricing comparative analysis proceeds with original requirement price being compared to procurement price. Tracking tool annotates both prices and calculates differential and resulting saving from project team/provisioning staff action.
    - Required Delivery Date/Estimated Delivery Date match: Each procurement action causes the delivery date analysis and computation of readiness to meet equipment operational timeframes within hospital areas. Delivery computations and adjustments are engaged by the Senior Logistics Planner and provisioning staff to target precise dates to lessen interim storage and appropriate schedule and balance installation and training resources. Acceptable parameters established and out of zone items are segregated to issue report.

The goal in Step 3 is to execute all purchase orders. This step creates a highly visible and measurable metric and indicator of project progress – the release of purchase orders to match each item requirement. Status is clear. Delivery timeframes can be entered to tracking tool and compared to Required Delivery Date. Computation of provisioning readiness to meet prescribed occupancy and transition dates is presented in monthly progress report and dissected by department, clinic, room, etc. Focus increasingly centers on delivery dates and any item out of zone for installation and training to meet occupancy and operational readiness date.

- Step 4 – ***Equipment Operational Readiness***: The final project management step in equipment provisioning is to achieve complete equipment perational readiness in concert with transition/occupancy planning. Equipment is in place, installed, trained, and ready to support clinical operations. The Government has accepted equipment and financial management actions are being completed. The following events and factors are intensively managed by the project team.

- Equipment delivery status: Each item has Required and Estimated delivery date in tracking tool. Any deviation outside of occupancy plan requirement is noted on issues report. Project team engages to reconcile with vendor or develop alternative approach acceptable to Government.
- Equipment storage and asset tracking: All items entering the interim storage locations are placed in the asset tracking system. Necessary assembly and preparation to move to the final hospital location take place. Reports from the warehouse operations confirm asset availability. Tracking tool annotations are made. Monthly reports contain current listing of all items at interim storage location and waiting movement to hospital.
- Installation planning report: Each item is annotated within the provisioning tracking tool for its specific installation, test, and calibration requirements. Source of support is identified, i.e. manufacturer or biomedical equipment support team. Senior Logistics Planner, biomedical equipment support lead, and provisioning leads review each item's status and provide verification of installation support to meet occupancy plan.
- Warranty management report: Warranty information for each item is captured and entered to DMLSS equipment management record. Report captures item and summary for warranty in place and activated.
- DMLSS record compliance: Each item is entered to DMLSS system in accordance with property management and equipment management guidelines. Summary report on DMLSS item record requirements in comparison to total items provisioned and status of DMLSS compliance.
- Financial processing report: Invoice are received and filed appropriately to match purchase transaction file. Invoice verification/certification takes place and tracking tool receives invoice status for inclusion to item tracking. Open or overdue invoices awaiting verification are moved to issues report. Purchase control and financial management unit maintains daily summary and visibility of this step and prepares reports. Ensure all invoice status is routed to Provisioning elements for status entry to tracking tool. Project Manager receives daily report and accumulates for monthly progress report.
- Operational Readiness Summary: Important management view and report that provides all Government officials and project team members a clear status on equipment acceptance and readiness to support clinical and/or administrative operations in new facility. This is a key Project Manager analytical report that completes the equipment provisioning component of the report. The report is cumulative as all new hospital areas are operational. Equipment issues are noted; percentages of operational readiness are key dashboard/benchmark indicators for project completion and success.

Step 4 culminates the equipping process. The operational status of equipment is determined and reported. The equipment capability to support clinical operations in the new facility is defined and reported to Government officials. All warranty provisions are in place and DMLSS accounting has occurred. Acceptance and turn-over of equipment has been completed. The

Project Manager moves from specific item focus to determination of complete area readiness and availability for patient care operations.

6.3.2 Equipment Reuse and Relocation Services

Equipment reuse and relocation targets the specific items identified on Attachment 6 of the RFP, " Reuse Equipment to be Uninstalled, Moved/Relocated, and Reinstalled by the Contractor." Project Team resources to include Health Care Relocations (hospital relocation lead), Interstate International (supporting logistical capabilities), GRSi (supporting biomedical technician capabilities) will play key roles in this phase of project team support. These team components combine to provide comprehensive equipment reuse and relocation support. The following project management steps are essential to ensure the performance of critical tasks and to monitor, control, and effectively report on the status of relocation actions.

- Step 1 - ***Reuse/Relocated Equipment Validation and Item Capture:*** The immediate action in this step is to validate all equipment items to be relocated to new hospital facilities. *Every* item to be relocated must be entered to the supporting data base and tracking tool. Reuse/relocated items will join all new item procurements in the Attainia data base and then be mapped and visualized through the Accendo tool. The mapping tool will therefore provide a complete presentation of both provisioned and relocated items. The reuse/relocated item validation process requires direct engagement with hospital departments and user groups. Initial work sessions are already scheduled with Walter Reed Army Medical Center, the primary generator of reuse/relocated equipment, and with the other activities producing these items. The following project management actions will also constitute a major portion of, and be complementary with other elements of the Equipment Reuse Plan. There are very tangible reporting factors for this step. The PM, Senior Logistics Planner, and the Relocation Services lead will formulate all reports and will include the following information:
    - Activities, departments engaged; annotation of prescribed relocation timeframe.
    - Data capture completed – equipment lines in relocation data base and tracking tool; capture validates that relocation planning team has physically identified the item and cited location and initial observation of condition. Summary and departmental reports provide specific capture rate.
    - Transferable equipment record initiated for all items to be reused and relocated..
    - Movement guide report established; details to be added upon survey and final movement plan
    - Special packing and/or handling materials determined and contained in the transferrable equipment record.
    - Characterization of relocated equipment by department, area, type, timeframe, and special handling
    - Uninstall/reinstallation requirements noted; pending biomed equipment review. Coordination with full biomedical technician team to allocate resources to perform all uninstall and reinstall actions.
    - First cut movement guide book takes shape; with record for each relocated item in book. Summary compliance reported.

- Departmental summary on all office files, office records, patient records, and other supporting materials that are contained in the move.

The goal in Step 1 is the complete capture of all relocated equipment requirements and the department validation of the item listing and that physical identification and examination of item has taken place. Relocation validation also includes supporting items such as files and records. This information is reviewed and reported by department, area, clinic, room, etc. Data is also transferred to the web based mapping tool to provide visualization of all items relocating.

- Step 2 – ***Reuse/Relocation Equipment Movement Planning:*** The actions and objectives in this step involve the determination of all actions required to move/relocate the specified item requirements. Equipment becomes a pacing process to ensure successful transition and activation of hospital services in the new facility. The PM, Senior Logistics Planner, and the Health Care Relocations' lead will report the following information on a continuous basis. Tracking tool access and summary reports will be used daily and monthly to intimately characterize the status of the equipment relocation progress. This is intended to be a very intensively and highly detailed level of management. Continuous synchronization with the transition plan and occupancy readiness plan is applied in order to report specific area readiness to support relocated patient care operations. The Relocation Services elements will report the following:
  - Equipment relocation summary by department, clinic, room, or any operational area validated by the Government to be moved/relocated to a new hospital facility.
  - Movement date and operational readiness date
  - Lead time implications, exception report for any item requiring manufacturer intervention for technical or warranty management reasons.
  - Item grouping to determine impact across selective item types, item models, and item groups; impact on standardization for placement and mounting of item in new areas.
  - Selected item issues – i.e. interface between medical equipment and information technology and other critical issues that are unique to this item. Each issue is capture in an issue tracking report and resolved, with number, complexity, and final status of issue characterized and reported.
  - Tracking tool update and summary; Accendo update and summary
  - Movement guide book, transferable item documents, completed and compiled.

The goal in Step 2 is to compile and report all essential information related to the relocation of equipment, records, and files. This process provides timeframe analysis to align relocated items with readiness in patient and administrative areas to resume operations. The project management and reporting process maintains a continuous status on procurement readiness and the preparation to execute. Project management has several tangible data elements to analyze, evaluate, and report. Based on this reporting process essential resources can be realigned to ensure the relocation activities are in line with the transition and occupancy planning.

- Step 3 – ***Reuse/Relocation Equipment's Uninstall and Reinstall Report:*** The critical path in the reuse/relocation function is the uninstall and reinstallation of numerous

equipment items. This area requires specified analysis, evaluation, and reporting. Application of the equipment installation resources is dependent on careful and continuous analysis of requirements, alignment of requirements with transition and occupancy planning, and determination of the level of complexity and impact associated with the installation of the specific item or entire item group. The following events and factors are intensively managed by the project team.

- Relocation equipment installation support requirement.
- Allocation and utilization of equipment installation assets/resources.
- TMDE utilization and availability.
- Warranty impacts to include transfer and/or continuation.
- DMLSS tracking and record maintenance
- Item group standardization. Analysis of item group (e.g. otoscopes) and requirement to maintain standard wall mounting location in each exam or treatment room.
- Supporting supply and repair part assessment and compliance.
- Relocation status report: Important management view and report that provides all Government officials and project team members a clear status on equipment relocation and reinstallation. Readiness to resume clinical and/or administrative operations. The report is cumulative as all new hospital areas are operational; detailing all completed and on-going equipment movements and installations. Equipment issues are noted; percentages for operational readiness are used as dashboard/benchmark indicators for project completion and success.

Step 3 ensures that the critical function of relocated equipment installation receives the necessary management focus and reporting. The operational status of equipment is determined and reported. The equipment capability to support clinical operations in the new facility is defined and reported to Government officials.

- Step 4 – ***Reuse/Relocation Equipment Operational Readiness***: The final project management step in equipment relocation is to verify that all moved equipment has achieved operational readiness in concert with transition/occupancy planning. Equipment is in place; reinstalled, retrained, and ready to support clinical operations. The Government has accepted equipment, certified condition, validated warranty continuation as required, and signed the equipment transfer and move document. The following events and factors are intensively managed by the project team to ensure operational readiness for relocated items.
  - Equipment movement status pinpoints the exact timeframe for relocation and the supporting capabilities, i.e. reinstallation support that is necessary to ensure operational readiness and full equipment use in patient care operations.
  - Equipment storage and asset tracking: In the event that equipment must be routed to an interim storage area in advance of waiting for area availability, the equipment will be carefully packed and transported, and enter the asset tracking system in the warehouse operation. Management reports will detail any item in this status.

- Installation report: Each item is annotated within the relocation database with the appropriate uninstall, reinstallation, test, and calibration actions that have been completed. Source of support is identified, i.e. relocation services staff, manufacturer or biomedical equipment support team. Senior Logistics Planner, biomedical equipment support lead, and relocation lead review each item's status and provide verification of move and relocation to support the occupancy plan.
- Equipment record compliance: specified equipment record is verified and summary report provided on compliance. Focus is DMLSS equipment management and property accountability records. DMLSS support team verifies with hospital logistics division to ensure acknowledgement of location change and any impact on maintenance, warranty, and/or condition of the equipment. Summary report defines rate of equipment record compliance.
- Operational Readiness Summary: Important management view and report that provides all Government officials and project team members a clear status on equipment acceptance and readiness to support clinical and/or administrative operations in new facility. This is a key Project Manager analytical report that completes the equipment relocation component of the report. The report is cumulative as all new hospital areas are operational. Equipment issues are noted; percentages of operational readiness are applied as key dashboard/benchmark indicators for project completion and success.

Step 4 completes the relocation process. The operational status of equipment is determined and reported. The equipment capability to support clinical operations in the new facility is defined and reported to Government officials. Acceptance and turn-over of equipment has been completed. The Project Manager moves from specific item focus to determination of complete area readiness and availability for patient care operations.

7.0 Project Management Information System (PMIS)

7.1 PMIS Overview

GDIT understands that accurate, timely, and relevant information is essential to the decision-making processes that will be associated with this project. This fact is further escalated by the joint nature of having all branches of the service involved in the completion of the project. GDIT also recognizes the essential need to communicate a wide variety of IO&T information through an assortment of communications channels including more recent methods such as Facebook and Twitter. For these reasons, GDIT will utilize a Project Management Information System (PMIS) which has been built around our secure MS SharePoint platform. This secure portal can be accessed by both JTF CapMed and team staff members so that accurate essential information related to IO&T work can be disseminated appropriately. The PMIS is a tightly integrated system that utilizes:

- Web Portal - An external-facing website that provides access to NCR IO&T information via the World Wide Web
- SharePoint Technologies 2007 (MOSS)– A collaborative workspace for documents, applications, timelines, discussions integrated into desktop management systems (Microsoft Office Suite)
  - MS Project and MS Excel will be the primary program management tools utilized within Office 2007 to manage data within the SharePoint platform.
  - Accendo – Application to manage equipment inventory and related activities
  - Attainia – Application to manage all provisioning activities
- Deltek CostPoint – Application to manage financial and cost data
- Defense Medical Logistics Standard Support (DMLSS) System – Current “tracking tool” for the JTF CapMed.

7.2 PMIS Portal – SharePoint technologies

GDIT has selected to use SharePoint Technologies as the executive dashboard for the PMIS due to our extensive experience with it in other project management activities. SharePoint Technologies represent the industry standard and best practices for business collaboration, desktop integration, records management, content management, workflow management. From a portfolio management standpoint, the SharePoint Technologies PMIS Portal will enable a systems thinking and network-centric approach to effective and efficient IT solutions.

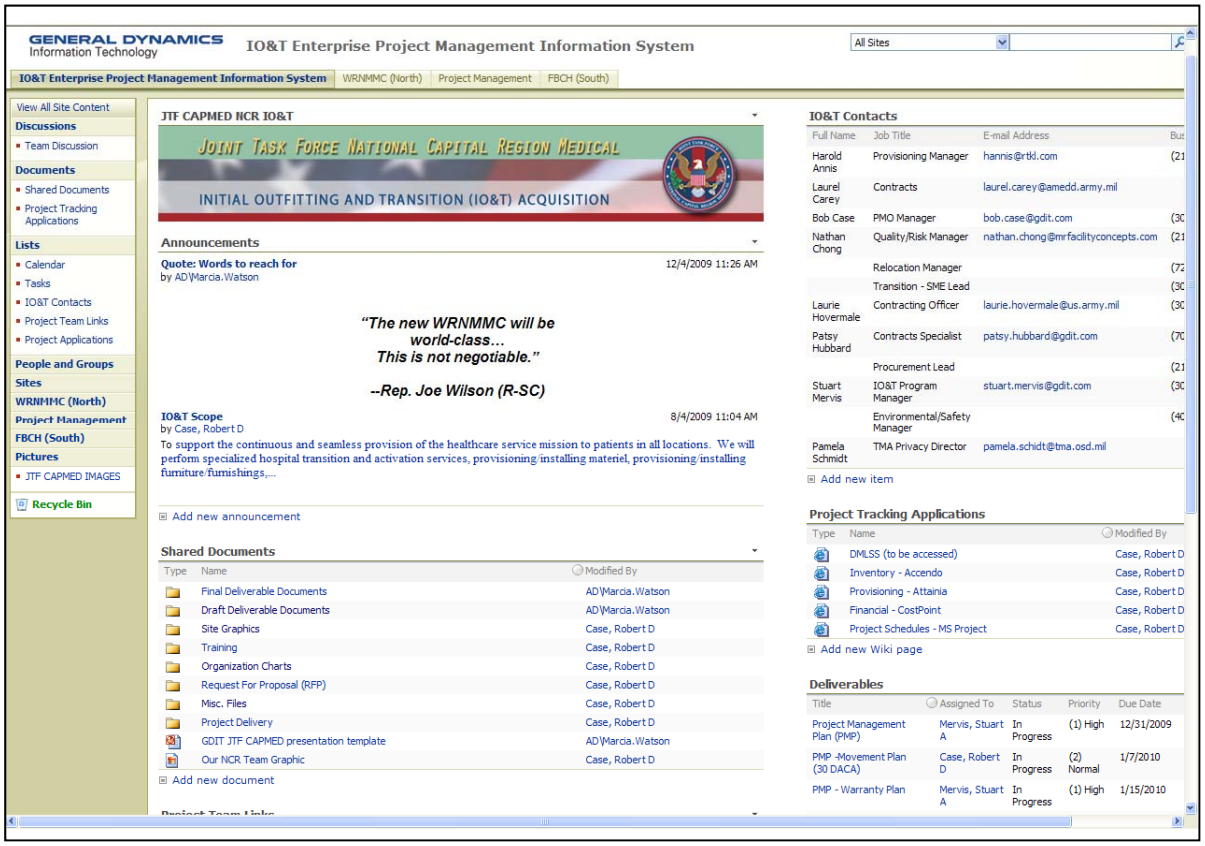
In addition, SharePoint Technologies meet DoD Information Assurance standards for secure data storage and information processing and provides audit and backup and restore features critical to mission success, INFOSEC and HIPAA compliance for medical data systems.

Finally, the use of SharePoint Technologies in a joint DoD healthcare management setting will provide a common access point for information sharing that will streamline communications across service-specific domains in Microsoft Exchange. Limitations on active directory

integration and authentication of joint services users on Army or Navy specific servers will be eliminated through the use of forms-based authentication via the PMIS site maintained on GDIT SharePoint Servers during the project implementation phase.

The following screenshot (Figure 7-1) displays a draft view of the IO&T PMIS, which is currently up and running and contains the draft content of various IO&T activities. SharePoint Technologies utilizes SQL Server databases and will be closely integrated with our equipment tracking tools Accendo and Attainia (COTS [commercial off the shelf]) applications, also in SQL Server. The innovative integration of SQL server data warehousing (Attainia) and visualization (Accendo) using Microsoft Silverlight and Microsoft Office front ends will provide a secure, highly customizable and easy to use executive dashboard interface.

Figure 7-1 PMIS Interface. *SharePoint will be closely integrated with our equipment tracking tools Accendo and Attainia*



Legacy systems (SharePoint, Excel, Access) currently in use by the services or other JTF IO&T partners to manage information in the initial planning phases of the IO&T project will be migrated onto the joint PMIS platform to maximize accountability, accuracy and integrity of JTF IO&T data across a geographically dispersed and diverse user base (military, government civilian and contractor) team to avoid redundancies and maximize efficiencies. GDIT is responsible for systems evaluation, integration and portfolio management to ensure the best possible product for the Government.

Government-furnished information (master schedules, facilities, equipment, DMLSS, etc.) will be integrated into a hybrid Accendo/Attainia back end by GDIT and its partners upon receipt from the Government and will be accessed by the Government via the SharePoint PMIS.

JTF IO&T data will be optimized via an executive dashboard tailored to the Government user to ensure prompt and accurate information transfer and communication. The current site contains:

- Announcements – any data worthy of reporting on short notice for a period of time
- Shared Documents – document areas where CONOPS, SOPs, Charts, Reports, and deliverables are maintained
- Links – internal and external links relevant to the work within IO&T
- Contacts – quick link to POCs
- Application links – access points to acquire application data such as Gantt charts, cost information, or equipment inventory
- Calendars – ability to maintain event information for staff
- Tasks – ability to set and receive task delegations
- Workflow – process to control document development, versioning, approvals, and access

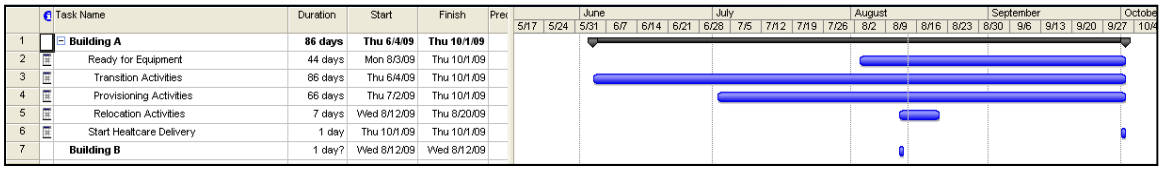
Under the direction of our PMO, the site will be maintained and updated on a constant basis, and features will be enhanced and modified as needed with the support of our Information Management (IM) team.

Access will be provided to all JTF IO&T staff via forms-based authentication (userid and password) to ensure real-time data transfer and collaboration between Government and contractor staff. The site will be administered by GDIT staff, including integration of the following Microsoft Office/.NET technology solutions:

7.2.1 Project Scheduling – MS Project

The single most important key to completing this procurement on budget and on time, will be our ability to effectively track and manage the project during all phases of activity. The GDIT team will use the MS Project software embedded in the PMIS. The MS Project software provides the enhanced tools to help us track and control the IO&T project work, schedules, and assist with finances. The most utilized feature will be the Gantt charts (Figure 9) that will display the task/timeline activities in real time. All dependencies and contingencies addressed in legacy MS Project schedules will be integrated in the Master Project Schedule on the PMIS.

Figure 9 Microsoft Project. *Tools such as this will help us track and control the IO&T project work, schedules, and assist with finances.*



7.2.2 MS Excel - General

MS Excel will be utilized for its ease of use template features to assist the manipulation of data including financial, tracking, list management, and other activities as needed. MS Excel is a spreadsheet application which features calculation, graphicstools, pivot tables, and macro programming language (Visual Basic). It is the most widely used spreadsheet application available for use in today's office automation tool set and can be configured to provide reports on a recurring basis.

7.2.3 Equipment Provisioning – Attainia

The Attainia applications "Budget, Plan, Predict, and Watch" have been utilized to supply the provisioning of equipment for the IO&T procurement. It is the most widely used equipment planning, budgeting, and tracking software within healthcare facilities today. IT will provide the management for all capital equipment. Attainia is a COTS system utilizing SQL server and is 100% interoperable with all Microsoft Technologies outlined here.

7.2.4 Equipment Inventory – Accendo

Accendo provides a total capital equipment control application that not only allows the user to review data sheets of equipment and inventory (warehouse to final location) information, but provides a Computer Aided Design (CAD) capability which allows the viewer to see the location and manage all aspects of equipment and what "space" it currently occupies. It tracks type, location, cost, and provides a "real time" view of the location. Accendo is a COTS system utilizing SQL server, MS Silverlight and is 100% interoperable with all Microsoft Technologies outlined here.

Figure 7-2 Accendo. *This tool allows the user to review data sheets of equipment and inventory and allows the viewer to see the location of equipment.*

7.3 Financial and Cost – Deltek CostPoint

CostPoint provides the best-of-breed cost management solutions which includes accounting aspects, project management, human resources, time and attendance, operations, expense management, and payroll. CostPoint has complex and unique processes for project and financial accounting such as billing, revenue recognition, expense management, and compliance. With

projects at the core of the solution, CostPoint will enable GDIT to provide accurate, up-to-date information to enhance GDIT and JTF staff decision making, and improve forecasting and budgeting of labor and equipment movement.

7.4 Defense Medical Logistics Standard Support (DMLSS) System

DMLSS is the current medical logistics system utilized by the JTF. It is the automated information system that provides support of reengineered medical logistics business practices and delivers a comprehensive range of materiel, equipment, and facilities management information systems. DMLSS includes the full suite of medical logistics capability to include stock fund level inventory management, quality assurance, medical technology management, and management of readiness materiel.

The PMIS will be the link to the DMLSS to both collaborate and share data and allow for all project data to be placed into the DMLSS system during project operations and after final close-out