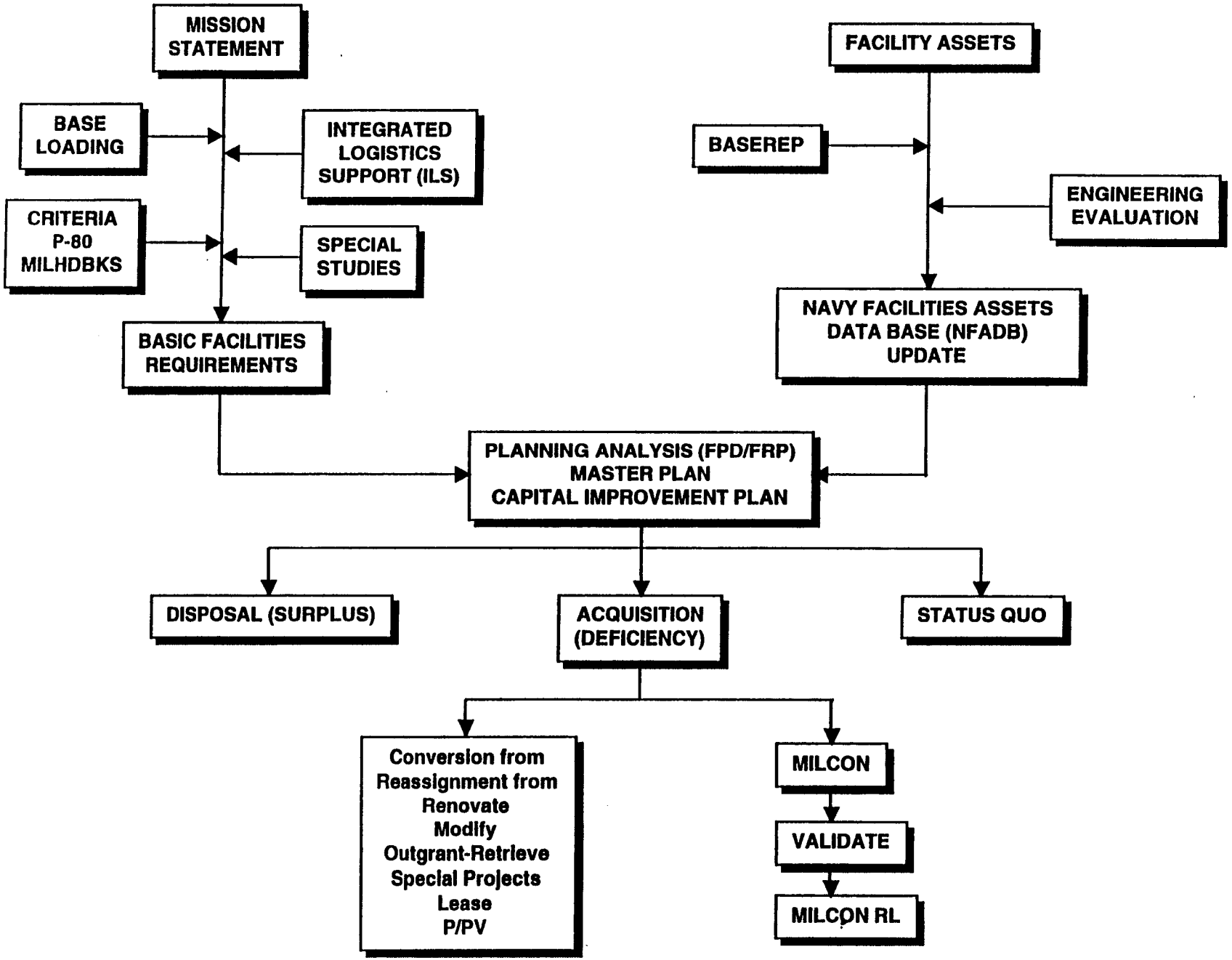
Shore Facilities Planning System Process



4804-96(1 of 1)

SOME WORKING DEFINITIONS

1. Health Facilities Planning and Project Officer: Ideally, a Medical Service Corps Officer (Specialty Code: 1804) that has extensive experience in healthcare facilities project management. Background will typically include: planning, programming, funding, design, and execution of a healthcare facility to include collateral equipment outfitting.

2. Military Construction (MILCON): Any Department of Defense (DoD) construction requirements that exceeds a $300k level of building requirements--NOT to be confused with maintenance and repairs issues/funding.

3. Project Data Sheet (PDS): This is the pre-cursor to the much more extensive DD1391. This form gives a very brief overview of the proposed MILCON--only the salient data is needed or required at this stage. Typically done wit "in-house" talent and, therefore, does not cost the commanding officer anything.

4. Military Construction Project Data/DD1391: This form documents in narrative/quantitative format the justification and validation for MILCON project. The data on the DD1391 must demonstrate: that the program is properly oriented, that the methodology is sound, that the workload justifies the capital investment, and that the proposed construction is essential. Unlike the PDS, the DD1391 requires obligation of command funds, since most site activities prefer to have the work contracted out (cost depends on the scope-of-work; anywhere from $-75k).

5. Architectural and Engineering Firm (A&E or A/E): The A/E (contracted firm that is staffed with planners, architects and engineers) is ultimately responsible to Naval Facility Engineering Command for design completion. The HFPPO works very closely with the entity.

6. Host Nation: A series of agreements between a foreign country's government and the government of the United States. In this case: Japanese/Facilities Improvement Program (J/FIP or sometimes written as GOJ/FIP) and Korean/Facilities Improvement Program (KCDIP--a new program within the host nation agreement of Korea--just coming on-line).

7. Collateral Equipment (CE): All equipment--both minor and investment--required to completely outfit the completed facility. Both O&M/N and OP/N--in addition to--MILCON, are the chief sources of funding.

8. Defense Medical Facilities Office (DMFO): A joint service organization (a directorate of OASD/Health Affairs, Washington, DC) that is responsible for construction priorities within the program. DMFO works directly with congress regarding certain notifications and approvals and allocates construction funds to the military construction agents for execution.

SOME WORKING DEFINITIONS
(Continued)

9. Chief of Naval Operations (N93 & N4): N093 acts as BUMED's resource sponsor for NON-medical MILCON projects, i.e., parking structures and garages; BOQ/BEQs and child development centers are funded by N4.

10. Naval Facilities Engineering Command (NAVFAC): The construction agency responsible for construction contract administration, funds management, construction management/supervision, inspection, and transfer of accountability after completing construction.

11. Engineering Filed Division (EFD): The EFD's relationship to NAVFAC is similar to the HSO/BUMED relationship. The EFD is the "eyes and ears" of NAVFAC and exists to support the customer at the field level.

12. Future Year Defense Plan (FYDP): A budgeting tool/format used by both NAVCOMPT and DODCOMPT to track any given budget issue within a six (6) year window.

Facilities Life Cycle Management

- Data shows that we spend too many of our MRP dollars on Minor Construction (R1/R2) and not enough on reducing our backlog of deficiencies
- FSM says: "Sustainment funds do not include the added cost of excessive deterioration and facility failure due to deferred sustainment tasks."
- Translation: You will be penalized for not funding your facility sustainment tasks because the additional funds required due to neglect will have to come from other sources!
- This might not be such a bad thing!

FACILITY LIFE CYCLE MANAGEMENT DEFINITION

The underlying element that drives every aspect of this report is the process titled "Facility Life Cycle Management" (FLCM). An understanding of this process is vital and the ensuing chapter is devoted to the definition of FLCM.

Definition

Facility Life Cycle Management is defined as the formal process of planning, managing, and resourcing the facility inventory from the initial local and regional health care business planning, through facility programming, design, construction, sustainment (preventive maintenance, repair and major repair), new mission or technology updates, and renewal and eventual demolition or reuse, to ensure the most favorable return on capital and operating investments.

This definition reflects the mutual understanding and endorsement of the three military Services and the MHSS Facilities Life Cycle Management Steering Committee. It is also supported by the International Facility Management Association (IFMA), the Association of Physical Plant Administrators (APPA), and survey respondents, who indicate that this definition is reflective of their informal goals to seek a more formal (structured) FLCM process.

Funding Sources

Funding sources to support FLCM are Medical Military Construction (MILCON) and Operations and Maintenance (O&M) funds. (See Appendix G for definitions)

Components of FLCM

To further assist the reader in understanding the definition and meaning of FLCM, it is necessary to understand the components of FLCM and the funding sources which will ultimately fund the Investment Strategy.

Replacement: Represents the initial construction or replacement/total renovation of the facility based on a fifty year life cycle. The underlying goal is cost effective facility replacement that meets the safety, operational, and functional requirements of the Military Health Services System (MHSS). Replacement is funded through MILCON funds.

Sustainment: Represents the day-to-day operations, preventive maintenance, repair, and major repair of the facility which assures achievement of a 25 year life. Sustainment is funded through O&M funds.

Renewal: Represents the work required at about the 25 year point (20 to 30 year range) when major systems need replacement; functional obsolescence needs correction; aesthetics need upgrading/ improvement; and exterior components must be replaced so the life of the medical facility can be extended at least another 25

years (to 50 years). Although normally conceived as a single project, Renewal may not necessarily be achieved through one project, rather it may be planned and executed through several phases over several years. However, the goal, and the results, are the same, which is to extend the life of the building to at least 50 years. Renewal is funded through O&M, but could also be funded through either MILCON or Unspecified Minor Construction (UMC). Under current operations within the US. Air Force, Renewal could be interpreted as being an extension of the Major Repair Program.

New Mission/Technology Update: Represents facility modifications required for managed care initiatives and new equipment. Examples of each might be the conversion of a nursing unit no longer required to a clinical function as proposed in the business plan. It could also include the incorporation of new technology such as conversion to filmless radiology. This component could be considered an extension of the major repair program and may be funded through either O&M, MILCON or UMC.

Retirement/Reuse: Concludes the life of the structure as a medical facility through either adaptive reuse or demolition, and may be funded through either O&M, MILCON or UMC.

Facilities Included in FLCM

- Hospitals, including Regional Medical Centers and Teaching Hospitals
- Medical Clinics
- Dental Clinics
- Veterinary Clinics
- Laboratories
- Research and Development Facilities
- Training
- Medical Storage Facilities

It should be noted that other non-medical categories of facilities are funded by the Defense Health Program and these are not included in this Investment Strategy.

(However, the Investment Strategy is appropriate to any category of facility since the level of investment is determined by the sophistication of construction via the construction cost per square foot.)

Facility Life Cycle Management

Strategic Planning

MED-33's primary task is to provide Facility Life Cycle Management for the Navy Medicine. This involves working closely with field activities, contractors, our Sister services, NAVFAC, TMA, and preparation of supporting material for congressional programs and inquiries. We strive to optimize the limited funding provided in the replacement, upgrade, maintenance, and repair of BUMED facilities worldwide. In an effort to meet the needs of our MTFs and DTFs, we put a heavy emphasis on strategic planning to ensure long lead items are appropriately addressed.

Approach

What are Facility Life Cycle Management's key Strategic Planning Objectives and timetable for accomplishing them?

The first three objectives listed in Table 1 emphasize our efforts.

Deployment

How does MED-33 develop action plans that address your key Facility Life Cycle Management Strategic Objectives? What are the key short and longer-term action plans? What are the key performance measures and/or indicators for tracking progress relative to your action plans?

The basic outline for our strategic objectives does not change. The scope of our work does. The action plans are based on strategic objectives and are accomplished primarily via face to face interaction with critical field personnel. Subsequently, MED-33 personnel change the action plans as conditions dictate.

Table 2 addresses strategic objectives, key action plans and their development and design.

Customer Focus

Facilities management focuses on a myriad of customers, primarily interfacing with project and facility personnel from the HSOs, TMA, NAVFAC, and associated contractors, designers, and consultants.

Table 1 Strategic Planning Objectives

Strategic Planning Objective	Success Factor	Timetable
MILCON Program Execution	Near year projects prove to be solid in cost, scope, design, and justification, and are approved by TMA, DoD, and Congress.	Continual flexibility for change but major emphasis Nov-Jan in preparation for formal submission to TMA.
Special Project Program Execution.	Next year projects prove to be solid in cost, scope, and justification. Design efforts are given specific attention to ensure projects are ready to go in case greater funding materializes.	Continual flexibility for change but major emphasis during the Fall, the couple months leading up to and then including the Special Projects Prioritization Board.
BUMED Claimancy facility inventory (NFADB) is accurate.	Inventory is utilized with confidence. Spot checks result in a very small error rate.	Inventory maintenance is a continual effort. Spot checks are performed several times yearly.
Current, accurate, relevant assistance to the HFPPOs and Facility Management personnel in the field.	Guidance for accomplishment of routine field requirements is clear and utilized. Confusing, errant field input and requests are minimal. MED-33 continued web site development is a high priority.	Ongoing. Web site development completed in FY01, then regularly maintained thereafter.
MED-33 Personnel Development	Individual Development Plans (IDPs) are accomplished. Goals and training are realized. Performance feedback is meaningful and regular.	IDP formally reviewed/revised yearly, then continual monitoring thereafter.

Source: MED-33

Table 2 Strategic Planning Objectives Key Action Plans

Strategic Planning Objective	Key Action Plans	How the plan was developed
MILCON Program Execution	The three services and TMA have jointly established the complete timeline for a MILCON project (prioritization, planning, programming, design, and construction). The sub-step "Planning" has been further detailed in BUMED ISO Process M030907. The other critical sub-step is "Prioritization" based upon facility needs and available MILCON TOA.	The Tri-Service effort was accomplished over a period of six months via frequent email interaction and round-table discussion. The ISO process was developed by the MED-33 MILCON branch based upon recent experiences and under the guidance of the MED-33 Deputy. Prioritization largely occurs via round table discussion between MED-33 and the three HSO HFPPO heads. Approval is obtained throughout the BUMED chain of command up to the SG.
Special Project Program Execution	The entire plan is outline in BUMED ISO Process M030910. Major steps include project identification, scope acceptance and approval, prioritization, funding, design, construction.	The MED-33 Special Project Branch based upon past experience and interaction with chain of command developed the ISO process. Prioritization largely occurs via round table presentation, discussion, and voting at a once a year Board meeting which includes MED-33 personnel and the facility managers from the three HSOs and the three NNMCs. Emergencies and direction from chain of command often changes these priorities throughout the year.
BUMED Claimancy facility inventory (NFADB) is accurate.	Proper sustainment of the inventory occurs by field input to NAVFAC at any change in the facility affecting the fields of the property record card. Periodic discrepancy checks by MED-33.	Facility managers and their staff receive pertinent training via OJT, formal instruction, or web-site (BUMED) guidance.
Current, accurate, relevant assistance to the HFPPOs and Facility Management personnel in the field.	Periodic update to MED-33 website. Phone and email interaction with field.	Website possibilities solicited from field reps. Brainstormed at HFPPO quarterly meetings. Interaction between MED-33 personnel.
MED-33 Personnel Development	Supervisor and subordinate jointly develop IDP. Divisional rollup of training requirements is submitted in the summer for funding in the next FY. Execute plan.	Plan is developed within a two-week period based upon interaction between MED-33 members. Plan is executed during the year subject to funds availability and flexible prioritization.

Source: MED-33

Approach / Deployment

How does MED-33 listen and learn to determine key requirements and expectations from customers/ stakeholders?

MED-33 utilizes a combination of ISO 9000 and regularly scheduled interfaces with TMA, our sister Services, and our facility and projects personnel in the field to develop and refine our processes. They are recorded formally either as part of ISO 9000, our MED-33 web page, and/or in-group distribution email.

Occupants and field project/facility management staff of our BUMED facilities are our primary customers. Table 3. presents a complete customer listing and includes organizations with which we interact to accomplish facility projects.

Table 3 Customer Focus

MED-33 Customer	Requirements/Expectations the Customer has of MED-33	How Ascertained
Facility Occupants	Functional efficient layout. Trustworthy utility systems. Critical facility deficiencies are quickly fixed. Confident technical support to Project and Facility Field Staff.	Preponderance of interaction occurs during the MILCON project planning and design stages via email, phone, and on-site meetings. Interaction at other times normally limited more to times of problems or regular briefs to SG.
Project and Facility Field Staff	Clear HQ guidance. Frequent HQ update on funding projections and priorities. Minimal HQ taskers. Confident technical advice. Strong advocate for facility issues. Sufficient MRP funding levels.	Detection of field confusion. Solicited input via email. Yearly AIS submission. Field visits. Experience.
Planning KTRs	Clear SOWs. Plentiful and accurate historical facility data, clear future staffing/functional projections. Thorough meaningful timely submittal reviews. Firm decisions.	Discussions with the contractors. Discussions with associated government personnel. Obvious issues in submittals.
Design KTRs	Clear SOWs and 1391 documentation. Plentiful and accurate historical facility data. Firm, clear guidance in gray areas. Timely and logical submittal input.	Discussions with the contractors. Discussions with associated government personnel. Obvious issues in submittals.
NAVFAC	Strong supportable priorities. Accurate timely designs. Funded contingency on projects. Timely logical design/construction decisions.	Discussions with NAVFAC.
TMA	Strong supportable MILCON priorities. Timely and accurate submittals of programming documents. Timely logical response to taskers.	Frequent interaction.
Congress (via chain of command and TMA)	Strong supportable MILCON priorities. Timely logical response to questions.	Frequent interaction.
USA/USAF	Full participation in MHS tri-service issues; shared leadership on various committees.	Quarterly meetings of the HFSC; periodic meetings of HFSC subcommittees.
Patients	Attractive, operationally efficient medical and dental facilities.	Surveys completed outside of MED-33.
Taxpayers	Justified, financially and operationally efficient medical facilities.	Newspapers, Congressional pressures.

Source: MED-33

Process Management Approach

(1) What are the key production/delivery processes and their key performance requirements for Facility Life Cycle Management?

(2) How does day-to-day operation of key production/delivery processes ensure meeting key performance requirements?

(3) What are your key performance measures and/or indicators used for the control and improvement of theses processes.

Table 4. identifies our Key Products that are related to our key action plans identified in Table 2. Key Processes are then identified for each Key Product.

In Table 5, several of the Key Processes are decomposed to identify critical elements of the process. Analysis and development must give considerable leeway to the large amount of subjectivity involved with the nature of the work.

Organizational Effectiveness

The ability of MED-33 to meet all the critical facility needs of Navy Medicine is very closely tied to the funding provided. We have effectively utilized the limited amount of funding provided over the past several years. This has been demonstrated with project readiness both with DMFO and the BUMED comptroller when new funds have surfaced with little time for full preparation. We have been proactively prepared with projects ready to execute.

Table 4 Key Products

Key Products / Service	Associated Key Processes
Yearly MILCON FYDP submission to TMA	• Quarterly HFPPO meetings. • BUMED chain of command endorsement. • MILCON planning BUMED ISO Process M030907.
MILCON programming documentation to TMA	• MILCON planning BUMED ISO Process M030907. • In-house review, approval, and packaging of submittals required for TMA submission.
Special Project Prioritization List	• Special Project BUMED ISO Process M030910. • Yearly prioritization board. • In-house review/validation of board results. • Annual Inspection Summary / Facilities Condition Assessment
Field Assistance and Guidance	• Guidance via web site. • Guidance via email. • Availability, technical knowledge, process knowledge

Source: MED-33

Table 5 Key Processes

Key Process	Requirements	Measures	Standards	Control Strategies
ISO M030907 (FYDP Submission product)	Thorough consideration of optional planning elements, accuracy and timeliness of data	Tracks with milestones	Effort is completed 3 years prior to intended execution year.	ISO Auditing Process. Internal office tracking and review systems.
ISO M030910 (Special Project product)	Thorough field paperwork, logical prioritization, timely funding.	1391 project scopes and estimates are logical and accurate. Prioritization is collaborative.	1391 approved based on personal knowledge and/or experience of the reviewer, and/or after on-site field visit. Major field players are invited to brief and vote on projects.	ISO Auditing Process. Internal office tracking and review systems. Review and analysis of prioritization results. Frequent interaction with comptroller.
Web site development and upkeep. (Field Assistance and Guidance product)	Timely, meaningful, helpful information and updates to current events.	Relevance to present day issues.	Inapplicable or inaccurate web site information is removed or corrected within four weeks.	Routine checks by staff. Recommendations from the visitors

Source: MED-33

Results

(1) What are your current levels and trends in key measures and/or indicators of key design, production, delivery, and support process performance? Include productivity, cycle time, and other approach measures of effectiveness and efficiency.

(2) What are your results for key measures and/or indicators of accomplishment of organizational strategy?

Figures 1 and 2 depict actual and target funding goals and changes in critical backlog. Both figures contain an element of O&M MRP funding. MRP funding is broken down into two primary sources: field funding and Special Project funding. Field funding is fairly constant; changes in MRP funding levels in the charts below are more reflective in changes in Special Project funding. – thus the tie to Special Project discussion previous in this document.

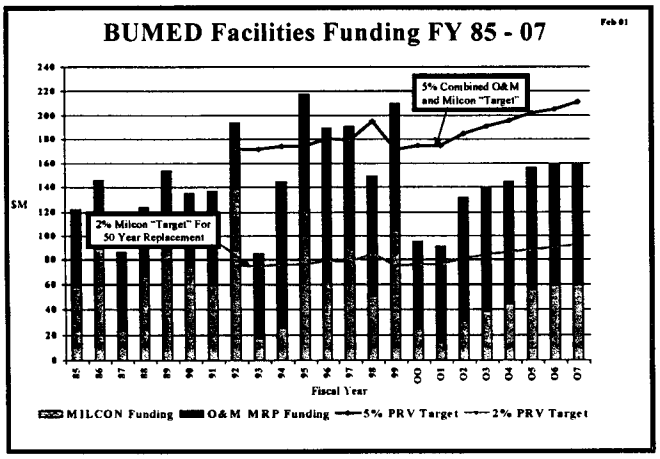


Figure 1 BUMED Facilities Funding FY 85-07
Source: MED-33

1) Figure 1 depicts actual funding compared to funding targets. Funding for facility upkeep is primarily from two sources: MILCON and O&M MRP.
2) A 50-year facility replacement target is common with industry; a 50-year target is dependent on significant repair/upgrade effort at the 25-year point and sufficient O&M MRP funding during all the intervening years.

3) The effort at the 25 and 50 year point would commonly be MILCON scope. In order to meet this target, industry standards reveal the MILCON effort should be funded at 2% of plant replacement value (PRV) and the O&M effort at 3% of PRV; a combined total of 5% yearly.
4) The gray columns and target line in the chart represents MILCON. Including the out year budget figures, only 4 times in 17 years is the 2% MILCON funding level met.
5) The black columns represent O&M funding. When they are added to the gray columns, a total funding is shown – against a total funding target of 5%. Only 5 times in 17 years is the 5% target met.
6) Future funding does not depict any better condition. If MILCON funding were to average $50M/year, and given BUMED PRV of $4300M, then the replacement cycle is 86 years! For all of the MHS, the figure is over 100 years.

MRP Backlog and Funding

1) Figure 2 is specific to the O&M funding information presented in the previous chart – but also depicts the change in the facility deficiencies identified as critical (BMAR).

2) Comparison with the 3% goal is favorable during the late 1990s but shows a drastic change for FY00 and FY01.

3) The detriment of insufficient funding in the 80s resulted in a buildup of BMAR. This buildup was halted when funding was increased. In FY00 and 01, we now see BMAR increasing again.

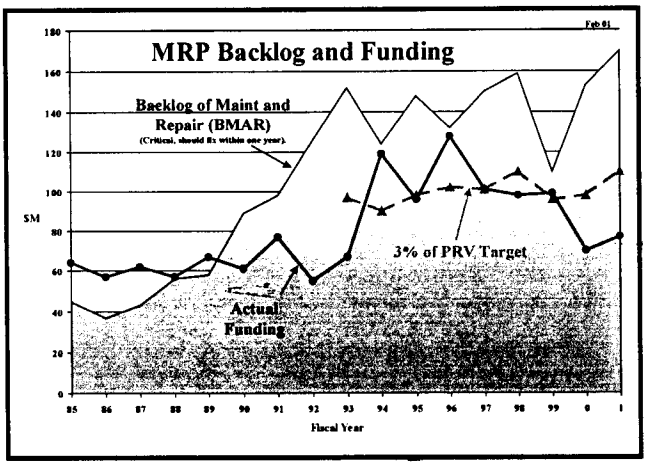


Figure 2 MRP Backlog and Funding
Source: MED-33

Navy IG Inspections Self-Assessment Template / Facilities

The following issues are from the Navy IG Inspections Self-Assessment Template, the Facilities section, (Section D). Paragraph 1 states, "'Facilities' encompasses the key aspects of your organization's facility maintenance process. Your assessment should answer the following questions:" Eleven questions then follow which are identified alphabetically (a-k). The questions did not lend themselves easily for fitting within the assessment development, so are answered separately here. They are addressed below per their alphabetical identity.

a. What are the results for key measures and/or indicators of regulatory/legal compliance?

Legality checks are part of the ISO process for Special Projects and are intensely scrutinized in the MILCON realm by MED-33 staff and DMFO.

b. What percent of your Master Plan's Capital Improvement Military Construction Projects are programmed?

Based on current information within our MILCON database, roughly 40% both in number of MILCON projects and their estimated project cost are programmed.

c. What are your critical Backlog of Maintenance and Repair (BMAR) trends and what is your plan to gain additional resources?

BMAR trends are shown in Figure 2. BMAR held steady during the late 1990s, a period of respectable MRP funding. In FY00 and FY01 BMAR begins an increase due to serious funding deficiencies. Additional resources are hard to obtain. Energy programs and natural resource programs are researched for funding. Constant interface with the BUMED comptroller is the primary means of obtaining additional funding.

d. Is your Naval Facilities Asset Database (NFADB) accurate and how did you determine this?

Our comfort level regarding the accuracy of the NFADB is steadily increasing. Much effort has been made to improve the accuracy over the past year. MED-332 is responsible for this effort and has performed considerable analysis and interacted with NAVFAC inventory folks and BUMED field folks toward this end.

e. What are your plans for improving the ratio of Real Property Maintenance (RPM) funding to Current Plant Value (CPV)?

Our plans for reducing the ratio may include a recommendation for shutting down facilities or portions thereof if funding does not improve. Awareness up the chain is critical regarding the state of facilities. We must continue these matter-of-fact presentations to alert the senior leaders regarding the increasing rate of deterioration.

f. Do you have a Long-Range Master Plan for maintenance and repair projects and does this plan correct deficiencies identified in your BASEREP?

The long-range MRP plan exists at the claimancy level only to the extent that the activities have submitted special projects. Approximately 50 projects are prioritized each year. 50 projects would span between two to five years dependent upon MRP funding. BUMED claimancy does not utilize a BASEREP but instead relies on the Annual Inspection Summary (AIS). Most Special Project submittals originate from AIS results. We have a contractor that visits all BUMED maintained sites once every three years. They develop an AIS and they develop an action plan to address deficiencies in the AIS.

g. What benefits have you gained and what problems have been created as a result of Regionalization?

BUMED has not participated in Regionalization thus far. Initial steps are occurring at NNMC Bethesda. BUMED position thus far is that there are no advantages to BUMED to participate. Perhaps even the reverse is true whereby BUMED would take ownership of over a couple hundred clinics which currently receive their MRP financial support from line Navy – at a much diminished level that that which BUMED would provide.

h. How has Regionalization effected your Readiness and Quality of Life? See "g." above.

i. What is your most critical Special Project?

Navy Medicine's most critical unfunded Special Project is a $2M project to correct life safety electrical problems at NH Great Lakes.

j. What is your most critical MILCON Project?

Navy Medicine's most critical MILCON is NH Naples. The contractual arrangement requires the US to lease the building at roughly $9M/year for 25 years unless we can perform a buyout within 5 years. It currently is programmed for $39M buyout in FY03. It was scheduled for FY01, but was marked from the program. It is currently under construction and we cannot afford to have it marked again.

k. Fill in the blank as it relates to your facilities program: If I had _____, I would _____.

If MED-33 had control over the timing of funding Special Projects, it would set up a schedule of contractual awards with the field activities which obligates 50% of Special Project funding within the first four months of the fiscal year, and 75% by six months.

Point of Contact Information:

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Master Plans

Annually, CNO N4 distributes a letter to all major claimants reinforcing the importance of activity master plans and capital improvement plans to the shore activity planning and management process. The letter also reiterates the role of Commander, Naval Facilities Engineering Command (COMNAVFACENGCOM) as delineated in OPNAVINST 11000.16A to provide technical assistance to claimants and their activities in implementing the shore activities planning and management process. Major claimants are tasked to review their activity needs and to specify the COMNAVFACENGCOM services needed during the next fiscal year. Typically, activities that have undergone significant mission changes, growth, realignment, or reduction in operations and workload or that suffer from a backlog of land and facility problems would be prime candidates for COMNAVFACENGCOM planning services. Historically, these services have been provided to claimants utilizing funds provided directly to COMNAVFAC-ENGCOM for this purpose. As the Navy transitions into DBOF, major claimants will be required to budget for these services. Activities are urged to participate in the planning and management process by utilizing their master plans and capital improvement plans and by keeping their claimant(s) up to date as the the status of planning documents relative to activity needs.

The successful employment of the planning process is heavily dependent on the communication skills of all the participants in the process. Typically, the participants include the activity, the Engineering Field Division, the activities major claimants and resource sponsor and the architectural/engineering/planning firm (s) that will provide much of the professional expertise during the process. The first structured communication tool used in the process is the Scope of Work. It is in drafting this document that the participants describe what they hope to accomplish. Properly done, the Scope will identify the goals of the planning effort, generic and specific tasks to be accomplished and the methods to be used to accomplish those tasks. To the extent possible, standard Scopes of Work have been developed to ensure that key requirements are met and while each planning effort must be tailored to the specific activity involved, that there is some consistency and uniformity in the products of the process. Participants in the planning process are encouraged to become involved in drafting the Scope of Work. It is only through this involvement that all parties will achieve the goals they have in mind. The completed Scope of Work becomes part of the contract with the A/E firm. While Scopes of Work are not mandated for planning projects accomplished by COMNAVFACENGCOM field divisions and activities using in-house resources, they serve a valuable purpose and their use is encouraged.

Naval Facilities Engineering Command field activities are empowered to contract for architectural, engineering , planning and other related professional and technical services to develop or update activity master plans and capital improvement plans. Such a contract is termed an Architect-Engineer or A/E Contract. To qualify for the award of an A/E contract, the firm must have registered professional engineers, architects or planners in their employ. A/E contracts are awarded under "Brooks Act" procedures in accordance with FAR 36.6. Refer to NAVFAC P-68, Contracting Manual for more information. Scope of work in hand, all participants to the planning process meet at the activity to discuss the tasks to be accomplished, how they will be accomplished and specific individual responsibilities. The goal is to be able to leave the meeting with a completed Plan of Action and Milestones (POAM).

To be fully successful, the meeting should be attended by all key activity personnel, including the commanding officer, department heads, the comptroller, head of ADP, the Public Works Officer and the Head of Station Resources and Plans, if there is such a person. All tenant activities, operational units and detachments should be represented. The COMNAVFACENGCOM Engineering Field Division will orchestrate the meeting and will have established a Planner-in-Charge (PIC) who will act as the point of contact and coordinator during the process. Either the activity or the Engineering Field Division should arrange to have representation from key commands including the activities claimant (s) and the claimants for significant tenants. If the activity is located in a complex or is a part of a Naval Base, representation from COMNAVBASE and other coordinating commands including the Public Works Center, if there is

one serving the activity, should be in attendance. The EFD PIC will start the meeting by introducing all parties. At the option of the activity and the EFD, the activity might follow with a briefing of the activity, its mission, its land and facility assets, known planning issues and other pertinent subjects. Following the briefing, the PIC should review the scope of work to ensure a common understanding by all participants. Next, the PIC should summarize the planning process and indicate those steps that will follow in the short term. For instance, the PIC may want to review the status of data gathering by the EFD and the contractor with emphasis on missing data. Usually, the PIC will take advantage of the meeting to arrange interviews with key participants, perhaps distributing a questionnaire to gather information or collecting questionnaires if this step has preceded the meeting.

The meeting should end with a brainstorming of issues and problem areas to be addressed during the planning process and points of contact for following up on these and other issues.

A complete Basic Facility Requirement (BFR) update should precede preparation of a Master Plan. The Master Plan uses the proposals of the Facilities Requirements Plan (FRP) to develop the Land Use Plan. The Master Plan also includes the Capital Improvements Plan (CIP) which provides specific information on construction projects required to meet the activity's mission. Planning provides a practical process to support current and projected mission requirements, improve operational capabilities, protect required resources and the environment, and demonstrate the Navy and Marine Corps commitment to the implementation of DOD and Federal policies. The Plan is a comprehensive review and modernization of the Base providing all of the facilities and improvement necessary for mission accomplishment. It is updated periodically to reflect changes occurring in either the existing situation or in the planned development made necessary through mission or workload modification. Additionally, it identifies and analyzes the requirements of the activity to perform its mission.

1. Prerequisite Planning Data Requirements

Prior to the initiation of activity or complex master plans, the following information should be available or under preparation by the cognizant activity or command:

a. Approved statement of mission and tasks of the activity (major claimant responsibility).

b. Current and projected base loading (major claimant responsibility).

c. Current Basic Facilities Requirements (BFR) (activity responsibility), Engineering Evaluation (EE) and the Requirements List (1360 Report) showing proposed projects in the upcoming programs and unprogrammed projects (EFD responsibility) (Marine Corps Forms 10915, 10651, 10801, 10956 and 11055).

2. Activity Master Plans

Basically, the Plan is a compendium of factual material describing the activity, its mission and the environment in which it operates. In particular, the document will contain a Requirements Analysis Section commencing with a description of the mission, tasks, organization, and base loading of the activity.

COMPLEX MASTER PLANS

These Plans are developed where two or more significant Navy or Marine Corps activities exist in a common environment. Complex plans are similar to an Activity plan but also address the activities' interrelationships and dependencies. In particular, the Plan will contain a section on the description and analysis of Navy/Marine Corps functions in the Complex. The element will describe the scale and nature of operations and support functions, the interrelationships and interworkings of functional departments of individual activities as they relate to other activities in the complex, problem areas, potential areas of concern, and feasible solutions to those problems.

LAND USE COMPATIBILITY

What is an incompatible land use?
An incompatible land use is an inharmonious condition affecting the utilization of land both on and around a naval installation. The definition of an incompatible land use is any existing or potential land use which may reduce, deter, or cancel the mission, safety, or quality of life of the United States Navy.

Who is responsible for addressing incompatible land use issues?
The responsibility of the Activity is to monitor development, both on-base and off-base, and to ensure compliance with the Installation Master Plan. The EFD reviews Activity projects, plans, and issues, and advises on the development of projects. The EFD also reviews, forwards, and grants site approvals. NAVFAC is responsible for establishing standards, providing guidance, and reviewing projects.

What factors should be considered in on-base incompatible land use?
The Activity planning department (staff civil or equivalent) should be actively involved in all issues pertaining to current and projected development on the installation. The planning process includes interaction with all tenants of the installation and determining what their mission needs and requirements are. These needs and requirements usually have a direct influence on land use and facility assets.

Installations can be categorized as either single mission or multiple mission. An example of a single mission installation is NAF El Centro, which serves as a training airfield. An example of a multiple mission installation is NAS North Island which serves as an air station with homeported aviation squadrons, homeported ships, and hosts of Naval Aviation Depot. Multiple mission installations sometimes generate incompatible land uses due to conflicts in mission needs. To avoid incompatible land uses in the planning process, similar or compatible land uses and missions should be grouped together. Periodically, requests are received for incompatible land uses by non-Navy entities. These requests have to be considered with respect to the Navy's mission. Additionally, environmental conflicts are identified which may require mitigation. An example of this would be the 22 acres dedicated and fenced off for an endangered species, the California Least Tern nesting area in the center of the tarmac at NAS North Island.

What factors should be considered in off-base incompatible land use?
Off-base incompatible land uses are those which inhibit or impede the mission of the Navy. When adjoining land (civilian or publicly owned) which has been either vacant or of low intensity development changes land use, the use may cause a conflict with the adjoining naval installation. An example of an off-base incompatible land use would be the development of a residential area underneath the approach and departure areas of a runway. The residential development would be an incompatible land use due to excessive noise and potential aircraft accident hazards. Ancillary problems, such as increased traffic flow, and overburdened public facilities and services may also result. Additionally, concern should be given towards communities which plan growth in proximity to naval installations, which later would be adversely impacted by naval operations. Examples of this would be a planned community or development next to an existing naval weapons station. The potential hazards from ordnance detonation should be a consideration in determining what types of development (land use) should occur around this type of military installation. An incompatible land use adjacent to or in the near vicinity of an installation would be an encroachment problem if the land use affected or had the potential to affect the activity's mission.

What is the planning process for land use?

The Activity planning department needs to be involved in all issues affecting the installation, its land use and facility assets. Besides being involved with all tenants on-base, the Activity planning department must also e involved with the various departments and agencies including regional, county, state and federal agencies that influence land use decisions for the area in which the installation resides. Working closely with municipal governments, Activity planning departments can explain the Navy's mission, and projected plans to ensure that not only are the present Navy land uses compatible with the surrounding communities but also the future land uses. Activity planners need to cognizant of plans for development for lands around their installation to ensure that the present and future land use will be compatible with the Navy's missions. Being unaware or uniformed of any community issues could affect the Navy's mission. A coordinated planning effort will enhance the likelihood that the land uses are compatible with the Activity's mission, environmentally compatible and that they preserve the quality of life. A pro-active position by the Activity planning department will help to preserve the Navy's land and mission and avoid encroachment. By working with the surrounding communities, Activity planners can explain not only the mission, but also why certain naval operations take place thereby pursuing a good neighbor policy.

CAPTITAL IMPROVEMENTS PLAN

Introduction

A Capital Improvements Plan (CIP) is the second part of the master plan that lists and describes the projects necessary for the implementation of the Land Use Plan (LUP), the first part of the master plan. It is a dynamic working document used by the activity as their Future-Year-Defense-Plan (FYDP). Although it is a part of the master plan, it should be prepared so as to be a stand alone document. To provide early POM support and guidance, the update cycle should coincide with the two year POM cycle.

Responsibilities

The activity, the EFD, and the Major Claimant each have a role in preparing and maintaining the CIP.

Activity: Identify land and facility requirements and maintain CIP between EFD/EFA updates.

EFD/EFA: Provide technical assistance to formulate achievable projects. Update on a two year cycle to coincide with the Program Objectives Memorandum (POM) cycle. Major Claimant: Provide overall direction for activity development and seek funding to execute projects.

CIPs that are prepared as a part of the master plan undergo the same review chain and are approved by CNO. Other CIP updates between master plan updates are approved by the activity Major Claimants. Marine Corps activity Major Claimants. Marine Corps activity CIPs are approved be CMC (LFL).

Primary Objectives

The CIP is the sequential step in the planning process after the LUP. Its primary purpose is to develop an achievable FYDP. It implements the activity master plan through a series of achievable steps.

* Identifying the projects and actions necessary to satisfy the goals and objectives of the plan.
* Prioritizing and phasing (as appropriate) projects.
* Providing specific project sitings.

Contents

The CIP should consist of the following three sections:

1. **Introduction**: This section briefly describes the issues, concerns and problems identified in the master plan andthe proposed concepts to resolve them. If the CIP is an update of the one developed in conjunction wit the master plan, then any changes that may have occurred since then that could alter the original concepts are discussed. A listing of the projects and the concept they relate to areincluded in this section.

2. Project Identification: This section contains a listing of all proposed projects to include project numbers, project titles, scopes, type of funding, proposed program year and costs. A demolition list is included if appropriate. For activities with large numbers of projects, separate listings are utilized to indicate projects by type of funding or to show those that are programmed and unprogrammed. A brief description of each project, why it is need, its relationship to any other project(s), phasing or demolition information and this priority is included. A base map(s) indicating the location of all projects using a dot or some other similar method is furnished. Where scale permits, the building footprint method of indicating projects will be utilized since it helps relate the size of the proposed project to surrounding buildings and structures.

3. Project Data Sheet (PDS) Section: This section included PDSs for projects expected to be supported bythe resource sponsors and major claimants for inclusion in the FYDP. The EFD/EFA certifies the project scopes and provides site approvals for all projects in this section. Signatures are required for both the scope certification and site validation. The standard PDS form with all sections ompleted is to be used. The siting rationale block of the PDS addresses operational and cost considerations and significant environmental factors for sites considered for the project. When alternative sites are feasible, they must be considered and the rational for selecting one site over another must be provided as a supplement to the PDS. This can be achieved using the site analysis matrix with appropriate graphic and narrative information. The reader can then ascertain that the selected site was chosen to minimize impacts t the natural environment within the parameters of operational requirements and cost considerations. When projects must be sited in environmentally sensitive locations, mitigating actions which should be a part of the project, if known at this stage, are identified and discussed.

Projects for which alternative sites are not available or practicable, such as additions to existing structures, and for which not significant environmental impact will occur, are site approved and excluded from further environmental review using appropriate categorical exclusions. In some instances, projects are site approved and categorically excluded on the obvious environmental merit of the selected site.

When sufficient information is not available to adequately site a project or to substantiate a siting, the CIP will identify the need for additional information. Projects that require NEPA documentation will be so identified, including those which likely can be categorically excluded.

In no case will a project be a site approved without proper consideration of the natural and man-made constraints, environmental impacts, mitigation measures, siting alternatives, and economic considerations. Please refer to the section on site approval which amplifies these considerations.

INSTALLATIONS PLANNING

SPECIAL STUDIES

The purpose of a Special Study is to investigate or conduct research concerning a specific topic, such as a proposed facility or a new land usage. A special study can be defined as a report devoted to a particular area of investigation which may be a portion of a project.

The special study is initiated when an activity identifies the need for specific research into a subject of interest. These needs could be influenced by either internal requirements or due to external influences. After the need has been established and justified, the activity then establishes the customer requirements. The activity should develop the most specific and detailed requirements as possible, so as to ensure that the special study will provide the requested and required information. All requirements that are possible to identify at this time should then be compiled and forwarded to the repective EFD via an Engineering Service Request (ESR). The EFD is then tasked with developing the special study. The EFD determines whether the project should be accomplished in-house or with an A-E contract. The EFD develops the scope of work and obtains concurrence on the scope with the activity. The scope of work contains an introduction of the project, project description, objectives of the study, project requirements.

The activity provides funds to the EFD for the cost of the study.The special study should include areas such as an executive summary, project description, data acquisition process, site conditions, design criteria, constraints, concept alternatives, graphics, evaluations of concept alternatives, costs, a recommended alternative, and any related appendices.The proceess of developing a special study varies with the requirement of each project. Generally, however, the process includes several steps or phases of development to include initial coordination meetings between the customer and the A-E/EFD, data acquisition, periodic coordination and update meetings between the customer and the A-E/EFD, site visits, draft submittal, prefinal submittal, and final submittal.

Types of special studies could include projects to consider new construction, repair or overhaul of facilities, environmental documentation, land use changes, traffic circulation issues and cultural or historical studies. Examples of special studies have included carrier homeporting, new pier feasibility, land use compatibility, magazine siting, proposed project site evaluations, environmental assessments/impact statements and wetlands analysis.

SYSTEMS STUDIES

A Systems Study focuses on a functional grouping of facilities, equipment and people within the Navy and Marine Corps, that perform interrelated taskes and have the mission of providing a singular, specific type of operational, logistical or personnel support. Examples of previously accomplished systems studies include: pilot training, aircraft maintenance, ordnance handling and storage and communications. Systems studies are undertaken to analyize the physical workings of a particular system, the requirement for facilities equipment and people and to provide recommendations for improvements. Such studies can be worldwide in scope or deal with specific segments of a larger system. To a large extent, systems within the Navy and the Marine Corps have sponsors represented by command organizations.

ILS

To provide the military with an effective military force, weapons systems need to be able to respond when called upon. The reliability of the hardware, its maintainability, and logistics support needs to be provided to accomplish this goal. Effective logistics support of weapons systems consumes a major portion of the annual defense appropriations; about 60 per cent of the total life cycle cost of a system goes into its operation and support.

Integrated Logistics Support (ILS) is the process used to ensure that all elements required for a given weapons system or other hardware component are properly planned, acquired and sustained. ILS managers, in coordination with logistics personnel, plan and develop the maintenance capability and

material support to maintain these systems in a state of readiness. This programmatic approach ensures that the total resource commitment to develop not only the hardware system itself but also support, on a life cycle cost basis, elements such as training, maintenance, safety, supply, human engineering, and facilities, is identified as an integral part of the weapons system acquisition process.

Although each of these elements may be developed or managed by a different individual or activity, the focus of the ILS Manager is to ensure that each element receives appropriate consideration. If properly applied and monitored through the design and production phases of the acquisition process, these elements will optimize the supportability of the equipment over its life. Failure to provide resources and to coordinate the development of these elements early in the acquisition process will increase life-cycle costs and reduce operational readiness.

REGIONAL STUDIES

What is a regional profile?

A regional profile contains a data base of general planning information for a given region. This document is a non problem solving document intended for information only. System studies will be used when there are regional issues that require a solution on a regional issues that require a solution on a regional level. It documents regional issues with an emphasis on public planning, socio economic considerations, vicinal factors, and general environmental issues. It identifies and provides functional profiles of all major government agencies and military installations in the region. It identifies potential regional issues and concerns. A matrix should summarize sensitive issues/concerns that are to be addressed in the development of specific master plans or Systems Studies.

Why is a regional profile necessary?

Regional profiles will help satisfy the Congressional requirement to look at regional planning issues with a Department of Defense wide perpective. Functions with an inter service impact will be easily documented in the regional profiles.

Who requests a regional profile?

The regional profile should be request by the area coordinator or by Naval Facilities Engineering Command (NAVFACENGCOM). The funding will be provided by requestor.

Who approves a regional profile?

The regional profile is a non problem solving document intended for information only. As such, it will not be considered a study. Although NAVFACENGCOM will review draft profiles, no Washington level approval will be required for these documents.

How to get data for regional profiles?

A good source for data is Naval Facilities Engineering Command, Data Collection and Application for Navy Master Planning (P 1022), August 1986.

Criteria and Planning Factors

Introduction

Definition

Facility planning criteria are guidelines for determining the size and type of facilities needed at Navy and Marine Corps shore installations. The criteria answers questions such as how much hangar space is needed to support one aircraft squadron or what is the size of a standard enlisted barracks module. Also, it may include very specific space allowances or provide a methodology for the planner to use in developing a requirement.

When are criteria used?

The criteria are used for all types of planning studies and specifically to develop Basic Facility Requirements, determine project scopes and evaluate the adequacy of existing assets.

Where can I find the criteria?

The primary source is NAVFAC P-80, Facility Planning Criteria for Navy and Marine Corps Shore Installation and its Appendices:

- P-80.1, Runway Capacity Handbook-Fixed Wing
- P-80.2, Naval Mobile Construction Battalion Facilities
- P-80.3, Airfield Safety Clearances

The P-80 is divided into two Chapters. Chapter 1 provides definitions and the rules for the proper application of criteria, and is essential reading before using the criteria given in Chapter 2. The criteria are arranged by 5 digit category codes defined in NAVFAC P-72, Department of the Navy Facility Category Codes.

While P-80 is the primary source of planning criteria, it is not the only source. Other documents include:

- **NAVFAC P-272, Definitive Designs for Naval Shore Facilities.** Provides layout sketches of a typical facility type. Department of Defense Military Handbook, MIL-HDBK-Series. Formerly titled NAVFAC Design manuals, these manuals contain some space allocation criteria and typical facility layouts.

- **Department of Defense Medical Space Planning Criteria.** Contains detailed information for determining requirements for medical and dental facilities. NAVFAC P-970, Planning in the Noise Environment. A joint service manual which addresses the impact of aircraft and other noise sources on planning decisions.

- **Automated criteria.** The P-80 criteria is a part of a personal computer based Facilities Planning Model (FPM). In order to use the FPM, the user must have an IBM compatible PC with 640K or more of RAM and a hard disk drive with at least 2 megabytes available. The PC must be configured with DOS 3.3 or later. Information on obtaining the model is available from NAVFAC Headquarters, Code 200. The P-80 is also available on CD ROM. It is available as a part of the Construction Criteria Base on a subscription basis from the National Institute of Building Sciences, Washington, D.C.

What if planning criteria are not available?
Criteria are not available for all facility types. In this case requirements should be based on an engineering analysis of the space needed to support the function. Two commonly used methods are:

(1) A scaled drawing showing the layout of equipment, desks, workbenches etc., along with the required access and support space.

(2) A columnar chart listing the net-work areas and support spaces to which a net to gross area conversion factor is applied.

Whatever approach is taken, the justification must include a logical step by step process which can stand alone when reviewed by others.

Guidelines

Guidelines for Applying Criteria
The information in P-80 is a planning guide. The planner must exercise professional judgment in determining requirements. It is impossible to establish absolute planning factors which will fit every circumstance. The planner may need to modify criteria to satisfy individual activity requirements.

A fundamental aspect of the P-80 criteria is that an activity is not automatically "entitled" to the facility allowance, or even the facility itself, simply because it is listed in the manual. The majority of the criteria represent the optimum requirement, but they are based on Navy wide data. Based on an engineering analysis and judgment. A smaller (or larger) facility may be needed.

Local community facilities can reduce requirements when the activity is located near urban areas. Certain support facilities, in the morale, welfare and recreation field have a general similarity to Navy needs and must be recognized in the planning process. The P-80 accounts for this through the application of Environmental Adjustment Factors (EAFs). The EAFs represent the Lower limit of on-base facility requirements, and if applied, no further reduction of the requirement is needed. The EAFs methodology is being phased out of the P-80 with criteria that reflect actual utilization rates for recreational facilities.

Regional military facilities can also reduce requirements. Where military installations are closely situated, some facilities can be planned to accommodate the population of a number of military activities yielding a more efficient operation than providing separate facilities. Regional planning should be coordinated with the Engineering Field Division and Area Coordinator.

Equipment. Some facility types are heavily impacted by the equipment to be installed. This is true for operational trainers, industrial shops and research, development, test, and evaluation laboratories. In these cases, the planner must work closely with the organization responsible for procuring the equipment to insure that adequate space requirements are identified.

Medical Facilities. The criteria in NAVFAC P-80 for medical facilities will be deleted in the next change. Requirements should be generated by regional Health care support offices (HSO) using Department of Defense Medical Space Planning Criteria.

Where can I get help?

Activity planners should seek advice on criteria application from their Engineering Field Division. In some cases, the P-80 will reference another agency as a source of information. Information for locating these sources can be provided by:

(1) Atlantic Division, Naval Facilities Engineering Command, Mr. C. Walker, DSN 565-2310.

(2) Headquarters, Naval Facilities Engineering Command, Mr. D. Kurtz, DSN 221-7370.

Suggestions for improvements to criteria should be forwarded to: Atlantic Division, Naval Facilities Engineering Command, Code 20, 6500 Hampton Blvd., Norfolk, VA 23508-1297

540 DENTAL CLINICS

A dental clinic is an oral health care service facility equipped and staffed to perform dental procedures for general practices, a specialty, or a grouping of specialties. A dental facility will normally include treatment areas, administrative, support and storage areas.

540 10 DENTAL CLINIC (sq.m./SF)

The Bureau of Medicine and Surgery (BUMED), subject to the approval of the Assistant Secretary of Defense (Health Affairs), is responsible for the determination of scope of dental clinics planned, programmed, and constructed. The following information is provided as a guide to be utilized for planning and preliminary programming purposes.

Step 1: Beneficiary Population. Determine the active duty beneficiary population. On average there will be 1 dental officer per 700 active duty beneficiaries. The authorized number of dentists and the specialty mix at an activity should be confirmed through the Regional Naval Dental Center.

Step 2: Staffing. Obtain staffing figures for the planning year from the Authorized Manpower documentation for the military personnel and the authorized positions for the civilian personnel. The planning documents must be submitted via the major Claimant for confirmation of support for any increased staffing, both military and civilian.

Step 3: Dental Treatment Rooms (DTR's). Determine the number of required DTR's from the following criteria.

1	DTR for each dentist in training.
1 1/2	DTR's for each general duty dentist assigned to clinical dentistry.
2	DTR's for each Prothsodontist, Periodontist, Endodontist, Oral Surgeon, Pedodontist, Orthodontist, and Comprehensive General Dentist assigned to clinical dentistry.

NOTE: When the total number of dentists is five (5) or less, use a DTR factor of 2 DTR's per dentist Clinics with six (6) dentists will have a minimum of 10 DTR's.

1	Oral Hygiene Treatment Room (OHTR) for each oral hygienist or technician functioning as oral hygienist.

Step 4: Clinic Space Required. After calculating the number of DTR's required, consult table 540-10A to determine the gross area required. Interpolation is required. These figures include space allowance for all functions that are in direct support of the dental clinic, such as administration, locker rooms, conference rooms, limited prosthetic laboratory, storage of operating supplies, a central sterile, and dental X-ray. This also includes waiting rooms, mechanical spaces, restrooms, circulation, walls and partitions, and consultation rooms. Interpolation, as explained at the front of the 500 series, is necessary.

TABLE 540-10A
Space Allowances for Dental Clinics

Number of DTR's and OHTR's	Gross Area per DTR and OHTR	
	sq.m.	SF
2	88 sq.m.	950 GSF
3	88 sq.m.	950 GSF
4	79 sq.m.	850 GSF
6	70 sq.m.	750 GSF
8	68 sq.m.	730 GSF
10	68 sq.m.	730 GSF
12	68 sq.m.	730 GSF
18	68 sq.m.	750 GSF
25	65 sq.m.	700 GSF
30	65 sq.m.	700 GSF
40	65 sq.m.	700 GSF
50	65 sq.m.	700 GSF
100	56 sq.m.	600 GSF

step 5: Optional Functions: (must be specifically justified and documented)

A. Naval Dental Centers. Naval Dental Centers have administrative personnel not normally associated with a branch dental clinic. Determine by Authorized Manpower Document the number of such personnel and calculate requirements at 15 sq.m. (162.5 GSF) for each full-time administrative person.

B. Dental Equipment Repair. For clinics with equipment repair technicians assigned, determine the number of repair technicians from Manpower Authorization and consult table 540 10B to determine the gross area required.

TABLE 540-10B
Space Allowance for Dental Equipment Repair Technicians

Number of Repair Technicians	Gross Area	
	sq.m.	SF
1	25 sq.m.	270 GSF
2	46 sq.m.	500 GSF
3	60 sq.m.	650 GSF
Add 9 sq.m. (100 GSF) more for each additional repair technician.		

C. Special Education Functions. Where specifically justified, an education training room can be planned based upon documentation of course title, frequency and duration of courses, and average on board students. A space factor of 2.6 sq.m. (28 GSF) per student will be used to size the facility based upon the average monthly student population that can be justified. Routine classroom/conference room functions are already included in TABLE 540-10A

D. Full Prosthetic Lab. If authorized and staffed with a full time prosthetic lab technician, additional space may added for a fill prosthetic lab. Consult Table 540 10C for the gross square area required.

TABLE 540-10C
Space Allowance for a Full Prosthetic Laboratory

	Gross Area	
	sq.m.	SF
Dental Prosthetic Lab	63 sq.m.	675 GSF
Each technician over 3	8 sq.m. each	85 GSF
If Required:	sq.m.	SF
Ceramic Room	19 sq.m.	200 GSF
Casting & Grinding	19 sq.m.	200 GSF
Model Storage	11 sq.m.	120 GSF

E. Naval Dental Center. If the facility is serving as a Naval Dental Center additional space may be provided for regional storage for Branch Dental Clinics. Consult Table 540 10D for additional gross square area.

TABLE 540-10D
Space Allowance for Regional Storage

Number of Branch Clinics Served	Gross Area	
	sq.m.	SF
up to 5	19 sq.m.	200 GSF
6 to 10	65 sq.m.	700 GSF
11 to 20	93 sq.m. max	1000 GSF

Step 6: Total Gross Square Footage Required. Add the gross square footage for the clinic obtained in step 4 to the gross square footage of the supported options obtained in step 5. The sum is the total space requirement for category code 540-10 and includes all functions that are normally associated with a Dental Clinic or Regional Dental Center.

Step 7: Parking. Based on the 15 Oct 1991 MIL-HDBK-1191 (DOD Medical and Dental Treatment Facilities Design and Construction Criteria), for clinics with less than 30 DTR's, provide 3 parking spaces per DTR For larger clinics, 2.5 spaces per DTR should be planned. One space per organizational vehicle is also authorized.

Step 8: Site Selection.

A. Site facility convenient to active duty beneficiaries.
B. Collocation of Dental Clinics with Medical clinics is operationally efficient and desired.
C. In site selection provide a minimum of 25% expansion capability of the facility square meters, as calculated in step 6, & parking requirements, calculated in step 7.
D. Facility should be sited convenient to existing utility support.

550 MEDICAL CLINICS

A clinic is a free standing health care treatment facility primarily intended and appropriately staffed and equipped to provide urgent care and routine outpatient services. A clinic is also intended to perform certain non therapeutic activities related to the health of the personnel served such as examinations, immunizations, staff education and training, medical administration, and preventive medicine services necessary to support a primary military mission. A clinic will not normally be equipped with beds. The key planning factor for medical clinics is sizing the facility based upon data obtained in the approved clinic business plan/concept of operations. This document will be provided by the regional parent medical command.

550 10 MEDICAL CLINICS (sq.m./SF)

The Bureau of Medicine and Surgery (BUMED), subject to approval of the Assistant Secretary of Defense (Health Affairs), is responsible for the determination of scope and size of a naval medical clinic to be planned, programmed, and constructed. The following information is provided as a guide to be utilized for preliminary planning and programming purposes. The space allowance in Table 550-10 assumes the clinic will be staffed with physicians and nurses and provide X-Ray, pharmacy, laboratory, and other services normally associated with outpatient clinics.

Step 1: Population Supported/Projected Clinic Workload. In accordance with current DOD criteria, the population supported is defined as those eligible persons, regardless of service affiliation, who reside within a 40 mile radius of the medical facility. This population information is available in the approved Clinic Business Plan/Concept of Operation prepared by the parent medical command and approved by the regional lead agent. This business plan should contain the projected clinic workload for each beneficiary category for the planning year and consider what portion of each category will be served in the military treatment facility (MTF). The calculated Outpatient Clinic Visits (OPV's) is determined by the approved Business Plan's estimate of outpatient clinic visits per year in the MTF only.

Step 2: Space Requirement. Once the number of OPV's per year is determined, use Table 550-10A to determine the preliminary planning area required. Table 550-10A includes space allowance for all functions that are in direct support of the medical clinic such as administration, locker rooms, conference rooms, and management information. Space for waiting rooms, mechanical spaces, restrooms, circulation, wall and partitions, and supply storage is also included in the table. Interpolation, as explained at the front of the 500 series, is necessary.

TABLE 550-10A
Space Requirement - Medical Clinics

OPV's/yr.	Gross Area	
<=1000	46 sq.m.	500 GSF
2,500	167 sq.m.	1,800 GSF
3,500	353 sq.m.	3,800 GSF
5,000	511 sq.m.	5,500 GSF
10,000	883 sq.m.	9,500 GSF
15,000	1,301 sq.m.	14,000 GSF
20,000	1,719 sq.m.	18,500 GSF
30,000	2,044 sq.m.	22,000 GSF
40,000	2,601 sq.m.	28,000 GSF
60,000	3,716 sq.m.	40,000 GSF
80,000	4,274 sq.m.	46,000 GSF
100,000	4,831 sq.m.	52,000 GSF

Step 3: Medical Clinic Options: (must be specifically justified and documented)

A. Administration. If a clinic command structure is present (the facility is not a branch clinic), determine by Authorized Manpower Document the number of such personnel and calculate the requirements at 15 sq.m. (162.5 GSF) for each administrative person.

B. Occupational Health/Industrial Hygiene. If the clinic provides occupational health/industrial hygiene support to a Navy Industrial Activity (i.e. Shipyard, NADEP, etc.), use Table 550-10B to determine the additional space allowance.

TABLE 550-10B
Space Allowance for Occupational Health

		Gross Area
Each staff person	19 sq.m.	200 GSF
Audio Booth	33 sq.m.	350 GSF
Eye screening	16 sq.m.	170 GSF
Testing Lab	16 sq.m.	170 GSF
Pulmonary Function	16 sq.m.	170 GSF
Counseling	15 sq.m.	162.5 GSF
Records	1.1 sq.m. (12 GSF) per file cabinet	

C. Social Work. If full-time social workers are present in the medical clinic an additional 22 sq.m. (240 GSF) per social work staff may be provided.

D. Physical Therapy/Wellness. If the medical clinic will be equipped with physical therapy equipment and staff an additional 56 sq.m. (600 GSF) per therapist may be provided.

E. Holding Unit. For remotly isolated clinics, a 2 bed holding unit may be provided at an additional 65 sq.m. (700 GSF), when authorized by Parent Command.

Step 4: Total Gross Square Footage Required. Add the gross square meters for the clinic obtained in step 2 to the space determined in the supported options. The sum is the total space requirement for category code 550-10 and includes all functions that are normally associated with a Medical Clinic or Regional Medical Center.

Step 5: Parking. The following formula, extracted from the 15 Oct 1991 MIL-HDBK-1191 (DOD Medical and Dental Treatment Facilities Design and Construction Criteria), may be used to estimate the required number of parking spaces

# of parking spaces = (.59)(X1) + (.21)(X2) + (X3) + (X4) +(X5)

X1 = All personnel working in the Medical Treatment Facility on a full time basis, minus the Dental staff, plus an allowance for visitors and part-time staff. (List each category separately)

X2 = Average daily outpatient workload for "peak month" using 21 workdays per month and 250 workdays per year as a basis for calculation.

X3 = One space for each patient bed.

X4 = See Category Code 540-10 for detailed Dental parking requirements.

X5 = One space for each medical and dental organizational vehicle.

Please consult MIL-HDBK-1191 for further clarification of variables and updates. Additional parking spaces beyond the above calculations shall be separately justified (i.e. pharmacy)

Step 6: Site Design. Provide an additional 25% of the total gross square meters required calculated in step 4 for expansion capability when siting the facility.

DOD SPACE REQUIREMENTS DATA

PART I - SUMMARY

(SEE INSTRUCTIONS ON REVERSE SIDE)

DATE	PAGE NO.	NO. OF PAGES

DEPARTMENT OR AGENCY	FIRST SUBDIVISION	PREPARED BY
SECOND SUBDIVISION	**THIRD SUBDIVISION**	**APPROVED**

A - SUMMARY

1. PERSONNEL					2. SPACE		
a	b	c	d	e	a	b	c
AUTHORIZED	0	TOTAL IN PRIVATE AND OPEN OFFICE TYPE SPACE	0		**TYPE OF SPACE**	**PRESENT SQUARE FEET**	**REQUIRED SQUARE FEET**
VACANT BILLETS	( )	E 1-7, GS 1-6	( )		OFFICE TYPE SPACE	0	0
ON BOARD, PAYROLL	( )	E 8 AND 9, WO, 0 1 AND 2, GS 7-1 1, SUPERVISORY	( )		PRIVATE WORK STATIONS	( )	( )
ON BOARD NON-PAYROLL		E 8 AND 9, WO, 0 1 AND 2, GS 7-1 1, NONSUPERVISORY	( )		OPEN WORK STATIONS	( )	( )
TOTAL	0	0 3 AND 4, GS 12-13 SUPERVISORY	( )		UNIT EQUIPMENT	( )	( )
INDEYES (For OSD Use Only)		0 3 AND 4, GS 12-13 NONSUPERVISORY	( )		ADMINISTRATIVE SUPPORT	( )	( )
PRESENT OFFICE USE INDEX		0 5 AND 6, GS 14-15 SUPERVISORY	( )		STORAGE AND SPECIAL TYPE SPACE	( )	( )
OFFICE USE INDEX, GSA SCHEDULE		0 5 AND 6, GS 14-15 NONSUPERVISORY	( )		TOTAI		
OFFICE USE INDEX, DOD ALLOWANCE		0 7 AND 8 GS 16-18, P.L.	( )				
ADMINISTRATIVE SUPPORT INDEX		TOTAL IN ADMINISTRATIVE SUPPORT SPACE					
STORAGEINDEX		TOTAL IN STORAGE AND SPECIAL TYPE SPACE					
SPECIAL TYPE INDEX		TOTAL PERSONNEL	0				

B - GENERAL

1. MISSION - THIS UNIT IS GENERALLY RESPONSIBLE FOR

2. STATEMENT ON FEASIBILITY OF RELOCATION *(DOD Directive 5305.2)*:

3. ADDITIONAL FACTORS - THE FOLLOWING ADDITIONAL FACTORS SHOULD BE CONSIDERED IN DETERMINING THE SPACE REQUIREMENTS OF THIS UNIT

INSTRUCTIONS

A. GENERAL. This form is designed for use with the DoD Space Occupancy Guide for the National Capital Region *(DoD Instruction 5305.3)* to determine new space requirements or to analyze present space utilization. Parts I and 11 should be completed for each division or comparable unit. In larger organizations, both Parts I and 11 should be completed for the office(s) at the next supervisory level(s), and a Part I completed to summarize the total requirements listed on all of the Part 11's.

B. DEFINITIONS

1. OFFICE TYPE SPACE: This is space which provides an environment suitable for an office operation. This includes, but is not limited to suitable and adequate lighting, heat and ventilation, appearance, accessibility, circulation, floor covering, and sound control. The space may consist of a large open area or may be partitioned into rooms. Examples of office type space include conventional offices, conference rooms, classrooms, credit unions, and supply rooms *(when in office space)*. For the purpose of detailing space requirements on DD Forms 1450 and 1450- 1, Office Type Space is subdivided into "private work stations", "open work stations", "unit equipment", and "administrative support space", defined below.

2. PRIVATE WORK STATION: A room occupied by one principal, or, in some instances, by a principal and his secretary.

3. OPEN OFFICE SPACE: Office space occupied by two or more individuals *(other than a principal and his secretary)*, the furnishings and equipment required for their work, plus circulation space.

4. OPEN WORK STATION: That portion of an open office space area allocated to an individual to accommodate the furniture and equipment necessary for performing his work, plus a share of the adjacent aisle.

5. UNIT EQUIPMENT: Those items of furniture and equipment housed in Open Office Type Space which are not assigned to any one work station, i.e., bookcases, costumers, office machines, safes, files, table, etc., not used exclusively by one individual.

6. ADMINISTRATIVE SUPPORT SPACE: All office type space not classified either as private or open office space, e.g., conference rooms, supply rooms, training rooms, file rooms, reception rooms, duplication rooms, supply rooms, libraries *(exceptfixed* stacks), etc.

7. STORAGE TYPE SPACE: This is space which is suitable for storage of supplies, equipment, records, materials, etc., and which does not provide an environment suitable for an office operation. This type would include but not be limited to vaults, closets, and unconverted attic and basement areas, as well as space built for warehousing and records storage. Its interior treatment is such that it cannot be classified as suitable for office space.

8. SPECIAL TYPE SPACE: This is space which by reason of installed fixed facilities or utilities is adapted for special use. Included would be laboratories, dark rooms, electronic data processing rooms *(computer rooms)* with special air conditioning, industrial type operations with installed equipment, etc.

C. PART 1.

1. HEADING. Indicate the activity, e.g., Navy Department, Bureau of Naval Personnel, Assistant Chief for Plans, Policy Division, and the names of the persons who prepared and approved the report. Pages should be numbered consecutively to include all DD Forms 1450 and 1450-1 submitted.

2. SUMMARY.

a. Personnel. Complete columns b and d, leaving column e blank. In column b, the sum of "Vacant Billets" and "On Board, Payroll" should equal the "Authorized" figure. In Column d, the "Total in Private and Open Office Type Space", which is the sum of the figures to be entered in parentheses, when added to the "Total in Administrative Support Space" and the "Total in Storage and Special Type Space" should equal the sum of Authorized" and "On Board, Non-Payroll" personnel shown in column b.

b. S~ Enter present square feet occupied in column b. Enter totals from Part 11, columns e, f, g, 1, and p on appropriate lines in column c.

3. GENERAL. Under "Additional Factors", enter requirements for special construction, security, adjacency, etc. Attach pertinent organization charts.

D. PART 11.

1. COLUMNS a, b, c, & d. Do not include personnel whose work stations are located in administrative support, special, or storage space. In column d, when the grade or rank of an incumbent differs from what is authorized, list the authorized grade or rank and indicate in remarks the grade or rank of the incumbent.

2. COLUMNS e AND f. Use allowances shown in the current DoD Space Occupancy Guide for the National Capital Region *(DoD Instruction 5305.3)*. Any departure from the guide will be justified in remarks or on the reverse side of the form.

3. COLUMNS g AND h. Do not list furniture or equipment included in private offices or open work stations, or in administrative support, storage, or special type space.

E. SPACE REQUIREMENTS FOR UNIT FURNITURE AND EQUIPMENT

Listed below are common items of unit furniture and equipment and the square footage of floor space they require. Working area is included where appropriate. The space requirements for items not listed may be calculated from actual measurements or by using the items below as a guide.

ITEM	SQUARE FEET
Bookcase, 13 x 33	6
Bookcase, unitized, 22 x 18	4
Cabinet, storage and wardrobe, 18 x 24	6
Cabinet, storage and wardrobe, 18 x 36	9
Cabinet, storage and wardrobe, 24 x 26	11
Cabinet, stationery, 18 x 36	9
Cabinet, filing, letter size, 15 x 25	6
Cabinet, filing, legal size, 18 x 25	7
Cabinet, filing, safe, 19 x 28	8
Cabinet, filing, map and plan, 36 x 48	20
Cabinet, filing, map and plan, 36 x 60	25
Chair, side	4-6
Chair, lounge	10
Costumer	4
Credenza, 18 x 66	9
Locker, clothing, 18 x 21	5
Locker, clothing, 36 x 21	9
Safe, one door, 21 x 23	8
Safe, one door, 27 x 27	10
Safe, two door, 42 x 36	18
Sofa	30
Stand, Dictionary	4
Stand, office machine, 18 x 18	3
Stand, office machine, 18 x 34	5
Stand, office machine, 24 x 36	6
Table, 14 x 26	3
Table, 24 x 36	6
Table, 34 x 45	12
Table, 34 x 60	15
Table, 36 x 72	18
Valet rack, 30 x 20	6
Valet rack, 51 x 20	8

DOD SPACE REQUIREMENTS DATA

PART 11 - DETAILED SPACE REQUIREMENTS

(SEE INSTRUCTIONS ON REVERSE OF ED FORM 1450)

DATE	PAGE NO.	NO. OF PAGES

OFFICE TYPE SPACE

PRIVATE AND OPEN WORK STATIONS

LINE ITEM a	JOB TITLE (Including Vacancies) b	NAMEOF EMPLOYEE c	GRADE OR RANK d	SQUARE FEET REQUIRED PRIVATE e	SQUARE FEET REQUIRED OPEN f	SQUARE FEET RE-QUIRED g
			TOTALS	0	0	0

UNIT EQUIPMENT

DESCRIPTION h

ADMINISTRATIVE SUPPORT SPACE

DESCRIPTION i	PERSON-NEL j	PRESENT SQUARE FEET k	SQUARE FEET RE-QUIRED l
TOTALS	0	0	0

STORAGE AND SPECIAL TYPE SPACE

DESCRIPTION m	PERSON-NEL n	PRESENT SQUARE FEET o	SQUARE FEET RE-QUIRED p
TOTALS	0	0	0

REMARKS *(Continue on reverse)*

POINT PAPER
ON
FACILITY MASTER PLANNING PROCESS

PURPOSE

- To describe the facility master planning process

BACKGROUND

- AFI 41-201, Managing Clinical Engineering Programs, describes the Facility Master Plan as a long-range planning tool that the MTF's Executive Committee uses to prioritize facility projects necessary for the operation, maintenance, and future development of the medical treatment facility (MTF)

- With the Surgeon General's goal for O&M facility project funds at a minimum of 3% of the replacement value of facilities, the Facility Master Plan has become critical to guide our facilities and facility management programs to success

DISCUSSION

- The Facility Master Plan:

  -- Identifies requirements, resources, and priorities for a five-year program

  -- Relates, integrates, and balances equipment plans, accreditation standards, space utilization objectives and studies, safety codes, energy goals, mission changes, appearance enhancement plans, strategic plans, etc.

  -- Forms the basis for managing facilities maintenance, repair, and modifications

  -- Forecasts medical requirements and priorities for projects by contract for the benefit of both the medical and Civil Engineering (CE) communities

  -- Provides a road map to the future for the MTF by providing continuity and coherence in resource expenditures over the course of many years

  -- Provides a management plan for use by many including: the Group Staff, MAJCOM, Regional HFO, etc.

  -- Shows relationships of planned facility improvements over time to simplify coordinating actions

- Contents and organization

  -- Format and media is not specified

    --- Any format or media that provides efficient means of access, update, and distribution is appropriate

  -- Minimum mandatory elements:

    --- Table of Contents

    --- JCAHO Statement of Condition

    --- List of medical buildings by building number that includes:

---- Building number

---- Gross square feet of space used by the MTF

---- Condition Code assigned by CE

---- Date of last and next Facility Survey and significant finding of last Facility Survey

---- Compliance with NFPA 99

---- Compliance with NFPA 101

--- List of building systems and real property installed equipment (RPIE) that includes for each RPIE system or sub-system:

---- Age (acquisitions date)

---- Brief description of condition

---- Normal source of preventative maintenance/repairs

---- Date of last overhaul/rebuild

---- Estimated FY and cost of replacement or overhaul/rebuild

---- The following items are minimum equipment items that should be included on an MTF RPIE list:

Emergency generators, emergency power switchgear, central vacuum systems, fire alarm systems, central air compressors, elevators and controls, chillers, air handlers, boilers, roofing systems, public address/paging systems, nurse call systems, medical gas systems, water heaters, medical incinerators

--- Schedule of planned facility projects

---- Plan should be broken down by fiscal year

---- Include Military Construction (MILCON) Projects

---- A copy of AF Form 332 and DD Form 1391 may be included or referenced

---- List of O&M projects and initiatives

----- Must be in priority sequence by FY

----- Project list should include title, brief description, project of work order number, estimated cost, type of project, impact if not funded, status, and other funding requirements

---- Minor construction by in-house personnel

---- Minor construction by contract (EEIC 529)

---- Maintenance and repair projects by contract (EEIC 521 and 522)

---- Architect and engineering (A-E) studies

---- Energy Conservation Investment Program (ECIP) Projects

---- Productivity Enhancement Capital Investments (PECI) Projects

---- RPIE replacement to be funded from Other Procurement 0130 Appropriation

- Relationship of Facility Master Plan to other MTF plans:

-- Must be coordinated to ensure consistency and coordination with other plans and actions

--- Coordinate with RMO to ensure the correct amount of O&M funding in the correct year is included in MTF financial plan

--- Coordinate with MEMO to ensure support of planned equipment purchases

--- Coordinate with Systems Officer to ensure support of computer systems

-- Must be in sync with the Strategic Health Resource Plan (SHRP)

- Preparation, Update, and Approval

-- Facility Manager gathers background information and prepares draft plan

-- Input is provided by Group Staff, RMO, Civil Engineering, Base Communications, Health Facilities Office

-- Facility Manager should review and integrate inputs as appropriate from:

--- The MTF SHRP, HSI reports, Facility Utilization Studies, JCAHO Accreditation Survey Findings, Resource Protection Reports, Safety Inspection Reports, Environmental Compliance Audit Reports, etc.

-- Plan should be reviewed by:

--- Director of Medical Logistics

--- Administrator

--- Group Staff and Commander at least once each year (or anytime a significant change in plan occurs)

-- Approved plan is forwarded to MAJCOM/SGA if requested

RECOMMENDATION

- None, for information only

CARES Planning Inititatives

Potential DOD Collaboration

VA Market and Facility Identification					Planning Initiatives		DoD Program Linkage and Follow-Up						
VISN #	Location	Market/ Sub-market	Station # / Station Name / Parent Station / Zip Code	State	Description	DoD Potential Issues	Region	MTF or Installation	Service	Tracking #	MILCON, Major Repair, GME, TNEX, other	POCS	Service SG Input
21	California Hawaii Pacific Rim Clinics	Pacific Islands	Agana	GU	CBOC integration	Resource agreement post construction, access, security	Pacific Island	NAVHOSP Guam, Marianna Islands	Navy	21.1	FY 07 -09 Phased Replacement Hospital $126M	VISN: Mr. Larry Jane, VISN 21 (707) 562-8330 MTF: CAPT W. Kiser DSN Guam 334-9234 Lead Agent: LCDR J. Denny, (619) 767-6585 Service HQ: Mr. James Burke 202-762-3526 TMA:	Master planning study currently in progress. VA CBOC to be built in Phase 1 of 3 phased NAVHOSP
16	[illegible] Alabama Louisiana Mississippi Arkansas So. Missouri East Texas	Eastern Southern	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
7	Georgia Alabama South Carolina	South Carolina	[illegible]	SC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	VISN Director notified BUMED on 13 Nov 02 in writing and declined to participate in joint construction project. Hospital will relocate to the Beaufort Marine Corps Air Station.
7	Georgia Alabama South Carolina	South Carolina	Charleston	SC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20	Idaho Washington Oregon Alaska	Western Washington	Seattle	WA	Potential for DoD to satisfy VA need for acute and inpatient psych and specialty care.	Staffing, access, resources	11	NAVHOSP Oak Harbor, / Naval Medical Clinic Everett, / NAVHOSP	Navy	20.2	Everett is new, Oak Harbor recently upgraded, Bremerton upgrade recently completed.	VISN: Karen Weidner 612-970-5897 Local VA: MTF: Capt Jensen 360 257-9974 Lead Agent: LCDR Jeff Denny (619) 767-6585 Service HQ: LCDR Tom Yancoskie 202-762-3525 TMA:	
12	Illinois Wisconsin Upper Michigan	Chicago	North Chicago	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
9	Kentucky Tennessee Ohio	Western	Memphis	TN	Potential CBOC Co-located with MTF	Security, access	4	Branch Medical Clinic, NSA Millington, TN	Navy	9.3	None	VISN: Jimmie Tyus, Jr. 205-554-3623 Local VA: MTF: Capt Past 901 874-6100 Lead Agent: Mike Plant 904 542-7200 ext 8250 Service HQ: LCDR Tom Yancoskie 202-762-3525 TMA:	No MILCON issues identified, however, OIC evaluating resource sharing initiatives.
22	Nevada California	California	San Diego / LaJolla	CA	Potential sharing of services, possible IP and ancillary	Access, security, resources. Potential for DoD beneficiaries to be seen at La Jolla.	9	NAVHOSP Camp Pendleton, CA	Navy	22.1	Not in FYDP, but currently being studied by Navy for replacement	VISN: Jill Powers 678-924-5793 Local VA: MTF: Capt Heroman 760 725-1305 Lead Agent: LCDR Jeff Denny (619) 767-6585 Service HQ:LCDR Tom Yancoskie 202-762-3525 TMA:	BUMED forwarded letter to VISN Director 13 November 02 inviting joint construction project. Expect a negative response as noted from recent CARES conference.

NOTE: Highlighted rows = highest priority

CARES Planning Inititatives

Potential DOD Collaboration

As of: 12/6/2002

VA Market and Facility Identification					Planning Initiatives		DoD Program Linkage and Follow-Up						
VISN #	Location	Market/ Sub-market	Station # / Station Name / Parent Station / Zip Code	State	Description	DoD Potential Issues	Region	MTF or Installation	Service	Tracking #	MILCON, Major Repair, GME, TNEX, other	POC's	Service SG Input
8	Southern Florida Puerto Rico	North	Jacksonville	[illegible]	Undefined but large gap in all services for VA [illegible] identified	[illegible] development	[illegible]	NAVHOSP [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Expansion includes enhanced OB and surgical capabilities. VISN Director declined to participate in joint venture.
6	Southern Virginia Northern Noth Carolina	Southeast	Durham/Fayetteville	NC	Undefined	Distance, convenience	2	NAVHOSP Cherry Point, NC	Navy	6.3	None	VISN: Mark Hall 919-956-5541 Local VA: MTF: Capt Thompson 252 466-0266 Lead Agent: Pete Prescott 757 953-7113 Service HQ: LCDR Tom Yancoskie 202-762-3525 TMA:	No Navy MILCON issues identified.
17	Texas	North	Ft Worth	TX	Joint Federal Facility at former Carswell AFB. Land ownership issue.	Unmet demand in Ft Worth for retirees and 5000 AD plus ADFM's. Land use issues at Carswell. Current clinic at JRB Dallas	6	Naval Branch Medical Clinic, Joint Reserve Base, Ft. Worth, TX	Navy	17.1	No construction, TNEX implications	VISN: Lou DeNino 713-794-7489 Local VA: MTF: Capt Barker 361 961-2365 Lead Agent: Mike Plant 904 542-7200 ext 8250 Service HQ: LCDR Tom Yancoskie 202-762-3525 TMA:	No Navy construction, TNEX implications
6	Southern Virginia Northern Noth Carolina	Northeast	Hampton VA	VA	Migration of Hampton VA inpatients to DoD facilities	[illegible]	[illegible]	[illegible]	Navy	[illegible]	[illegible]	[illegible]	Navy working with Hampton VA to identify potential [illegible]

NOTE: Highlighted rows = highest priority

To support development of a comprehensive and integrated health services delivery system, the Principal Deputy Assistant Secretary of Defense (Health Affairs), the Director TRICARE Management Activity in conjunction with the Deputy Surgeons General created the Military Health System Optimization Team (MHSOT). In the overall ASD(HA) directed effort to create a benchmark health services delivery system and an executable funding program, twenty nine initiatives were identified in the overarching strategy for implementing the high performance military health system. Facility optimization was identified as Initiative #4 and quickly became the central focus of MHS reengineering. Herein is the MHSOT's multi-dimensional approach to System/Facility Optimization.

Our focus will shift from providing primarily interventional services to better serving our beneficiaries by preventing injuries and illness, improving the health of the entire population while reducing demand for the more costly and less effective tertiary treatment services.

Full implementation of this comprehensive optimization plan will result in a high quality, cost effective health service delivery system that will be understood by all its users and withstand the scrutiny of critics and cost analysts. We will be the benchmark health service delivery system in peace and war and the health services delivery option of choice for our beneficiaries. We will be a best-buy for both our beneficiaries and the Nation. Most importantly, our focus will shift from providing primarily interventional services to better serving our beneficiaries by preventing injuries and illness, improving the health of the entire population while reducing the demand for the much more costly and less effective tertiary treatment services. We anticipate significant cost avoidance as the need for interventional services diminishes.

MHS optimization has these underlying tenets:

- Effective use of readiness-required personnel and equipment to support the peacetime health service delivery mission.
- Equitably align resources to provide as much health service delivery as possible in the most cost effective manner - within the MTF.
- Use the best, evidence-based clinical practices and a population health approach to ensure consistently superior quality of services.

Our strategy includes development of these eight component tasks, coordinated and integrated into the overall plan:

- Determine the ideal standardized model for personnel readiness requirements and how to distribute them in peacetime.
- Determine the "cost of readiness" so they can be subtracted from the total DHP costs, yielding the true costs for the non-readiness service delivery portion of our mission.
- Use civilian "best practice" enrollment models to determine the reasonable potential system capacity based on readiness-driven staffing.
- Use "best clinical practices" and other initiatives to focus on population health and maximize quality, productivity, and consistency of MHS health services service delivery (clinical system optimization).
- Determine a uniform system which allows Services to accurately report and compare

workload delivered in our MTFs and through Managed Care Support contracts.

- Determine an allocation system which allows all Services to apportion resources based on comparable processes and equivalent reporting methods.
- Determine comparable metrics which allow the Services to report progress toward goals.
- Determine the requirements of a "most effective" health services delivery system using benchmarked business practices and analyze how to best augment our readiness-based staffing to maximize resource efficiency.

While several of the MHS initiatives can produce significant cost avoidance in the short term, MHS reengineering and resource realignment can only be accomplished in the POM cycle. Therefore, major components of this plan will be incorporated in the FY2002-FY2007 POM submission.

Charters, plans of action, and milestones have been developed and deployed. Many of the workgroups already existed without the integrated and coordinated focus and tri-Service commitment with active senior leadership involvement. Timelines vary - some are nearly complete while others will require several months to finish. The MHSOT provides weekly interim reports to the Deputy TMA/Surgeons General. The objective is to define and program for the most effective organization, facility by facility until the MHS is populated with the best solution in both business and clinical practices.

Implementation of these plans will lead to profound improvement in our service delivery methods as well as our ability to support staffing and other resource allocations. Many of the other MHS reengineering initiatives are critical inputs into our complete system. Policies on pharmacy redesign, role and number of lead agents, redesigned managed care support contracts, and the need for an integrated clinical information system are critically important to completing the optimization. Using the "most effective organization" approach to ensure adequate staffing and resourcing, we anticipate being able to serve more of our beneficiaries in the direct care system (our MTFs) where quality services are delivered for costs less than our civilian counterparts. We will clearly demonstrate the cost effectiveness of our system.

[Optimization Plan Home Page]
Last update: 7/16/99

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

SEP 10 2001

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (SAF/MI)
EXECUTIVE DIRECTOR, TRICARE MANAGEMENT ACTIVITY

SUBJECT: Medical Program Guidance FY03-07

The attached Medical Program Guidance (MPG) supplements the FY 2003-2007 Fiscal Guidance for the Defense Health Program (DHP), and sets forth a framework of requirements necessary to execute the Department's health care mission. Defined within this document are the core areas comprising the Department's health care program and the broad priorities that will shape the direction and structure of the Department's health care mission. The DHP must address a number of challenges that are summarized as follows:

1. Creating a stable business environment for the direct care system by ensuring that it is appropriately funded and focused on recapturing appropriate workload through optimization initiatives with substantive performance measurement;
2. Developing a new generation of TRICARE contracts, which have greater financial predictability, are simplified, create more competition, and reduce administrative costs;
3. Strengthening our ties to other federal healthcare systems, including the Department of Veterans Affairs and the Centers for Medicare and Medicaid Services, to optimize all federal healthcare resources.
4. Implementing the new TRICARE benefits for beneficiaries ages 65 and over, and establishing the accrual fund mechanisms for FY 2003.

This guidance should be used in developing the component submissions for the current DHP POM. The Executive Director, TRICARE Management Activity, is responsible for integrating component input and developing the Department's single Defense Health Program POM submission. The POM will be reviewed for compliance with this guidance during the program and budget reviews. Given the compressed program and budget cycle this guidance is intentionally limited to those aspects sustained solely through the DHP and accompanies the Fiscal Guidance which has been issued for the Defense Health Program.

My point of contact on this guidance is Mr. Ed Chan, the Program Director for Financial Plans and Policy, Office of the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy, who may be reached at 703-697-2111.

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Attachment:
As stated

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

Medical Program Guidance

POM FY 2003-2007

PURPOSE

The medical program guidance is issued to support the dual missions of the Military Healthcare System: 1) Provide a prepared and deployable medical force to support worldwide military operations; and, 2) Provide high quality and cost effective peacetime health care through operation of an integrated health care delivery system that sustains the health of members of the Armed Forces, their families, and other authorized beneficiaries with a focus on population health improvement. Given the desire to focus on sustaining and improving this world class health care system this guidance reflects unique and urgent requirements of a concurrent program and budget development process that emphasizes FY 2003, but is also intended to provide a blueprint for preparing for the FY 2004 –FY 2009 POM cycle. Given the compressed program and budget cycle this guidance is intentionally limited to those aspects sustained solely through the DHP and accompanies the Fiscal Guidance which has been issued for the Defense Health Program.

TRICARE

The DHP shall program during this review for a world class health care system that provides a predictable and stable program and performance profile using the most current FY 2002 baseline. By submission of the FY 2004-FY2009 POM, the program should be constructed using a common activity based resourcing model that links resources to performance goals and auditable measurement.

The DHP shall program and budget for the Services to expand direct care system capability, consistent with implementation of optimization objectives to recapture appropriate civilian sector provided care with a continuing emphasis on population health improvement. This program strategy must maximize efficiency, based on solid business case analysis and identify any programmatic tails associated with optimization investments.

The DHP shall program and budget for those product lines unique to the DHP such as pharmacy costs, TRICARE contracts, and blood program replenishment of stocks, etc. The DHP shall be particularly sensitive to and aware of experiences in the civilian sector where the MHS is subject to similar market forces.

The DHP shall optimize health care personnel recruitment, selection, utilization and performance with relevant, timely and focused education and training programs throughout the continuum of their careers.

The DHP shall continue the Military Health System Executive Review (MHSER) to monitor and manage the military health care system consistent with the stable business environment. DHP components shall focus priority on data quality of health care delivery workload and other statistics.

The DHP shall program and budget for all costs associated with the implementation of the FY2001 National Defense Authorization Act requirements and new benefits to include accrual funding for Medicare-eligible retiree health care in FY 2003.

The DHP appropriation will reflect the participation of MTFs in the newly established DoD Medicare-Eligible Retiree Health Care Fund. Beginning in FY 2003, the Medicare-Eligible Retiree Health Care Fund will be the funding source for all Medicare-Eligible retiree health care programs, including MTF care. The determined level of effort will be used to offset the Department's normal cost contribution to the DoD Medicare-Eligible Retiree Health Care Fund, and be reflected as an earned reimbursement for both the DHP and Component MILPERS accounts. The level of effort methodology used will also be the basis for projecting earned reimbursements from the fund.

The DHP shall program sufficient resources to fund advances in medical practice (AMP), exclusive of pharmaceutical requirements.

The DHP shall fund Real Property Plant Maintenance (RPM) at 3-percent of category code 500 building plant replacement value, taking into account the program definition changes associated with full sustainment, restoration, and recapitalization of facilities.

The DHP shall ensure implementation of the newly legislated Health Insurance Portability and Accountability Act requirements and the quality of care initiatives, with particular focus on coordination with other federal health care agencies as appropriate and will identify any unforeseen additional funding requirements as over-guidance requirements.

The DHP shall program for TRICARE contracts and other purchased care within the levels provided in the Fiscal Guidance and will identify any additional funding requirements as over-guidance requirements.

The DHP shall aggressively support the Services in the conduct of reviewing and achieving previously established objectives of the Competitive Sourcing and Privatization Program. Studies areas should include those broad areas with common tri-service functions.

The DHP shall implement critical "Manage the Business" processes and information systems that improve management and oversight of MTF level resource allocation, with particular emphasis on human resource accountability and management, and supports an accrual financing methodology for pricing workload that is auditable, equitable, and supports improved regional integration.

The DHP shall strengthen the TRICARE management structure through centralized program design and supervision with decentralized regional management and accountability by empowered TRICARE Regional Directors to optimally reduce infrastructure and support efficient regional contracting. Cost effective collaboration with the Department of Veterans Affairs for resource sharing shall be identified.

The DHP shall develop plans for the transition to a new generation of TRICARE Purchased Care Contracts, which must be reflected in the FY 2004 POM submission.

The DHP shall begin a Total Force Medical Personnel Zero Based Review to address medical recruitment, retention, training, shape of the force, and specialty mix issues.

Force Health Protection

The DHP activities shall maintain 95-percent of active duty personnel in Dental Class 1 and 2.

The DHP shall implement plans for surgeon trauma sustainment training. Develop and expand trauma team (specific for individual), enroute care provider, and first responder sustainment training.

The DHP shall plan and program annually for Weapons of Mass Destruction Mass Casualty exercises at each MTF.

The DHP shall program personnel costs for a level of medical readiness training that assures adequate initial training for all personnel and a minimum of five days of sustainment training per year for deployable platform personnel per DODI 1322.24, Medical Readiness Training.

The DHP shall program for the acquisition/development and integration of approved Information Technology capabilities to meet approved Force Health Protection (military medical readiness/theater) requirements, i.e., Theater Medical Information Program (TMIP).