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Hospital Transition Planning at Womack Army Medical Center, Fort Bragg, North Carolina

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HOSPITAL TRANSITION PLANNING AT WOMACK ARMY MEDICAL CENTER, FORT BRAGG, NORTH CAROLINA

Chapter 1

Introduction

Over the past 20 years, the Department of Defense (DOD) has built a number of new medical facilities or renovated existing facilities on military installations throughout the world. In the past 15 years, the United States Army has been the recipient of several brand new hospitals in the United States. The most recently constructed army hospitals include Madigan Army Medical Center (MAMC) located at Fort Lewis, Washington; Reynolds Army Community Hospital (RACH) located at Fort Sill, Oklahoma; and Brooke Army Medical Center (BAMC) located at Fort Sam Houston, Texas. The latest major army health facility construction project is the replacement hospital for Womack Army Medical Center (WAMC) located at Fort Bragg, North Carolina. In a time when defense spending is closely scrutinized, it is highly probable that this $250 million facility will be the last major army hospital built for a number of years.

Planning for the transition to a new hospital is a very complex task. It involves much more than simply relocating the facility's equipment and patients. When effectively carried out, the process of transition planning can make the relocation from one hospital to another seem almost easy. Given the fact that there have been several army hospitals built over the past 10-15 years, one might assume that some of the more challenging aspects of executing a transition plan would already be solved through the application of lessons learned from past experiences. Taking this assumption one step further, since WAMC is the fourth major army hospital

constructed over the past 10 years, one might also assume that the Army Medical Department (AMEDD) would be somewhat of an expert at the process of transition planning by now. This study attempts to prove this assumption at the local level by examining the transition planning process at WAMC. The purpose of this study is twofold. First, it will serve as a reference for use by transition planning offices that can be applied to future health care facility projects. Second and most importantly, it will provide the leadership at Womack Army Medical Center with recommendations on how to improve their transition planning process or reward them with the knowledge that they are either paralleling or leading the industry with a functional model that can be applied to nearly any health care facility transition project.

Conditions Which Prompted the Study

Change has dramatically affected the health care delivery systems for both military and civilian organizations. As the business of healthcare delivery continues to evolve, hospitals and healthcare executives are struggling to realign themselves to better meet their emerging needs. Issues such as capitation, collaboration, and increased accountability for community health status present challenges to healthcare executives and their management teams.

The U.S. Army's most recent modernization efforts can be observed at military installations around the world. Not unlike the current trend to provide better living accommodations to our soldiers, the AMEDD has been upgrading a number of older hospitals and clinics to provide better health and dental care. To better enable the delivery of efficient,

cost-effective medical care, hospitals need to be managed in a more business-like manner if they are to survive in a time of reduced reimbursement rates and cost-containment. Health care executives need to measure, evaluate, and determine the nature and scope of the health care services which will best serve their patient beneficiary population. This is one key reason the leadership at WAMC is experiencing some significant management challenges. The new facility's original design was approved back in 1991 and had a little over 400 beds. Many changes in health care have occurred since then, such as better technology and an increased emphasis on outpatient services and wellness. Bed census numbers for hospitals have declined. The WAMC replacement hospital was funded by congress based on the original design and a number of internal structural changes have been required. Several key design changes have already been implemented. Many of the desired changes can no longer be incorporated into the current construction project and will have to be accomplished during the retrofit period as separate construction contracts. Funding constraints may prohibit some changes even during the retrofit period.

The Health Facility Planning Office (HFPO), the on-site agent from the Health Facility Planning Agency (HFPA), works directly with the U.S. Army Corps of Engineers to affect any requested design changes. These are commonly referred to as engineering change proposals (ECP) and must be approved by the WAMC transition committee, the WAMC executive committee and the hospital commander. The Transition Office Complex (TOC) is the internal organization that is responsible for planning the transition to the new facility with oversight

provided by the WAMC transition committee. As one can imagine, even if there were no structural changes to the original hospital design, just the aspect of planning for the relocation to the new facility is quite an immense task. In addition, they are also responsible for acquiring the new equipment and furniture, planning for the occupation of the new facility, and for the reclamation stages of medical services. Once the new hospital is occupied and fully operational, the TOC focuses on turning over the old facility and equipment to the Fort Bragg installation. When the turn-in phase is complete, the TOC will stand down and its staff will be reassigned.

The TOC serves as the WAMC liaison to the HFPO for customer input to the new facility's design and operation. The move to the new facility is more than a relocation. It will also mark a change in the way that most divisions and clinics conduct their operations. The layout of the new facility is completely different from the current facility and will require an adjustment by all, to include both employees and patients alike. The organization has an obligation to employees, patients, and the beneficiary population to ensure that this transition minimizes turbulence.

During the author's orientation visit to the HFPO and the TOC, many questions were asked in an attempt to learn as much about the transition process as possible. It was quite apparent that both organizations played significant roles in the process of getting the new facility fully operational. Fortunately for WAMC, several staff members from both the HFPO and TOC had been involved in previous construction projects at MAMC, RACH, and BAMC. If these

experts were not available to share their knowledge and expertise at WAMC, similar mistakes or undesirable outcomes that had happened at the previous projects might occur again.

The U.S. Army is a big proponent for collecting lessons learned from actual military operations and major training exercises. The Center for Army Lessons Learned (CALL) at Fort Leavenworth, Kansas, maintains a database of lessons from past experiences so that many others may learn from a few mistakes. In the business of spending the taxpayers dollars to build brand new hospitals, one would assume that the AMEDD would have a collection of lessons from past experiences to prevent costly errors from happening again. During the initial research, it could not be determined that such a source of centrally maintained lessons from past transitions existed or was readily available to and accessible by the people who need it most.

Education is a key component of transition planning and when applied at the right time during the process, it can prevent undesirable events from recurring. As evidenced by the many military leaders who have trained at one or more of the U.S Army's Maneuver Training Centers, lessons are simply lessons unless they are applied to prevent a similarly undesirable outcome from happening again.

The literature is replete with articles that address individual hospital and medical office relocations. There are very few that address the detailed programmatics of transition planning, however, especially from the organization's perspective. The U.S. Army is fairly proficient at publishing doctrinal manuals that tell soldiers how to do everything from performing physical training to maneuvering a combined arms task force. As stated previously, one of the purposes

for conducting this study was to compile a reference manual or simplified guide to assist hospital transition planners. During the initial research at the beginning of this study, there was no evidence found that a U.S. Army publication on health facility planning or transition planning existed. A need exists for a doctrinal or "how to" manual that prescribes the best way to conduct transition planning for health care facilities. Even though further research revealed a locally produced manual that had been specifically developed for the WAMC project by the HFPO, the need for a simplified version or leader's guide to transition planning is still valid.

Problem Statement

The WAMC commander and staff deserve to know that the TOC is organizationally and functionally designed after a proven model that has recorded numerous successful transitions in both the military and civilian health care industry. Additionally, they need to know that the TOC is organized for cost-effectiveness with a focus on saving organizational resources through effective planning. If the TOC or the process it is using needs improvement, the WAMC leadership must be advised of the changes that should be made in order to make the planning process better and allow for a smooth and seamless transition to the new hospital. With this, the two primary research questions that must be answered are:

1) Is the current composition and function of the TOC at Womack Army Medical Center effectively preparing the organization for the transition to the new facility?

2) What changes, if any, can be incorporated to make the TOC more effective and cost

efficient?

Since the transition process will not be complete until late 1999 or early 2000, one limitation of this study is that it is almost impossible to prove the effectiveness of the transition process until after the move to the new facility is complete.

Background

WAMC and Fort Bragg is where the military and medicine meet. WAMC is at the forefront of military medicine delivered with a customer-service focus and is an innovator in providing primary health care to nearly 165,000 military-related beneficiaries in the 40-mile area surrounding Fort Bragg. WAMC's staff of approximately 2000 military and civilian employees work in close collaboration with civilian health care professionals in the local area to provide care for its population. The three largest health care areas are primary care, orthopedics and women's health. These areas reflect the diversity of young families having children and Fort Bragg being home to the U.S. Army's airborne contingency corps and special operations forces.

WAMC is the only U.S. Army medical center to be named after an enlisted soldier, Private First Class (PFC) Bryant Homer Womack. PFC Womack was a native of North Carolina who was killed during the Korean conflict. He was awarded the Medal of Honor for his courageous actions.

Prior to being officially activated as a medical center on October 10, 1991, WAMC was a community hospital built in 1958. The 50 year old facility is a 206-bed military treatment

facility and the organization has literally outgrown it. A number of clinical and administrative offices are located outside of the main hospital due to space limitations. As the organization grew, several buildings located near the main hospital were constructed or modified to house the overflow that could not fit in the main hospital building. Several WAMC clinics and storage facilities could not be housed within walking distance and are located several miles away from the main hospital. Nearly all of this will change with the opening of the new hospital.

In an effort to provide continuing quality care in a state-of-the-art facility, construction began on the new $250 million medical center in 1992. The new facility is scheduled to open in late 1999 on a 163-acre site one-half mile from the current medical center. The old facility will be turned back over to the installation with plans being made to use it for a consolidated in and out processing center and central issue facility (CIF). The new facility will be approximately one million square feet in size, more than twice the size of the current facility. For anyone familiar with Fort Bragg and the city of Fayetteville, one million square feet is approximately the size of the Cross Creek Shopping Mall in neighboring Fayetteville.

The replacement hospital is projected to open for patient care in the summer of 1999. The planned beneficial occupancy date (BOD), the date when ownership of the facility is officially transferred from the construction contractor to the government, is set for January 1999. This equates to a very ambitious 6-9 month window of time to complete all the necessary tasks prior to terminating operations in the old facility and commencing operations in the new facility.

The new hospital has undergone several interior modifications since it was originally designed. Several inpatient wards have been converted to clinical and administrative areas. At 920,779 square feet, the new facility will be approximately double the size of the current facility. It will include a six-story patient tower on the east side with a three story ancillary building in the center of the complex and a two-story clinic wing on the west side. The facility is being constructed with 287 beds during normal operations with an expansion capability to 431 beds during mobilization. The project is a multi-year phased project and funds in the amount of $250 million have been appropriated over a five-year period for its completion. Many technological advances will be realized with the opening of this new facility as the budgeted cost includes the purchase of new equipment for the facility. The new medical center will increase quality care and access to beneficiaries by bringing more medical and specialized resources to Fort Bragg. Some of the specialties added since the current facility became a medical center include cardiology, hematology-oncology, pulmonology, and endocrinology. Additional new services offered at the new medical center will include a level II nursery, cardiac catheterization lab, plastic and thoracic surgery, complicated obstetrics, and child and adolescent psychiatry.

In addition to the replacement hospital, the overall strategic plan for upgrading the medical facilities on the installation called for the construction of three new consolidated primary care clinics to replace a number of aging troop medical clinics located throughout the installation. Many of Fort Bragg's troop medical clinics are located in World War II vintage temporary buildings that have been used well beyond their intended lifecycle. The first

consolidated primary care center was completed in 1995 when the Robinson Health Clinic in the 82nd Airborne Division area opened for the more than 30,000 soldiers and their families. This $5 million clinic is named after Major General Roscoe Robinson, Jr., the division's first African-American commander. The remaining two consolidated primary care clinics currently under construction are the $12.2 million Joel Health and Dental Clinic in the 1st Corps Support Command (COSCOM) area and the $11.6 Clark Health Clinic in the Smoke Bomb Hill area. The Joel Clinic is projected to open in late summer of 1998 while the Clark Clinic is due to open in the fall of 1999. The Robinson, Joel, and Clark Clinics will provide outpatient health care to the Fort Bragg active-duty service members and their families.

Medical Military Construction Project Development.

Since the funding of a medical military construction (MILCON) project is unique compared to that of a civilian medical construction project, it is important to first understand how such a project is initiated. First, a statement of need is initiated by the requesting organization and submitted through their local installation command and their respective major medical command. The installation command initiates the MILCON process by developing the programming document, which defines the scope of the project. Normally, this is prepared by the installation Directorate of Engineering and Housing (DEH) after close coordination with the local medical center or medical department activity. The programming document, Department of Defense Form 1391 (DD Form 1391) is then entered into the 1391 processor, a computer program accessible by the U.S. Army major commands: Forces Command (FORSCOM),

Training and Doctrine Command (TRADOC), and the major medical commands. The major medical commands then prioritize their respective programs and submit them to the U.S. Army Health Facility Planning Agency (HFPA), the Army's proponent for medical facility planning. The HFPA is organized under the Office of the Surgeon General, Department of the Army. After review and prioritization, The U.S. Army Surgeon General's program is submitted to the Office of the Assistant Secretary of Defense for Health Affairs, Defense Medical Facilities Office (DMFO), for integration into the tri-service MILCON program. The background for facility planning will start with the Department of the Army once congressional approval has been gained for funding a new health care facility.

Before a project can be included in the President' s budget and presented to Congress for approval and appropriation, a project is reviewed and prioritized at several different command levels: 1) the major medical command's installation planning review board; 2) Office of the Surgeon General, U.S. Army Health Facility Planning Agency; 3) Department of the Army; 4) Department of Defense, DMFO. Once a valid requirement has been identified, an economic analysis may be necessary. According to the HFPA, economic analyses are required for all medical MILCON projects in the continental United States (CONUS) that service retired military personnel. The economic analysis influences the scope of a project, determining if it will be a replacement facility, an addition, or an alteration. Economic analyses are administered from the DMFO.

Programming and planning begins before Congress has authorized funding for a medical MILCON project. The development of the Program for Design (PFD) is the first step. The PFD provides the space allocation for every activity in the new or renovated facility. The DMFO organizes the study around the mission of the facility and the projected workload. At the request of the DMFO, the HFPA sends out a facility questionnaire to the subject facility. The necessary data such as workload, table of distributions and allowances (TDA), and catchment area are obtained from the local medical department activity through the facility questionnaire and matched against established Department of Defense (DOD) space planning criteria. The PFD is developed from this information. As approved by the Assistant Secretary of Defense for Health Affairs, the PFD becomes the basis of the functional concept design.

The PFD is given to the Medical Facilities Design Office (MFDO), U.S. Army Office of the Chief of Engineers and to the HFPA. These two activities work together closely to establish the design criteria and a document for obtaining the services of an architect/engineering (A/E) firm. An A/E selection board meets at the Office of the Chief of Engineers level to select and award the design contract. From this point, the A/E develops the total design package through a series of six submittals and design reviews. The A/E, MFDO, and HFPA and the medical facility staff are intimately involved throughout the design process.

The program objective memorandum (POM) establishes the desired construction start date and all service planning is oriented toward that date. The actual construction start date is

determined by the year Congress appropriates the money for the project. The contract cannot be awarded until Congress has authorized and appropriated funds for the project (HFPA, 1995).

Department of Defense Health Facility Planning Process.

The Assistant Secretary of Defense for Health Affairs, through the DMFO, establishes construction priorities for the consolidated Department of Defense (DOD) program. This includes planning, programming, and budgeting for all military health facility design and construction projects which requires congressional notification or approval. The DMFO further allocates construction funds to the various DOD construction agents and has final authority on issues surrounding the final scope of the project.

Department of the Army.

The U.S. Army Corps of Engineers is the construction agency responsible for construction contract administration, funds management, construction management, supervision and inspection, and transfer of accountability of completed construction for the Army. The Office of the Chief of Engineers is the headquarters of the Corps of Engineers and is consulted on all matters regarding program management and funds authorization.

The U.S. Army Surgeon General is the primary using agency and customer for major Army medical military construction (HFPA, 1995). In negotiations with the Office of the Chief of Engineers and the construction contractor, the U.S. Army Surgeon General is the user, not the local medical command. The local medical command is identified as the commander of the subject facility.

Health Facility Planning Agency.

The HFPA commander is the program manager and represents the Army Surgeon General as the user during the construction project. As the Surgeon General's representative he is responsible for the approval of all changes that have an impact on the medical aspects of construction. An HFPA representative will attend the quarterly Corps of Engineers management meetings and participate in a review of change orders, fund status, and construction progress. The HFPA also manages the transition funds for outside the continental United States (OCONUS) projects, less Hawaii and Alaska, and operational funds for all Health Facility Project Offices (HFPO).

Health Facility Project Office.

The HFPO is the designated field representative of the HFPA commander and the U.S. Army Surgeon General. This office is the on-site user's representative in terms of the construction project and acts as a liaison between the construction agency and the local medical activity and installation. The HFPO may be responsible for other MILCON projects as determined by the HFPA. In fact, the HFPO located at Fort Bragg is responsible for all U.S. Army medical MILCON projects in the Southeastern United States (Rinehart, 1997). The HFPO has the responsibility for health facility design and construction management for the replacement hospital, the Joel Health and Dental Clinic, the Clark Health Clinic, and a medical warehouse project for the 44th Medical Brigade at Fort Bragg. The HFPO also provides technical assistance

for other medical design and construction projects in the Southeastern Region of the United States.

Specific project management responsibilities for the HFPO include representing the HFPA as the user during design and construction, on-site representative for ECPs, on-site liaison for the Fort Bragg DENTAC and WAMC to the Corps of Engineers and the Office of the Surgeon General. Additional responsibilities include supporting the eventual user in planning, education, and transition needs, and assisting the Corps of Engineers with their quality assurance (QA) program. The HFPO at Fort Bragg is staffed with the following key personnel: chief, HFPO; deputy chief, HFPO; nurse methods analyst; HFPO Intern; two biomedical maintenance specialists; information management assistant; interior designer; furniture coordinator; facilities management and maintenance specialist; architect; network manager; and an office administrator.

Transition Office Complex.

The Transition Office Complex (TOC) is the prospective user's agent for managing the transition into the new hospital. The mission of the WAMC TOC is to facilitate the transition into the new replacement hospital. The TOC develops and executes the transition plan. The transition plan will include operations preparedness, equipment planning and procurement, staffing requirements, staff training, patient orientation and education, the patient move and the post-occupancy evaluation. The goal of the TOC is to have as little confusion and disruption in services as possible for the patients and the staff (Brocker, 1997).

The chief of the TOC is responsible for managing the overall transition effort for the WAMC commander. The chief manages the concepts of how the organization will operate in the new facility and interfaces with the hospital leadership and outside agencies. The TOC is organized with three sections under the direction of the chief: transition, logistics and information management. WAMC has also placed a nurse in the TOC as the clinical systems coordinator to study and make recommendations for the procurement of clinical and physiological monitoring systems.

The transition section is comprised of a transition coordinator, a resource management specialist and a marketing specialist. The transition coordinator is responsible for developing and tracking nearly 1,000 tasks that must be completed in order to move and operate in the new hospital. The transition coordinator is assisted by a move specialist and a training coordinator. The move specialist is responsible for planning the actual move to the new facility and the training coordinator is responsible for preparing an extensive training plan that will prepare the entire organization to operate the new facility. The resource management specialist plans the TOC budget and interfaces with the WAMC resource management division on issues involving transition funds. The resource manager also coordinates staffing requirements with the current medical center staff and manages space issues in the new facility.

The logistics section is responsible for equipment planning and procurement for the new medical center as well as the Joel and Clark Clinics. The logistics staff consists of a logistics officer, contracting specialist, logistics management specialist, property book specialist and an

assistant, an office automation clerk, and two warehouse management specialists. The logistics section identifies the type and quantities of equipment needed to make the facilities complete and fully operational on the day they are opened. Once the equipment is identified, an equipment summary list is generated and staffed throughout the entire hospital. The TOC logistics section assists the users of the equipment and the medical staff by researching potential sources for procuring the equipment, preparing the equipment summary list and completing the procurement packages.

The information management section coordinates the procurement, installation, training, implementation and support of all existing and new communications and information systems planned for the new medical center, the Joel Health and Dental Clinic and the Clark Health Clinic. The primary objective of the information management section is to plan and implement the best possible information and communication system possible (Hodges, 1997). The operational philosophy is that information is power, but true power comes from the ability to get the right information to the right person at the right time so the best decisions are made and appropriate actions are taken. Some of the planned systems for the new facilities include: 1) DOD Clinical Information System (CIS); 2) digital radiography; 3) physiological monitoring system; 4) video teleconferencing and telemedicine.

Literature Review

As mentioned previously, not many sources of literature were found that focused

specifically on the transition planning process as it pertains to moving into a new health care facility. One reason could be that the term "transition planning" also refers to the planning that is conducted for a patient to be moved from one level of care to another, usually transitioning from an inpatient to a long term care facility or just being discharged to go home.

Several articles addressed employee and patient associated health issues that were believed to be caused by being moved or relocated from one health care facility to another. Many of these articles looked specifically at long term care facilities or nursing homes. None of these provided much insight to the transition planning function of moving into a new health care facility.

Several authors address transition planning from the theoretical perspective and describe the roles and functions of the transition team members. Hosking (1995) devotes an entire chapter to describing the process of planning health care facilities and managing the development process. The author describes the importance of having an internal and an external planning team. Members of the internal planning team include the governing board, CEO, medical staff, user groups (key staff and physicians associated with a particular department), and an in-house planner. Hosking (1995) says that educating the internal planning team on the process of facility planning is the most important step in establishing a control mechanism for the internal functional planning team. In most cases, a health care facility cannot rely on internal resources augmented by an architect/engineer to conceive, orchestrate, implement, and activate a major facility development program. The need for an external planning team is best indicated by the

vast quantity of details required by the external regulatory and approval processes. A comprehensive external planning team consists of a facility planning consultant, equipment planning consultant, architect/engineer, financial advisor, financial feasibility consultant, fund-raiser, construction manager, legal counsel, and underwriter. The external team's composition is related directly to project complexity and the hospital's internal expertise and varies by project (Hosking, 1995).

In a pocket-sized booklet designed specifically for CEOs, Weeks (1992) provides a brief, yet superb assembly of transition activities that must be accomplished in health care facility planning. Effective transition planning and implementation is as critical to the overall perception of a quality project as is the actual construction (Weeks, 1992). Transition activities, a part of the construction phase, include crucial pre-move tasks that help to ensure smooth occupancy and initial operation of the completed facility. Both Hosking (1995) and Weeks (1992) suggest that a transition committee should be established early to oversee all aspects of the institution's involvement in the construction project and a transition manager should be appointed from that committee and must be a top priority for the CEO. Hosking (1995) and Weeks (1992) agree that management of the transition process must begin immediately after the award of the construction contract if the activities that rely on such management are to be completed and ready for use at occupancy and operation dates. These closely timed activities include equipment acquisitions, concepts of operations activities, and any other activities requiring long lead-times. The occupancy date does not signal the completion of the project. After occupancy, two important

tasks that must still be completed include reviewing the development process and ensuring that all aspects of the project have been documented correctly and thoroughly (Weeks, 1992). The author describes the responsibilities of the transition committee and the transition manager and their relationship with the HFPO. Although this booklet is an excellent guide to follow, the checklist for the HFPO appears to overlap with the responsibilities of the transition planning team. This seems to be a commonality with several sources of information that have been reviewed. The duties and responsibilities of the HFPO and the transition planning team overlap and may even be duplicated in some cases.

Munn (1992) discusses the importance of basing facilities planning on the overall strategic plan of the healthcare organization. Monitoring and planning for changes in facility structure are part of the institution's overall strategic planning process (Munn, 1992). Proper planning is the first step in transition project management and is essential in ensuring a smooth move into a new facility. Organizations transitioning to new facilities that begin with well-developed plans generally experience fewer problems and save costs in the end (Souhrada, 1990). A written plan and strong department organizational structure are crucial to a successful move (Saunders, 1979). Several noted transition experts agree that comprehensive advanced planning is critical to a successful move (Handel, 1983, Kuntz, 1980, Jaeger, 1990, Thompson, 1990, Pallarito, 1992). Their common essential steps to transition planning are: 1) Thorough planning; 2) an interdisciplinary approach; and 3) clear communication among all involved.

Handel, Hilling and Lingo (1983) offered an approach they used while at Vanderbilt

University Hospital, a 561 bed facility that was to be moved into an inpatient replacement facility. The management approach included the definition of objectives (planning), the establishment of a management structure (organization), the assignment of tasks (direction) and the implementation of monitoring mechanisms (control). The outcome was a highly successful move of 309 inpatients without any undesirable outcomes (Handel, 1983). One of the primary reasons for this success was the decision to intentionally emphasize transition planning rather than simply move planning. Vanderbilt's transition objectives included the following: 1) Adopt a management structure that would ensure adequate integration of related activities as well as establish effective controls; 2) provide for maximum involvement of the hospital staff at all levels of the organization, including the medical staff; 3) involve the community in the transition; and 4) minimize the psychological stress of the move by comprehensively training and orienting the staff. One of the most important developments before the move was the publication of an initial operating guide that was distributed to all hospital supervisors and clinical services. It contained everything anyone would want to know about the new facility to include detailed department summaries, building descriptions, general policies, systems descriptions, and pertinent safety and emergency instructions. The post-move activities firmed up the success of the transition by maintaining strong communication throughout the hospital and directing immediate attention to issues. This was accomplished by holding additional meetings with department heads, administrators, move coordinators and head nurses. Key administrators carried pagers on a 24-hour basis to ensure immediate availability for problem

resolution and enhanced communications.

Schwartz (1977) states that an occupancy project is an exacting project that demands systematic planning, accurate timing, and close cooperation among hospital departments, equipment vendors, installation subcontractors, professional movers, and the personnel who are relocating. The author highlights useful concepts and techniques employed by the management team at Mount Sinai Medical Center, New York City, during a three year program to activate the medical center's new 31-story Annenburg Building. In this particular project, complex network techniques such as PERT and CPM were avoided. The move managers found straightforward charts, tables, and graphs were more than adequate for determining the interdependency of activities, for manipulating time or resource variables, and for predicting bottlenecks. Times have changed since this article was published, but the desire to keep the planning tools simple and understandable by all are still valid recommendations.

Thompson, Parenti, and Peterson (1990) address the planning aspects of moving into a new 845 bed Veteran's Administration Medical Center in Minneapolis, Minnesota. The length of time devoted to the planning process allowed the hospital personnel to undertake planning the move along with their regular duties and without the need for additional staff, plus allowed for very detailed planning. In this article, the authors present a two year timetable that identifies key activities that were completed to assist them in accomplishing the transition to the new hospital in addition to checklists for the movement of patients and equipment. The article also highlights the duties and responsibilities of the key players involved in the planning process.

Numerous articles offer insight to the ways in which hospitals and clinics facilitated their moves into new facilities. Most are restrospective reviews but offer worthwhile considerations to their planning and execution techniques. Sheppard (1979), Handel (1983), Hanlon (1978), Kuntz (1980), Humphreys (1987), Estep (1986), Bunning (1982), Gray (1987), Hughes (1981), and Powers (1982) all provide valuable lessons from different facility moves. Key similarities from all the moves included the importance of having a plan, remaining flexible, and maintaining open communication to the entire organization. Although the conditions for each move varied, each facility broke their move into two main parts: the non-patient move and the patient move.

Hanlon (1978) provides an excellent overview of San Francisco General Hospital's move into a newly constructed facility. The hospital administrator chose to form a central planning team led by a consultant who specialized in governmental planning to manage the broad activities of the move. The team found the critical path scheduling technique to be the most useful in determining the order of tasks to be completed.

Hughes (1981) discusses the shortfalls in manpower projections for the new Victoria General Hospital in Victoria, British Columbia. The very process of planning the staffing needs for the new hospital meant putting the existing hospital's organizational structure and objectives under a microscope. The 100 year old existing facility had simply evolved over time and it was not known whether the way in which it operated was the best or most efficient. The organization conducted a detailed analysis to determine how the hospital's operations would change in the

new facility. Soon thereafter, an analysis was conducted to determine the appropriate staffing for the new facility. The result was an estimate that nearly 70% of the jobs in the new facility would be changed in some fashion while 20% would be totally changed.

A number of articles reviewed for this study focused on the physical and mental health impacts of moving patients from one health care facility to another. Another abundant source of literature related to the relocation of hospitals was found that centered on the the psychological and social impacts of changing the physical environment for employees. Although not specifically used for this study, these articles were referred to WAMC's Chief of Mental Health Services and to the TOC for use in planning. This topic most certainly deserves further analysis in the planning process based on previous military hospital relocation experiences (Harder, 1998).

Purpose of the Study

The purpose of this study is to develop a reference guide to transition planning based on an in-depth literature review, a comparative analysis of WAMC's transition office to other transition teams used by both military and non-military hospitals, and lessons learned from past new health care facility construction and relocation projects. Developing an understanding for the history, roles, characteristics, and current focus of transition planning teams is essential to this study. The ultimate objective of the study is to determine if the Transition Office Complex (TOC) is an appropriate model for all health care facility transitions and whether or not it can be

improved to better enable the transition to the new Womack Army Medical Center. This study will provide answers to the following questions: 1) Is the TOC effectively managing change? 2) When a civilian hospital builds a new hospital, how do they manage the transition process? 3) How do the functional responsibilities of the TOC compare to that used by a civilian transition team? 4) Is the transition team staffed from within the organization or with members of a consultant firm?

Chapter 2

Method and Procedures

The method of research used in this project is a telephonic survey to recently constructed hospitals and consultant firms specializing in transition planning. Qualitative research is best for this project since the primary purpose is to describe events and methods as opposed to determining causality. Qualitative methods of research allow the researcher to draw meaning from the participants experiences and perceptions, consider the underlying values as part of the phenomena, and gain a better understanding of what is happening through interaction and inquiry (Morse, 1992).

Morse (1992) states that one of the key strengths of qualitative research is its reliance on multiple sources of data rather than a commitment to any one source of information. The individuals who have the information are solicited while in quantitative research the individual may never be selected in the random sample. A key disadvantage of qualitative research is that it lacks predictability and the researcher cannot forecast what the results will look like (Maanen, 1982).

This study was conducted by compiling relevant information through various means. The mechanisms included a thorough literature review of both public documents and local command documents. Numerous interviews were conducted with many WAMC staff members, key transition planners from previous U.S Army hospital construction projects, and HFPA staff. A site visit was conducted at the U.S. Naval Medical Center at Portsmouth, Virginia, where a new

acute care center is nearing completion. Follow-up interviews were conducted with twenty different hospital transition planners that participated in a previous study by Page (1997) who had recently experienced moves into new facilities. Interviews were also conducted with nationally reknowned consultant firms specializing in hospital transition planning.

The findings of this study were obtained by conducting a follow-up query to a survey that was specifically designed by Page (1997) for hospital transition planners. The purpose of the follow-up interviews was to confirm and clarify information previously reported for use in this study. In addition to the follow-up query of the 20 hospitals previously surveyed, 20 consultant firms were surveyed to determine if any patterns could be identified in the size, composition and scope of responsibilities of transition planning teams. A list of the hospitals contacted and a copy of the telephone survey are located at Appendix B and C, respectively. A list of consultant firms contacted and a copy of the telephone survey are located at appendix D and E, respectively.

The telephone interview method presents a cost savings advantage over conducting interviews in person. In fact, Cooper (1995) found that cost was one of the most significant advantages to using telephonic interviews for research. When respondents are geographically scattered, the telephone is much more economical than the cost of travel to conduct interviews in person. Added technological features such as voice mail and answering machines allow the respondent time to prepare for the interview and select the time best for them to call back to provide their feedback. Using the telephone for conducting research is not without some disadvantages, however. Surveys cannot be conducted if the respondent is away from the phone

when the interviewer calls. Making appointments in advance, or "booking" a call, is one way to help eliminate this problem. Another problem stems from the high percentage of people who move or change jobs. This was encountered in this study when conducting the follow-up query to the hospitals. The small number of personnel changes that had occurred since the survey was conducted was not significant since the replacement personnel all were knowledgeable enough to answer the follow-up questions. The inability to use visual aides is another disadvantage to conducting telephonic interviews. Some studies suggest that the response rate in telephonic surveys is actually lower than comparable interviews conducted in person since respondents could more easily terminate a telephonic interview (Cooper, 1995).

Although the original survey was designed to question hospital transition planners about their relocation experiences, the follow-up query focused specifically on the organization of the transition team and any lessons they learned in the process that were previously unknown to them. The information collected previously was simply verified by the respondent for use in this study as necessary, but the objective of the follow-up survey was to identify any patterns of similarity between the transition planning elements used by the various hospitals.

Design guidelines adhered to in developing the original survey were: 1) Providing a survey overview to the interviewee; 2) Clarity of questions was ensured by using short, familiar wording; 3) Sentence length limited to 25 words or less to facilitate short-term processing and long-term memory retrieval; 4) Complex questions were reduced to smaller component questions; 5) Survey length was kept short with a minimum number of repetitious questions so

as to promote honest answering, reduce guessing, and minimize answering off the top of one's head or recollecting extreme cases to shorten their responses (GAO, 1993).

Interrater reliability is a measure of consistency among the various people categorizing the answers to the survey. Content analysis and interrater reliability was enhanced by having additional personnel conduct the same exercise (GAO, 1991). A colleague verified the categorization of responses according to questions by placing like responses into similar groupings. Numerical responses were more easily categorized than the responses to the open-ended questions about lessons learned and composition of the transition teams.

There were no preliminary tests or pilot studies conducted as part of this study. A pilot study would have been beneficial to the overall project had time not been a constraint. It would have provided the researcher with information to make modifications to the research design and improve the data collection methods and results. Since the original survey was conducted by telephone, the follow-up method of telephonic survey was chosen in order to obtain a 100% response rate. Taking into consideration the recency bias, social desireability bias, and tendencies to extremes of telephone surveys over mail bias, the telephonic survey was still determined to best meet the needs for this research project. Personal interviews would have been the preferred data collection method, but economic and time constraints prohibited their use.

There are both advantages and disadvantages to using surveys with essay or open-ended questions. Although a survey with these types of questions can provide incomplete, non-standard, or even ambiguous answers that are difficult or impossible to use in a project

conducting a quantitative analysis, there are noteworthy advantages. The use of open-ended questions can aid the researcher in developing a list of alternatives for close-ended questions, especially when there is uncertainty with the criteria. They also allow the interviewee to respond to the question while providing clarification to the subject that cannot be gained from the more structured alternatives.

The hospitals that participated in this study were selected based on meeting one of two criteria. They must have been hospitals that had either recently completed a transition to a new facility or were currently in the process of transitioning to a new facility. The list from which the hospitals were selected was generated from four different sources: 1) Recommendations from healthcare executives; 2) national healthcare transition planning consultants; 3) hospitals that had recently completed transitions to new facilities; and 4) hospital moving specialists. Twenty hospitals were selected and surveyed as a convenience sampling. Since this project is a follow-up to a previous study, the same sampling of hospitals was used for this study. This project also incorporates a survey of twenty national healthcare transition planning consultants. The list of consultants came from a listing of members of the American Association of Healthcare Consultants (AAHC) and twenty firms were randomly selected for inclusion in the survey to determine transition team composition. Challenges in the collection of data arose only with a few of the consultant firms. Not unlike what Page (1997) encountered with his study, the consultant firms were generally very courteous but most were more interested in selling their services than in answering survey questions. However, the fact that this survey was to simply

follow-up on information provided previously, the amount of time required to adequately answer the survey proved to be less time-consuming than the first time it was administered. There were several encounters with consultants whereby deals were attempted in order to obtain information in exchange for them answering the survey. These were successfully negotiated without any unethical commitments by the author. Another barrier to the conduct of this study was identifying or locating the intended respondent. In some instances, the intended respondent had either changed positions within the organization or departed the organization altogether. Fortunately, all the intended respondents were reached and most were more than happy to assist by completing the survey either at the time of the call or at a later time more convenient to them.

With regard to the survey of consultant firms specializing in transition planning, the questions were very straightforward and relatively simple to answer. However, most conversations tended to get sidetracked with how the firm might be able to provide a service either now or in the near future to the author at his present or future organization. No agreements or commitments to these offers were made.

Validity and Reliability

The concern of validity and reliability are important measures that any study must consider in the construction and interpretation of any data collected. Yin (1989) recommends several techniques to enhance construct validity and reliability. To enhance construct validity, he recommends the use of at least one of the following techniques: multiple sources of evidence,

establish chain of command, and have the draft case study reviewed by key informants. This study applies two of the three techniques to enhance construct validity: multiple sources of evidence and a review of the case study by key informants. These informants include, but are not limited to the author's preceptor, other key WAMC staff members, and several noted experts in the AAHC that specialize in transition planning. Reliability in the study was ensured by establishing and maintaining all documents, notes, and articles utilized in this study. Recognized as a limitation in this study, the true test for reliability cannot be achieved until several months after the transition to the new hospital is completed and a retrospective analysis of the entire process can be conducted (Fine, 1997).

Type of Analysis and Study Design

This study incorporates a qualitative study design to evaluate and determine the proper size and function of WAMC's TOC. TOCs from previous military hospital construction projects and transition teams from civilian hospital construction and relocation projects are compared and contrasted to determine an appropriate mix of membership and function. Additionally, common lessons from past experiences are introduced to support the findings. Two primary research publications were used in the preparation of this study: Case Study Research: Design and Methods (1989) by Robert K. Yin, and Qualitative Evaluation and Research Methods (1990) by Michael Q. Patton. Yin's book proved to be the most helpful in the preparation of this case study.

Ethical Issues

To ensure that this study complies with all ethical guidelines, everyone interviewed was informed of the purpose, the nature of the study, and that they had the right not to participate in some or all parts of the process. Additionally, everyone was allowed the right to provide information under complete anonymity with strict confidentiality maintained.

Chapter 3

Expected Findings and Utility of Results

During the course of this study, it was anticipated that WAMC's TOC composition and function would turn out to be very similar to the transition teams that served some of the most recent military health care facility construction and relocation projects. It was also anticipated that there would be some differences from the way civilian health care facilities conduct transition planning. The extent of these differences was not known.

The utility of the findings of this study are threefold. First, it will provide the commander and the senior staff of the organization a critical self-examination of its transition planning team. Secondly, by looking at how other organizations have conducted their transitions, it will provide a guide for WAMC and other military health care facilities to follow. Lastly, WAMC can incorporate other management techniques that will allow the medical center to better enable the transition to the new facility and ultimately make the entire process easier for the employees and the patients.

Results

Results from the follow-up to the survey previously conducted by Page (1997) revealed the same results that he had reported in his study. Before summarizing these results, it is important to understand the intent behind this follow-up. Many of the questions asked in the survey offered an option for the interviewer to ask for clarification. Since the original study did

not contain transcripts of the telephone interviews, there was no other way to obtain additional information from the person being interviewed than to ask them individually. Significant points of clarification are further highlighted in this section.

The follow-up survey was directed at the transition planners of twenty different hospitals asking questions related to the transition to their new facility. A list of hospitals surveyed and a copy of the survey is located at appendix B and C, respectively. All twenty hospitals selected for the original survey provided responses.

When questioned on their transition organization, it was confirmed that all twenty hospitals had used a transition planning model that consisted of a steering committee in conjunction with sub-committees. The number of sub-committees ranged from five to fifteen, with six being the most common response. Nine of the twenty hospitals used a consultant organization as their transition team. Eleven of twenty hospitals, just barely the majority, used their own staff to develop and implement their transition team. These two areas were significant points that required clarification with regard to the transition organization and the consultant services used and will be addressed further in the next chapter.

The responses for the three most important transition areas that senior management must identify and address included: facility readiness (85%), the patient move (75%), equipment selection (60%) and training (60%). Equipment selection and training received the same number of responses and tied for the third most important transition area.

The responses to the question of who was responsible for identifying and assigning responsibility to major transitional tasks revealed a variety of answers. The most common response was that the transition consultant was responsible (50 %), whereas 30% reported that the subcommittees were responsible, 10% reported that the transition task force was responsible, and the remaining 10% reported that it was a combination of the transition task force and the sub-committees.

The responses to the question of what the most important factors in designing a transition team organization included: allowing sufficient time for planning the transition (90%), selecting the leader of the transition team (75%), and selecting the transition sub-committee leaders (60%). This was another area that required some clarification and will be addressed further in the discussion section of this study.

Responses to the question asking what methods were used to track the completion of transition tasks included: the use of action item lists (80%), self-designed paper charts (60%), and Microsoft (MS) Project Software (35%). Further clarification revealed that several organizations started with a software-based project management approach, but as the volume of tasks increased, they switched to a manual approach. The reasons given for the switch were primarily based on the lack of training in using the software effectively.

Responses to the question regarding methods used to train the employees included: annual hospital training in the new facility (85%), creating equipment prototypes and simulations of work stations (60%), and a systems approach to how a patient moves through the facility

(50%). With regard to how employees were oriented to the new facility, 100% replied that they provided tours of the new facility. Additional responses included: exploratory games such as scavenger hunts (60%), and the use of mock work stations and simulations using new equipment (55%).

Responses to the question of what methods were used to overcome resistance to change and decrease relocation stress in employees varied greatly. Five of the twenty hospitals (25%) did not address these issues in their transition plan. Several hospitals reported that relocation stress was not a valid concern due to the age and condition of the older facility. The leadership of these hospitals felt that their staffs were excited and motivated about moving into the new facility. When asked how they had made this determination, most stated that they had conducted a survey of their employees. The most common methods used to overcome resistance to change and decrease relocation stress included the following: 1) Involve the staff in transition activities; 2) increase the flow of transition information through newsletters and by distributing the minutes of committee meetings over electronic mail; 3) reengineer work processes in the old facility to resemble the way services would be provided in the new facility; 4) celebrate major milestone accomplishments; and 5) educate the staff on how to cope with relocation stress.

Responses to the question asking for favorite transition success stories were also quite diverse. The most common responses included selecting the right individuals within the organization for key transition team and committee positions, hiring Allied Hospital Services, Inc., as their moving agent, and keeping the staff motivated and involved throughout the

transition planning process helping the staff to maintain the relocation as a top priority. The children's hospitals allowed the parents of the patients to move to the new facility, which helped the families to accept the new facility more readily. Another response centered around using staff members instead of department managers to manage transition activities. The department managers were allegedly too involved with daily operations to devote the necessary time to effectively manage the relocation details. Several facilities responded that moving equipment and furniture into the facility early helped to reduce the time required for the actual move.

The most common response to the question regarding the major problems experienced and what they would do differently next time was the following: eight of the twenty hospitals (40%) said their move went extremely well and they would not change anything. Several organizations wished they had addressed employee personal behavior problems and established new policies to eliminate this behavior prior to the move into their new facility. Many organizations wished they had appointed a member of senior management to be responsible for equipment acquisition during the transition. Critical equipment purchasing decisions were untimely, causing unnecessary stress and putting them behind schedule. Several facilities planned to have new medical equipment delivered to the new facility one week prior to the patient move due to lack of warehouse space. This caused stress for the department managers as they were uncertain that the equipment could be installed and certified for use prior to the patient move. They recommended that all furniture and equipment be delivered at least 30 days prior to the patient move. Several organizations wished they had started the planning process earlier.

Many replied that they did not begin their transition planning efforts until 6-10 months prior to the patient move. Most of these organizations were involved in significant expansion or relocation projects. Lastly, several organizations stated that they would focus more on preparing the staff for relocation stress if they had to do it again.

The remaining questions from the original survey were not asked as they were beyond the scope of this study. They focused on specific issues pertaining to how ancillary services, emergency room, operating room, and obstetric services were provided during the actual move. However, the responses to these questions are certainly useful to WAMC in the transition planning process and will be referred to the TOC for review.

The second part of this study involved conducting an additional survey with twenty consultant firms that specialize in hospital transition planning. The list of consultant firms surveyed and a copy of the survey used are located at appendix D and E, respectively. All twenty consultant firms selected for the original survey provided responses for a 100% response rate.

The first question posed to the consultant firms was what the typical size of their transition planning team was. Responses varied between nine and seventeen members. Five of the twenty firms questioned (25%) provided the most common response which was thirteen. Nearly all the firms stated that the size of their team depended on an initial assessment of the facility and the agreements made between the organization and the specified duties of the consulting firm. Several firms added that the number of members on their team also varied with

the level of experience of each member.

The second question asked what the typical composition of their transition team was. Most firms said they would need to know what the specifics of the job were to adequately provide a response. In specific, they wanted to know the number of employees working at the facility, the size of the facility in square feet, the size of the population served, and the level of participation expected from the organization in order to provide an accurate answer. Once they understood the situation at Fort Bragg with the relocation of WAMC to the replacement hospital, the most common response included: a transition team leader with three to four subgroup leaders charged with responsibility for facility readiness (plant and equipment), move planning (patient move and departmental moves), and operations preparedness (policies, procedures, training and orientation). Some of the responses functionally identified each individual and their responsibilities, but for the most part they were very similar. Some of the firms that normally provided larger teams included architects, engineers, financial managers, public relations, marketing, and information systems personnel in their team compositions.

The last question asked the firms to analyze the WAMC TOC in conjunction with the HFPO and offer their opinion as to whether it seemed more than adequate, adequate, or less than adequate in size and functional composition. A brief description of the TOC and HFPO was provided along with the date when the transition planning process began nearly three years ago. Fifteen of the twenty firms (75%) replied that it seemed more than adequate while the remaining

five firms (25%) replied that it seemed adequate to handle the transition to the new facilities. None of the firms responded that it was less than adequate.

Additional findings of this study included the fact that the U.S Army does collect lessons learned from past health facility construction projects. They are collected and submitted in the form of a post occupancy report. The transitioning organization is responsible for submitting this report to the U.S. Army Medical Command (MEDCOM) and the HFPA within the first six months after their move is complete (HFPA, 1998). As for a lessons learned database, one is being developed by the HFPA that can be accessed and searched through their Internet website. The completion date is unknown, but is anticipated to be within the next six months.

The WAMC TOC and the HFPO have copies of the post occupancy reports from Madigan Army Medical Center (MAMC) and Brooke Army Medical Center (BAMC) and have reviewed them as part of their transition planning process. The post occupancy reports for each facility along with the direct experiences of several TOC employees who took part in previous transition projects have been very useful in incorporating engineer change proposals for the new WAMC. In fact, the HFPO and WAMC TOC organizations were modified as a result of shortfalls identified from previous transitions.

Several members of previous U.S. Army transition offices provided some insight to the problems they experienced at their respective facilities. Some of the more critical areas included overlooking the changes in technology as they pertain to automation and information systems. Another was lacking the foresight to enforce standardization with medical equipment. The

impact of this particular shortcoming was a significant strain on the biomedical maintenance staff to maintain a variety of different medical monitoring systems (Wagner, 1997).

Chapter 4

Discussion

Planning and implementing a major construction, renovation or consolidation project at a health care facility is a long and arduous process. In order for the organization to provide quality patient care and support services, a detailed transition plan must be developed which enables the users to successfully transfer or start-up their functions to the new facility in an organized and efficient manner.

A well-developed transition plan accomplishes four major objectives. First, it provides organization to the transition process by placing the massive amount of detail required into a logical and manageable format. Second, communication tools are developed through the creation of centralized documents. Third, coordination is enhanced by the provision of a plan that accomplishes essential tasks in an efficient and timely manner. Finally, control and accountability are insured by assigning responsibility for all transition tasks and empowering those responsible with the authority to accomplish their tasks.

The transition planning process begins with the gathering of information through interviews with the hospital leadership, department heads, and key members of the hospital staff. Once the general concept of how the organization will operate in the new facility is determined, normally by the executive committee and senior leadership, the department heads provide their concepts of how their respective operations will be conducted. After the operational concepts are approved by the transition committee and ultimately by the executive committee, they are

matched with the necessary equipment, staffing, and space requirements to generate documents that are compiled for further analysis and funding approval. From this point action plans are developed for equipment and furniture acquisition, automation and information systems, staffing requirements, proposals for structural modifications to the new facility, and training requirements. The plans are then compiled along with any other pertinent information in documents that are passed back to the appropriate staff members and committees with guidelines for implementation. Incrementally scheduled reviews are scheduled to monitor the progression toward meeting the milestones established to keep the transition process on track with the most significant date being the projected BOD.

All facility managers have an important role in the transition planning process. Overall responsibility for the project lies with the CEO and the senior management team. They are charged with providing guidance and direction on major issues and making sound decisions in a timely manner. The organization's department chiefs, managers and supervisors are also very important to the transition planning process. They are responsible for the successful transition of their respective area to the new facility. This includes maintaining open and timely communication with their subordinates and superiors alike, orienting and training their staff, and implementing their piece of the transition plan. The success of the transition will heavily depend on the commitment of the middle and junior managers within the organization.

Comparison of Findings

The literature reviewed for this study supports the functional design and composition of the WAMC TOC. Both Rowland (1984) and Wolper (1995) outline the process of facility planning which address the planning for construction of new facilities. The DOD and U.S. Army facilities planning process seem to be properly aligned with these models. There is some uniqueness in the government model that is not found in the public or private sector, but fundamentally the process is similar. Transition planning at Vanderbilt University Hospital most effectively emphasizes a common sense approach using fundamental management techniques (Handel, 1983). The process used at Vanderbilt most closely resembles the process in use at WAMC. Most of the literature reviewed for this study simply did not address in any detail the transition planning process. The focus of the articles tended to center around specific cases of how a department or facility moved to another location and the problems they encountered. Each case provides valuable information to the transition planner, but the physical move is only a part of the overall transition planning process.

The results from the surveyed hospitals provide insight on transition planning in different hospitals. All sources surveyed stated that they created a series of committees by which decisions were made and transition strategies implemented. Like the transition planning effort at WAMC, the committee structure incorporated a steering committee and a series of sub-committees. The steering committee served as the oversight body and focused on hospital policy, while the sub-committee focused on procedural issues. The WAMC Transition

Committee, chaired by the medical center chief of staff, is the transition steering committee for the organization and reports directly to the WAMC Executive Committee. Examples of the issues addressed at the transition committee level include: key systems issues, concept of operations approval, and specific guidance for move planning, licensure issues, and equipment reclamation.

Like WAMC, hospitals surveyed for this study reported that their sub-committees are established with specific purposes and timelines by the Transition Steering Committee. WAMC made use of pre-existing product line committees in some cases to address specific tasks for resolution. Sub-committees are required to report to the Transition Committee regarding progress on their respective issues or tasks.

In the study conducted by Page (1997), six main components most often used in transition planning were identified: the milestone schedule, planning committees, project overview handbook, department transition manuals, patient move handbook, and an orientation program. The milestone schedule addresses issues that affect the overall occupancy of the new facility. Planning committees are used to carry out and oversee the development of the transition plan. A project overview handbook is compiled early in the process to guide team members through the planning sequence. Departmental transition manuals contain the occupancy plans and schedules of each respective department in the overall move plan. A detailed patient move handbook is necessary when patients are being transferred to the new facility. And in all cases, a

comprehensive orientation program needs to be developed for all employees, medical staff, volunteers, members of the community, and vendors.

The time and energy required to prepare a detailed transition plan is great. Those with military operations backgrounds can correlate this to the amount of time, effort, and attention to detail required to prepare an operations plan. A newly constructed facility will not remain empty for long no matter how much time and effort has been put into the transition plan. The research shows that several benefits can be achieved by organizations that take the time required to develop a detailed and highly organized transition plan. Good planning allows an organization to maintain its operational integrity without losing sight of the mission that must be accomplished and the objectives that must be met. Detailed planning of the patient move process and the patient unit orientation program assure consistent delivery of patient care. It was reported that various licensing agencies are beginning to request a review of the facility's written transition plans (Newland, 1997). A transition plan helps the organization maintain continuity throughout the transition, provides an accountability mechanism by identifying roles, responsibilities, and suspenses for specific tasks, which helps eliminate confusion and potential conflicts. Staff productivity is enhanced because everyone knows their role. They know what to do, where to do it, how to get it done, and when it must be completed during the move process and within the new facility. This helps to lower stress and reduce anxiety for all employees and helps to insure efficient use of available resources. Finally, participation in the transition plan development creates pride and a sense of ownership toward the new facility.

The results from the survey of the consultant firms help to validate the transition planning model in use by the U.S. Army. Specifically, these results help to substantiate the organization and functional composition for the WAMC TOC. The survey results from the consultant firms and the hospitals provided a varied response regarding the size of their transition team. The survey results were not sufficient to draw a conclusion as to the most effective size of the transition team. However, they were sufficient enough to draw a conclusion on the functional composition. How each firm chose to staff the key functional areas of their transition team varied with the specifics of the hospital they were helping to transition. None of the firms felt that the WAMC TOC and HFPO were insufficiently sized or poorly organized. In fact, 75% of the firms surveyed felt they were more than adequately sized and functionally organized to meet the needs of the hospital and clinics for which they were responsible. The remaining 25% felt that they were adequately sized and functionally organized.

Although the results of the two surveys for this study show a wide variation in the size of transition planning teams, the WAMC TOC is sized appropriately with the necessary functional expertise to carry out its mission. An organization chart depicting the WAMC TOC is located at appendix F. The TOC organization has requirements for a 28 member staff. Due to personnel shortages, they are manned with a little over half of their required staff. The planning processes in use by the WAMC TOC are very effective and soundly based in common sense. They center around attention to detail, a total integrated systems approach involving the analysis of each specific process, and the use of automated management tools to both simplify and enhance the

tracking of milestone accomplishments.

An example of one effective TOC process is highlighted by the sample transition booklet located at appendix G. This is a sample of the initial booklet used by the TOC to coordinate the requirements for information needed for transition planning by each level of manager at WAMC. This sample transition booklet is for the Ambulance Section Chief from the WAMC Emergency Department, but the structural outline is similar for each section, department, and division within the organization for developing their concepts of operation (McCracken, 1997). Another highly effective communication tool in use by the TOC is the monthly newsletter they publish, located at appendix H. The TOC queried the WAMC staff in late 1997 to determine the general level of knowledge about the replacement hospital and the new consolidated clinics. The results were published in the newsletter along with short articles designed to educate the staff on the transition to the new facilities.

Existing product line committees, resident medical experts on the staff, and process action teams were all used to help determine the standardized equipment needs for the new facility. The TOC incorporated a senior U.S. Army Nurse Corps officer to manage this extremely important task. Her clinical expertise was instrumental in coordinating with the technical equipment sales representatives and explaining the advantages and disadvantages of the biomedical monitoring equipment to the medical staff. She also provided an added advantage of being a trusted leader within the hospital with a solid rapport with the physicians and nurses. Recommendations were made by the process action teams to purchase specific features, not

brands, and then the action was passed to the logistics section for acquisition. Nearly all of the biomedical monitoring equipment went through a similar process to be identified for acquisition. This process helped involve many staff members in the transition process and made them feel like they had made a worthwhile contribution to the new facility. Several staff members who served on these process action teams expressed concern that they had made the right choices since their fellow staff members will have to work with their equipment decisions.

The WAMC TOC incorporated lessons learned from past transitions with the assistance of the HFPO through the review of post occupancy reports from MAMC, RACH, and BAMC. More importantly, personal experiences from members of past transition teams were incorporated into the transition planning process to preclude similar problems from reoccurring during the WAMC transition. There were several problems centered around the installation of the information system hardware and wiring at Brooke Army Medical Center (Hodges, 1997). One of the steps taken at WAMC to overcome this type of problem was the addition of an information systems planner with a master's degree in Nurse Informatics. This individual fills the nurse methods analyst position, but has the added expertise to work closely with the WAMC Chief of Information Management Division to plan the information systems architecture for the new facility.

Another process improvement based on previous transition experience is the systems review process. The TOC and HFPO conduct extremely detailed and thorough reviews of systems that are projected to be installed into the new hospital such as the nurse call system, the

fire control system, signage and wayfinding, and emergency lighting to name a few. The purpose behind this is to identify problems and shortfalls before the systems are installed. The systems review process continues until no further issues are identified and the planned system appears sound. Many different WAMC staff members participate in this process to insure that nothing gets overlooked. The process is lengthy and grueling to the untrained eye, but completely necessary and rewarding to the organization in the end. Corrections are made on paper prior to installation rather than tearing up the new facility after a fault has been discovered. This is clearly one of the most cost efficient processes in place at the TOC and HFPO. It is difficult to quantify the resources saved as a direct result of the systems review process.

Another important result used by the WAMC TOC that is a result of previous transition experience is the medical equipment standardization and acquisition process. The TOC Chief of Logistics has irreplaceable knowledge from his personal experiences with transition planning at MAMC and BAMC. The implementation of a program locally referred to as the "Buy Now" program is a result of his planning efforts. This program allowed the use of transition dollars programmed for the purchase of equipment for the new facility to be used now to purchase equipment for the current facility and then later move these items to the new facility. This example demonstrates the use of common sense to simultaneously overcome two hurdles in the transition process. The resources were available for use and the equipment was going to be purchased for the new facility anyway. By purchasing some of the items now and installing them in the current facility, turn-in of old items can commence, training on new equipment and

processes can begin, and the large bolus of new equipment arriving for the new facility can be made somewhat smaller and spread out over time. Overall, the "Buy Now" program contributed greatly to easing the strain of the entire transition process.

Another logistics success story for the WAMC TOC involves the use of pre-existing contracts within the U.S. Army MEDCOM and DOD. Lessons from past U.S. Army hospital transitions revealed problems that centered around the inability to prepare and execute contracts in a timely manner for the purchase of equipment, furniture, and miscellaneous services for the new facility. The WAMC TOC attempted to counter this by added a contracting specialist to work with the necessary contracting offices and identify pre-existing contracts that could be used to the needs for WAMC.

There are numerous other examples of how the WAMC TOC and the HFPO have implemented changes in their organization or the processes they use that are directly or indirectly related to the lessons learned from past transitions. Until the transition plan is actually executed, the relocation to the new facility is complete, and the old facility and equipment are turned over to the installation, there is no way of knowing just how good the transition planning process is (Fine, 1997). In order for this study to be completely valid and reliable, a retrospective analysis of the transition at WAMC is necessary. It would be too late to have an impact on the transition process at WAMC, but such a study would still benefit the U.S. Army and DOD community. To successfully impact the transition process at WAMC, comparisons to past hospital transitions,

their successes, failures and recommendations, and the published literature must suffice for this study.

Chapter 5

Conclusion

The initial purpose of this study was to develop a reference guide to hospital transition planning using published literature, a comparative analysis of the WAMC transition team to others used by military and non-military hospitals, and lessons learned from past hospital construction and relocation projects. The ultimate objective of the study was to determine if the WAMC Transition Office Complex (TOC) is an acceptable model for all health care facility transitions and whether or not it can be improved to better enable the transition to the new Womack Army Medical Center.

From the research conducted, it was difficult to show whether the WAMC TOC is in keeping with or exceeding the industry standard for size, composition and function. It was not possible to determine the industry standard from this study. It was evident that the size of the transition team varies from one facility to the next. This size variation is believed to be related to the specific information about each facility, the desires of the facility's leadership, and the expertise of the transition team members. The size and functional composition of the WAMC TOC and the HFPO were validated by a group of twenty consultant firms. So even though the industry standard could not be determined, this study succeeded in showing that the Army transition planning model is sound.

The research also revealed that the WAMC TOC is sized and organized sufficiently to perform its mission of managing the transition to the new replacement hospital and the new

consolidated health clinics on Fort Bragg. It is firmly believed that the TOC is an appropriate transition planning team model fully capable of managing any similarly sized or smaller hospital transition. The processes in use by the TOC and HFPO are effective and appear to be centered around cost efficiency and based on common sense. The TOC and HFPO have an added advantage over past U.S Army transition planners since they have several employees with first hand experience from other projects. There may be some other processes in use at WAMC that are unique to this particular transition project and deserve a closer look by transition planners for future projects. The post occupancy report and after action reviews will most likely produce several recommendations for improvement that this study missed.

Recommendations

The WAMC leadership should maintain the TOC in its current configuration, size, and functional composition with one exception. The TOC logistics section needs to analyze the workload carried by the two individuals who manage the new facility's property book. It appears that adding another assistant would be highly beneficial to this section as the new property is received and the equipment volume increases.

Personnel turnover in the TOC could negatively impact the WAMC transition process within the next six to nine months. The majority of the personnel positions were filled with temporary hires. These positions are for one year in length and are reviewed annually for renewal or termination. As the planned occupancy date for the hospital draws near, there is a

valid concern that the TOC employees will quit in search of permanent positions. An incredible amount of expertise and continuity will be lost if the organization does not step in and attempt to provide some stability to the TOC personnel. One recommendation is to assign the TOC employees to WAMC in vacant positions within the hospital and then detail them to work at the TOC until the transition process is complete. This issue should be analyzed further by the WAMC leadership to determine a course of action that best suits the needs of the organization.

Lastly, for the benefit of the U.S. Army and the Department of Defense, it is recommended that a retrospective analysis of the transition process at WAMC be conducted. A thorough review of the actual transition plan compared to what actually occurred during the relocation to the new facility would be highly beneficial to all health facility planners. This task would be an excellent graduate management project for the administrative resident assigned to WAMC in 1999.

APPENDIX A: ACRONYMS

ASD (HA) – Assistant Secretary of Defense for Health Affairs

BOD - Beneficial Occupancy Date

BAMC – Brooke Army Medical Center

DMFO – Defense Medical Facilities Office

DOD – Department of Defense

ECP – Engineer Change Proposal

HFPA – Health Facility Planning Agency

HFPO – Health Facility Project Office

MAMC – Madigan Army Medical Center

MFDO – Medical Facilities Design Office

MILCON – Military Construction

PFD – Program for Design

POM – Program Objective Memorandum

RACH – Reynolds Army Community Hospital

TOC – Transition Office Complex

WAMC – Womack Army Medical Center

APPENDIX B: SURVEYED HOSPITALS

Brooke Army Medical Center	San Antonio, TX
Metropolitan Nashville General Hospital	Nashville, TN
North Center Medical Center	Springfield, TN
Merrithew Memorial Hospital	Martinez, CA
LAC-Rancho Los Amigos Medical Center	Downey, CA
Loudoun Healthcare Systems	Leesburg, VA
Winchester Medical Center	Winchester, VA
Children's Hospital of the Kings Daughter	Norfolk, VA
Bon Secours-St. Francis	Charleston, SC
Genesis Health Systems	Flint, MI
Hasbro Children's Hospital	Providence, RI
Columbia Centennial Medical Center	Nashville, TN
Harborview Medical Center	Seattle, WA
Connecticut Children's Medical Center	Hartford, CT
Summit Medical Center	Nashville, TN
Richmond Memorial Hospital	Richmond, VA
Dartmouth-Hitchcock Medical Center	Lebanon, NH
Mary Washington Hospital	Fredericksburg, VA
Detroit VA Medical Center	Detroit, MI
Columbia-Presbyterian-St. Luke's Medical Center	Denver, CO

APPENDIX C: HOSPITAL SURVEY QUESTIONS

1. Did your hospital use a transition model that implemented steering committee and sub-committee approach?

2. How many sub-committees/transition teams did your organization have?

3. Did you use the services of a consultant or in-house staff?

4. What were the most important transition areas senior management had to identify and address?

5. How did you identify your major transitional tasks?

6. What were the most important factors involved in designing a transition team or task force organization?

7. How did you track the completion of transitional tasks? [project management software, paper charts, action item lists]

8. What methods did you use to train the hospital staff?

9. What methods did you use to orient hospital staff?

10. What methods were used to manage and overcome resistance to change and stress management?

11. What are your favorite transition success stories?

12. What major pitfalls did you experience during your transition? What would you do differently if you had the opportunity to redo your transition?

The following questions were not used during the follow-up survey:

13. How did you provide ancillary services to the hospital during the move?

14. How did you provide emergency room (ER) services during the move?

15. How did you provide operating room (OR) services during the move?

16. How did you provide obstetric (OB) services during the move?

APPENDIX D: SURVEYED CONSULTANT FIRMS

Argus Arista Associates	Northbrook, IL
The Bristol Group, Inc.	Boston, MA
Gene Burton & Associates	Franklin, TN
Damberg, Ltd.	St. Paul, MN
Ernst & Young, LLP	Chicago, IL
Fowler Healthcare Affiliates, Inc.	Atlanta, GA
International Health Management, Inc.	Phoenix, AZ
J B Associates	Joliet, IL
Lammers + Associates, Inc.	Reston, VA
MCR Healthcare	McLean, VA
MEDCO, Inc.	Hatboro, VA
Metis Associates, Ltd.	Chicago, IL
Morell & Associates	Northbrook, IL
Normandale Associates, Inc.	Reno, NV
T.M. Osborn Associates, Inc.	Gaithersburg, MD
PRISM Healthcare Consulting	Glen Ellyn, IL
W.W. Rice Healthcare	Alexandria, VA
TriBrook/AM&G L.L.C.	Westmont, IL
Hans Tronnes Associates	Minneapolis, MN
Walsh Consulting Group, Inc.	Glenview, IL

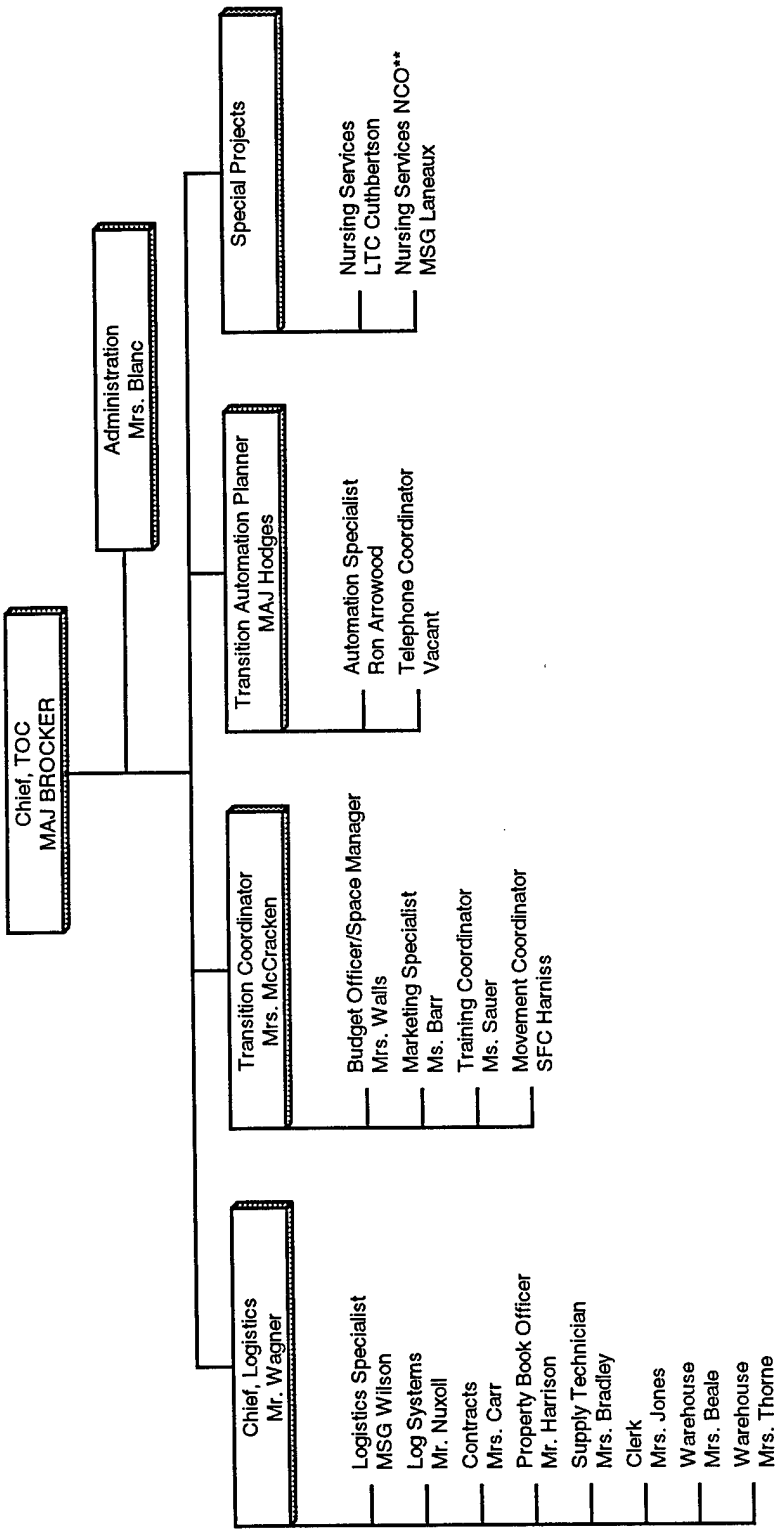
APPENDIX E: CONSULTANT FIRM SURVEY QUESTIONS

1. What is the typical size of a transition team that you provide to hospitals?

2. What is the typical composition or functional organization of a transition team that your provide to hospitals?

3. Given a brief description of the WAMC TOC and HFPO at Fort Bragg, analyze the WAMC TOC in conjunction with the HFPO and tell me whether it seems more than adequate, adequate, or less than adequate in size and functional composition.

TOC Staff



**Temporary Position

NEW WOMACK ARMY MEDICAL CENTER
TRANSITION FLOWCHART

ORDER	CATEGORY	POINT-OF-CONTACT	APPROXIMATE SUSPENSE DATE
1	NWAMC Orientation & Overview	MAJ Sharon Steele HFPO 432-8122/3340	
2	Concept of Operations	Ms. Kathie McCracken Transition Office 432-2215/2315	Draft: Final: Brief:
3	Automation & Communications	MAJ Robert Hodges/ Ms. Debra Owens Transition Office 432-2215/2315	
4	Equipment Planning and Procurement	Mr. Richard Wagner Transition Office 432-2215/2315	**S: NLT 30 Sep 97**
5	Furniture Planning and Procurement	Ms. Terri Sheckles HFPO 432-2359/3340	
6	Summary Meeting	Ms. Kathie McCracken Transition Office 432-2215/2315	
7	Keying and Signage Plan	MAJ Sharon Steele HFPO 432-3340	**31 July 1997**
8	Training Plan	Ms. Linda Sauer Transition Office 432-2215/2315	To be determined at a later date
9	Relocation Plan	Ms. Kathie McCracken Transition Office 432-2215/2315	To be determined at a later date
10	Building Release Plan	Ms. Kathie McCracken Transition Office 432-2215/2315	To be determined at a later date
11	Other Requirements		

Name: Mr. Dan Ayers, Department: Ambulance Section, Initiated: 27 August 97

HOW TO USE THIS MANUAL

1. PURPOSE:

The purpose of this manual is to provide a common location for information pertaining to the new Womack Army Medical Center (NWAMC) construction project and its associated transition requirements. The manual will be maintained by each clinic/activity (hereafter referred to as the "User") and will be used extensively by the Transition Office Complex (TOC), Health Facility Project Office (HFPO), and the Transition Committee.

2. DISTRIBUTION AND MAINTENANCE:

The initial issue of each manual will be to the applicable Users of each activity/department by members of the transition staff. Updates and additions to the manual will be distributed by the Transition Specialist. The manual is divided into several sections. Each section deals with pertinent items which will effect the transition of the User's activity into the new facility. Several sections have been left intentionally blank; information for those sections will be provided at later dates.

3. USE OF THE MANUAL:

The User should utilize this manual as the central focal point for the transition planning process. When properly maintained, the manual will include all transition Committee directions/decisions, construction data/schedules and logistical matters. This information will also provide the User with a complete history and single reference point for those actions affecting the User's area of responsibility. This point is especially important with respect to the multi-year length of the transition process. During this time, it is likely that the points-of-contact for User areas will change. The manual will then become the major source of continuity.

TRANSITION AUTHORITY AND PROCESS
NWAMC TRANSITION COMMITTEE

1. PURPOSE

The New Hospital Transition Planning Committee (hereafter called the Transition Committee - TC) was established by direction of the MEDCEN Commander (IAW MR 15-1) to serve during the period of construction and transition into the new hospital. It has been delegated sole authority to plan, coordinate, and implement all MEDCEN actions relating to the new facility. The TC bears responsibility for reviewing and approving/disapproving proposals including (but not limited to) the following:

a. Design changes
b. Selection of equipment
c. Development of functional systems
d. Organization manpower
e. Relocation from existing hospital to new facility

The TC is the focal point for coordinated decision-making on all issues/proposals regarding the new hospital. TC is the single conduit through which recommendations are forwarded to the MEDCEN Commander for final approval.

2. COMPOSITION

a. Deputy Commander for Administration - Chairperson
b. Deputy Commander for Clinical Services
c. Chief, Department of Nursing
d. Department representatives
e. Chief, Logistics Division
f. Chief, Clinical Support Division
g. Chief, PTM&S
h. Chief, Information Management Division
I. Chief, Resource Management Division
j. Chief, Transition Office Complex
k. Chief, Health Facility Project Office

3. REFERENCES

a. EP 415-1-260, para. 8-50.

b. SB 8-75 MEDCASE, Department of the Army Supply Bulletin, 6 June 1986.

c. Health Facility Project Officer's Guide, 1 April 1985.

4. MEETINGS

The TC will meet the second Monday of the month at 1000. Meeting will be held in the Transition Office Conference Room.

5. ADMINISTRATION

Formal written minutes of each TC meeting will be forwarded with specific recommendations for action for the MEDCEN commander for approval. Such approval and/or guidance by the commander will constitute the final decision on any issue or proposal. Following approval, minutes will be provided each member. Approved recommendations for action will be forwarded to the involved division/department/activity chief via a tasking document signed by the TC Chairperson.

Welcome to your new Womack Army Medical Center!

There is so much to learn and so much to think about. We want to try to put that all together in manageable pieces to make it easier to find your way through the process. This section will cover the information that you will receive during your first tour the new facility.

1. BRIEFING, ORIENTATION: The first step in your journey will be exposure to the big picture: the number of beds (287), the mission (Primary Care), the cost ($250 Million), size (almost a million square feet) and the projected time line (construction finishes around Fall 1998, move inpatients in 1999). We would love to give you either a semi-formal briefing, or we can walk you around the floor plans and the hospital model.

2. HOSPITAL TOUR: The next step is to tour the facility. Depending on the state of construction, we might be able to take you into your activity and walk through each of your rooms, or we may have to initially walk you around freshly poured (but dry!) concrete and judge your spaces by counting the columns. Our goal is to take you out at least twice during the construction, once when you have concrete poured and lines drawn representing your rooms and the next time when you actually have rooms framed and dry-walled. We will also proudly show off the whole facility, to the best of our ability (and the state of the construction).

3. PACKET: After you have had your tour, you will be briefed on the contents of your personalized packet on the new hospital.

A. USER DRAWING: In this packet will be a user drawing of your activity. You will already have a good idea of how to read this because we will have used it in our tour, but we will be glad to answer any of your questions on deciphering the drawing.

B. COMPOSITE DRAWINGS: You will also be given composite drawings of each floor of the hospital to give you an idea where all the hospital activities will be located. This will be helpful when you are working on your concepts of operations for your area.

C. EQUIPMENT LIST: You will be also provided with a listing of all your rooms and the equipment that was programmed to be in each room. The most important thing you will need to know about this listing is that there are two main types of equipment: Logistical Categories A and C. Log Cat A equipment is purchased by and installed by the construction Contractor. That means that it may already be purchased for your area and will be installed before we take over the building. If you see any problems with the Log Cat A equipment, please let the HFPO know. The Log Cat C equipment, on the other hand, are suggestions to you the user. You will be meeting with Transition folks to go over that list in depth about what you want to buy for your area.

D. KEY LISTING: There will be a key listing of your activity. This listing will give you a lot of information such as type of hardware, number of doors in each room, and keyset provided for each lock. We need for you to give us a reality check on the keysets. Each activity within the

hospital is keyed separately. There is one master key for each activity. Each lock has a keyset. All offices and/or exam rooms are keyed individually, therefore they have a different keyset. Some rooms we have keyed alike, such as supply rooms or treatment rooms within an activity. If you have more than one entrance into your activity they will also be keyed alike and will be designated XX01 (XX stands for your activity which will start with A, B, C, or E, depending on your location withing the hospital). Please check these to ensure that you will want them keyed alike. We will submit the final keyset list to the Contractor in August 1997.

E. SIGNAGE LISTING: The last major piece of your individual initial packet from the HFPO is the signage place. This list, like the key list, is by room number and will give you more information than you probably will need. It gives you the name of each room, the type of sign for each room (i.e., V is changeable, W is not changeable), and the message on the sign. Here again, we would like you to verify the sign message for each room. If you change the function in the room, (for instance you may be using it as the NCOIC office, but the sign says Head Nurse Office) please tell us so that the message can also change. On those V signs (most of the signs), we will have a sign maker to make new messages, but we would like to make most of them right the first time. We also must submit this list to the Contractor in August, 1997.

F. WHO TO CONTACT: One other part of your packet will be a listing of personnel in the Health Facility Project Office (HFPO) and in the Transition Office Complex (TOC). The HFPO represents the Health Facility Planning Agency (HFPA) and the Office of the Surgeon General (OTSG) in Washington, D.C. We work on building issues. We give the construction tours; we work on any necessary building changes; we review all the building systems; and we review all the Log Cat A equipment submittals. Please do not hesitate to contact us if you have any building issues to discuss. The TOC, on the other hand, works on people and equipment issues for the new hospital. They will work with you on your Concepts of Operations, your Log Cat C equipment planning, and any training or transition needs.

4. KEEPING UP: We have a web presentation on the World Wide Web. The address or URL is in the packet. Please check in frequently on the Internet for construction and transition updates. On behalf of the HFPO and the Womack Command, I urge you to get actively involved in your new hospital. We all have an exciting adventure ahead of us. Please call on us if we can assist you in any way.

5. Point of contact for the Health Facility Project Office is: MAJ Sharon L. Steele, Project Nurse, HFPO. She may be reached at 432-3340 or 8122.

MCXC-TO 20 February 1997

MEMORANDUM FOR: Transition Points-of-Contact

SUBJECT: Completion of Concept of Operations - First Draft

1. Developing a concept of operations for your area is the critical first step toward providing services in the new facility. The Concept of Operations is defined as a user-developed guide to the functional operation of the new facility. Because it provides the foundation for follow-on planning, it is one of the most important documents developed by the medical activity preparing for transition.

2. The Concept of Operations is prepared by each section/service. It will be used by the section, the Transition Office, and the Project Office to define transition activities, identify design problems, orient new personnel, highlight equipment and supply requirements, and validate manpower needs. Effective staffing and early completion of these concepts allows the transition process to achieve established milestones and objectives. *Failure to coordinate or meet established suspense dates can, and most likely will, create a chain reaction of delays affecting the entire organization.*

3. To assist you in meeting established requirements, four documents are attached: a flow chart illustrating the steps involved in developing a Concept of Operations, a Letter of Instruction (LOI), a questionnaire for initiating your department's Concept of Operations, and a sample staffing coordination cover sheet.

4. The primary function of the Transition Office Complex staff is to provide professional, courteous service to you -- our internal customer. I welcome the opportunity to work with you as we transition to the new Womack Army Medical Center!

//s//

KATHIE S. McCRACKEN
Transition Specialist
Transition Office Complex

Encls - as

INFORMATION PAPER

SUBJECT: Letter of Instruction (LOI) for Writing a Concept of Operations

1. PURPOSE: This LOI provides guidance for the completion of the Concept of Operations for your section, department, or service.

2. DEFINITION: The Concept of Operations is a user-developed guide to the functional operation of the new facility. The concept is more than just a single document; it is a composite of related documents, all of which address different areas of importance.

3. GENERAL:

a. The primary purpose of a detailed concept of operations is to provide information to the Transition Committee (TC) for transition planning, to assist each activity in preparing for an uncomplicated move, and to facilitate operations in the new facility. The template provided with this LOI will establish and ensure presentation of information in a standardized format. It will assure that primary areas of concern are formally and consistently addressed by each activity. It will provide an opportunity to identify methods or processes which could be changed to provide improved services to Womack beneficiaries. Finally, it will provide the opportunity to identify and present issues for resolution by the Transition Committee.

b. General guidelines for accomplishing this task:

(1) State the current mission and philosophy. This will include number and types of patients, level of care, and any other mission requirements that might impact on the operation.

(2) Identify any operational impact associated with the move. Will current policies/procedures/functional flow require revision as a part of the transition process?

(3) Isolate any resource requirements associated with the transition. Will more or less staff members be needed? Will changes to the TDA be necessary? What additional equipment will be needed? Will the new equipment require special support/maintenance of any kind? How will supplies and utilities be managed? Will more than one site of operation for an activity be required? For how long? Will additional funding be required? Would funding be a transition or new mission (continuing) requirement?

(4) Develop specific recommendations as to what must be done, by whom, and in what sequence in order to effect the move. Will operations need to be reduced, suspended, or maintained during the transition period?

(5) Review a copy of the new facility floor plan specifying the planned functional use of each area. Identify a traffic flow plan indicating how patients and staff will access and move through areas. Identify cross traffic points and potential areas of congestion.

(6) Coordinate and develop the operational plan of all new systems built into the new area (i.e., supply delivery, paging, patient flow, etc.). This should incorporate all systems that will impact personnel, training, space utilization, operating procedures, etc.

(7) Develop the operational narrative-- the most extensive portion of the Concepts of Operations. This narrative should consolidate all of the information provided in the various parts (mission statement, equipment and manpower lists, etc.) into one concise description of projected operation for the section/department. It should provide the reader with a mental image of the daily activities of all patients, staff, flow of supplies and use of equipment.

(8) Define the open issues list. This is a list of unresolved tasks or issues which must be accomplished prior to, during, and/or after the move. This list may assign suspense dates and responsibilities. Issues which cannot be resolved internally will be addressed during Transition Committee meetings.

4. Responsibilities:

a. The Department/Service Chief or designated point of contact (POC) is responsible for developing the Concept of Operations/Functional review for their activity. POCs are also responsible for updating their concept of operations as changes in procedures, personnel, and equipment occur.

b. The POC is responsible for the coordination of the Concept of Operations with other departments or services listed in item 12 (INTERRELATIONSHIPS WITH OTHER SERVICES). *Early concurrence of all stakeholders will promote comprehensive, successful concepts!*

5. POC for this portion of your transition planning is: Ms. Kathie S. McCracken, Transition Specialist. She can be reached at 432-2215/2315..

CONCEPTS OF OPERATIONS OUTLINE
DEPARTMENT/SECTION

MEMORANDUM FOR Transition Committee

SUBJECT: Concept of Operations/Functional Review for _____.

1. PURPOSE: To provide the transition committee with plans for the utilization/operations of the_____.

2. MISSION: What level of care is provided by your department?

3. POPULATION SERVED:
   a. To whom do you provide care?
   b. Approximately what percentage does each category represents. Example:
      Active Duty: 35%
      Active Duty Family Members: 30%
      Pediatric Family Members: 5%
      Medicare Eligible: 30%
   c. Do you anticipate TRICARE changing your population mix? If yes, how?

4. HOURS OF OPERATION:
   a. What are your existing hours of operation?
   b. Would your patient population benefit by changing hours of available service?

5. SCOPE OF SERVICES:
   a. What services do you currently provide?
   b. What services should you provide that are currently not provided?
   c. What services should be performed by your section to move our system to a wellness-based, preventive model?
   d. Do you anticipate TRICARE changing your scope of services? If yes, how?

6. MANPOWER REQUIREMENTS:
   a. What is your current TDA?
   b. Do you have any contractor funded positions?
   c. Do you have any borrowed military manpower positions?
   d. Do you have other manpower (volunteers, etc.)

7. EQUIPMENT ISSUES:
   a. What equipment will you require to meet patients' needs in the future?
   b. Briefly describe what training will be necessary to meet your future equipment needs.

c. Are you unable to provide a full range of service due to a lack of equipment?

CONCEPT OF OPERATIONS OUTLINE

8. SUPPLY/SUPPORT ISSUES:
   a. Will different supplies be needed for patient care (include treatments and procedures)?
   b. Will different supplies be needed for office/administrative activities?
   c. Who is currently responsible for supplies in your department?

9. FUNDING REQUIREMENTS:
   a. What are the budgetary impacts on any changes of operation?
   b. Will you require start-up or transition funding?

10. SPACE UTILIZATION REQUIREMENTS:
   a. After review of the user's plans, are requirements for space:
      (1) adequate for your requirements
      (2) inadequate for your requirements
      (3) in excess of your requirements
   b. Do you require unique storage or supply areas?
   c. Do you currently use some areas for a single purpose that would be better used for multiple purposes? If yes, describe.
   d. Do you currently use some areas for multiple purposes that would be better used for single purposes? If yes, describe?

11. TRAFFIC FLOW REQUIREMENTS:
   a. After review of the user's plans, have requirements for traffic flow been met for:
      1) patients
      2) staff
      3) materiel and supplies
   b., After identifying high traffic areas, can processes be modified to avoid cross-traffic and/or constricted areas?
   c. How will "way finding" be handled in your area?

12. INTERRELATIONSHIPS WITH OTHER SERVICES:
   a. Who are your customers (internal and external)?
   b. Who are your suppliers?

13. SYSTEMS OPERATIONS:
   a. To whom (within WAMC) do you report information?
   b. What data do you report?
   c. To whom (outside WAMC) do you report information?
   d. Who reports information to you?
   e. What data is reported?
   f. Do you have specific or unique security requirements?
   g. Do you have other specific or unique "system" requirements?

CONCEPT OF OPERATIONS OUTLINE

14. PROCEDURAL CHANGES:
    a. Given your current operations, what works *well* and needs to be *continued*?
    b. What is *broken* and needs to be *corrected*?
    c. Are there ways of doing your current operation differently that would improve service to the customer?
    d. If yes, briefly outline the plan to include:
        1) When would it start - before or after the move?
        2) Would new equipment be required?
        3) Would new policies/procedures be required?
        4) What training would be necessary?
        5) Other significant factors.

15. OPERATIONAL NARRATIVE:
    a. Describe your projected operation in the new facility. This narrative should allow the reader to "walk" through the new area and "see" your operation in action.
    b. Consider activities from both a patient-centered and staff-efficiency perspective.

16. OPEN ISSUES:
    a. What obstacles or questions need resolution to implement this operational plan?
    b. What efforts have been made to reach resolution?

17. RECOMMENDATIONS:

18. POINT OF CONTACT:
    a. Name:
    b. Alternate POC:
    c. Telephone number:

SIGNATURE BLOCK

CONCEPT OF OPERATIONS OUTLINE

SAMPLE

TRANSITION OFFICE COORDINATION SHEET

SUBJECT:	OFFICE SYMBOL:
	ACTION OFFICER:
	TELEPHONE NUMBER:

1. PURPOSE: To ensure proper coordination of the attached Concept of Operations with all appropriate departments and/or divisions .

2. DISCUSSION:

3. RECOMMENDATION:

COORDINATION				APPROVAL		
Office Symbol	Concur/Nonconcur	Name	Phone		Initials	Date
IMD				Transition Specialist		
LOG				Chief, Transition Office		
PHARM				Chief, HFPO		
RAD				Transition, Executive Committee		
LAB						
DoN						
RMD						

ENGINEERING CHANGE PROPOSALS (ECP)

GENERAL GOALS, PROCEDURE, AND REQUIRED DOCUMENTATION

1. GENERAL GOALS:

Change orders to a construction contract can come from anyone at anytime. In a utopian sense, a "perfect" project would not have any changes. Changes normally equate to delays, additional direct and indirect costs, and potential government liability.

In order to have the perfect construction contract, a perfect design is necessary. In order to have the perfect design, the User identifies specific needs to the architect. When determining the medical needs, the Users examine not only the current situation, but also speculate about the future situation. This is a tough and uncertain feat. Another fact of life emerges: change orders *will* be required.

Department of Defense medical projects historically have a record of cost overruns. Cost overruns can be caused by many reasons, but one reason is controllable---the User's change requests.

The MEDCEN medical "User" is normally the OIC/NCOIC of the clinic or activity which is to inhabit the new facility. This party will have to operate the area and is normally the local subject matter expert in his/her field of practice. This person is responsible to initiate the ECP for an area should alternative solutions not be possible. A change order to the construction contract should be considered a "last resort" measure for the user. *The individual who wants to initiate a change order should insure that the change is absolutely required, not just a matter of personal preference.*

The government Construction Manager and Contracting Officer is the Corps of Engineer's Hospital Resident Engineer (RE). This individual, and office staff, will insure that the Contractor builds the hospital in accordance to the contract specifications and blueprints. *The RE is the only person who can make a change to the contract for any User ECP which has been approved.*

The change order process should be understood by the medical User. The Health Facility Project Office should be consulted as soon as the "problem is discovered." History shows problems, and their subsequent solutions can be classified into three groups:

a) Eighty percent of the problems identified can be solved by the medical User and HFPO using alternative solutions. Alternative solutions can bechanging methods of operations or managements, new equipment procurement, or a complete understanding of the facility features and systems.

b) Ten percent of the problems may be the result of a design "bust" or poorly written blueprint or specification. In these cases, the HFPO will take initiation for resolution.

c) Ten percent of the problems can be defined as equipment utility needs, changes in medical practice, code violations, criteria changes, better ideas , or other "I just don't like it" reasons. In these cases, the User will have to initiate an ECP within the MEDCEN and gain the concurrence of the Transition Committee.

The ECP-approval process is intensively managed at several levels above the local MEDCEN. Any ECP greater than $1,000 must be approved by the Office of the Surgeon General and Corps of Engineers' corporate board. ECP's greater than $100,000 must also be approved by MEDCOM and DoDHA (MFO). The HFPO is responsible for coordinating the user's needs, providing an effective change design, and facilitating the change through the system. The corporate board has quarterly on-site meetings to insure timely inclusion of the ECP into the project.

Should the ECP be approved, the implementation process of the change has to be determined. There are two choices to implement changes:

a. Make the change now. Changes in this category are referred to as "mandatory changes," and are defined as changes necessary to complete the facility as designed. This alternative requires the Contractor to implement the change as directed. It is the most costly method of implementing changes. The determination to use this method is usually reserved for those changes which have extensive scope of work, unknown site conditions, or of great cost benefit to the government.

b. Make the change during the Retrofit Stage. Changes in this category are considered "non-mandatory" because the facility can be built without incorporation in order to meet design intent. However, many of these changes are considered "mandatory" for the current medical mission and will be incorporated dependent upon availability of funds.

The ECP can be approved in concept and be placed on the *Retrofit stage* of construction. This method is preferred. Once the ECP has gained approval, it (and other approved ECP's) will be grouped together, designed, advertised, and awarded by the RE in one procurement package. These changes will be completed during the Retrofit stage which occurs during transition into the new facility, but prior to actual medical operation. The benefit to the government is a cost savings since the work was let under a competitively bid situation.

3. METHODS TO INITIATE AN ECP:

An ECP can be initiated by verbal, electronic, or written communication with any staff member of the TOC or HFPO. You will be apprised of your request's status as it moves through the ECP process.

Automation Planning Information Sheet

Chief: MAJ Robert S. Hodges, M.S.N, R.N.
Informatics Nurse Specialist

Staff: Ms. Deborah Owens, SAIC
Systems Specialist

Mission: Coordinate the procurement, installation, training, implementation and support of all existing and new communications and information systems planned for the New Womack Army Medical Center, Joel Health and Dental Clinic, and Clark Health Clinic.

Objective: Plan and implement the best possible information and communication system possible.

Operational Philosophy:

-"Information is power, but true power is the ability to get the right information to the right person at the right time so the best possible decision can be made and the right action can be taken."

This philosophy is integral for all systems planned for the new Womack Army Medical Center. The customer of the Automation Planning Office is the patients and staff. Meeting their goals and objectives is the paramount objective of this office.

Some of the Planned Systems:

-DOD Clinical Information System
-Digital Radiography
-Physiological Monitoring System
-Video Teleconferencing/Telemedicine

Location:

Transition Office Complex
Bldg. 4T-2032 O'Brien Street
Womack Army Medical Center
Fort Bragg, NC 28307-5000

Phone: (910)432-2215
Fax: (910)432-5869
DSN: 239-XXXX
E-mail: MAJ_Robert_Hodges_at_HFPOSE@ftdetrck-ccmail.army.mil

MCXC-TO 25 November 1996

MEMORANDUM FOR RECORD

SUBJECT: Automation Procurement Rules for the New Womack Army Medical Center

1. Computer Systems/Equipment which will operate on or interface with networked systems.

a. The Chief, Automation Planning in the Transition Office Complex and the Chief, Information Management Division at Womack Army Medical Center must be informed of all information systems, automation systems, or equipment which will or may operate on or with any information or automation system which will be used or is planned to be used in the New Womack Army Medical Center.

b. This requirement is so that the support of these systems can be planned for. Support includes network connections, software, maintenance, supplies, personnel support requirements, and ensuring that the systems will be able to inter-operate with planned systems on the Wide Area Network in the new hospital.

c. Details on the planned network for the new WAMC are available from the Chief, Automation Planning or the Chief, Information Management Division.

d. Any vendor provided equipment or software which will operate on the network must be coordinated through the office of the Chief, Automation Planning and Chief, Information Management Division.

e. Any vendor provided hardware or software requiring interface with other systems at the new WAMC must have the interface provided as part of the initial procurement. All purchases must be staffed through the Chief, Automation Planning in the TOC and the Chief, Information Management Division.

2. Printers:

a. The current philosophy and plan is for the majority of printers used in the new hospital to be networked. This means that in a clinic for example, many computers can print to one printer. Unless exceptions are requested by the activity individual printing will be planned for Chiefs, NCOIC's, Head Nurses, and other supervisory personnel.

b. All printer purchases and new requirements need to be coordinated through the office of the Chief, Information Management Division with a copy to the Chief, Automation Planning at the TOC.

3. Desktop Computers:

a. The majority of software used on computers will operate off of the planned network at the new WAMC. Exceptions to this will be determined on a case-by-case basis.

b. All computer purchases and new requirements need to be coordinated through the office of the Chief, Information Management Division with a copy to the Chief, Automation Planning at the TOC.

4. Communications:

a. Telephones:

(1) The current types of telephones currently in use will be used in the new facility.

(2) Telephone requirements can be coordinated through the Chief, Automation Planning in the TOC.

b. Facsimile Machines:

(1). Only plain paper fax machines will operate in the new facility.

(2). Facsimile requirements can be coordinated through the Chief, Automation Planning in the TOC.

c. Pagers:

(1). A new radio-paging system will be installed for the new hospital. It will interface with the nurse call system.

(2). Pager requirements can be coordinated through the Chief, Automation Planning in the TOC.

4. Copy Machines

a. Copy machine requirements for areas will be determined by usage and location for maximum usage and sharing of resources. Areas with specific copier requirements should incorporate those into their concept of operations along with the appropriate justification for a dedicated copy machine.

b. Copier requirements can be coordinated through the Chief, Automation Planning

in the TOC.

5. POC for questions or actions related to this memorandum is the undersigned at 2-2215/2315 or e-mail at maj_robert_hodges_at_hfpose@ftdetrck-ccmail.army.mil

Robert S. Hodges
MAJ, AN
Chief, Automation Planning
Transition Office Complex

MCXC-TO

Date:
Suspense:

MEMORANDUM FOR:

SUBJECT: New WAMC Automation Planning Document

1. This document is to be used for general planning of automation in the new Womack Army Medical Center. The purpose is to identify your specific automation requirements and your general automation requirements so that they can be planned for in the new facility. Please keep in mind that your automation use and planning is a portion of your concept of operations. What you indicate in this document should be a more detailed description of your concept of operation for the new facility.

2. If there are any portions of this document which you have questions about, please do not hesitate to contact MAJ Hodges or Ms. Owens in the Transition Office at 2-2215/2315. It is important that what you indicate in this document is as accurate representation as possible of your concept of operation.

3. After this document has been completed and reviewed an appointment will be set up with the Automation Planning Session in the TOC to review this document with you in detail and answer any questions you may have. The goal of automation planning is to ensure that everyone has the tools they need to operate in the new facility to the maximum extent possible. Your support in completing this document is greatly appreciated.

4. POC is the undersigned at 2-2215/2315.

Robert S. Hodges
MAJ, AN
Chief, Automation Planning
Transition Office Complex

Department:_____
Location: Current:_____ NWAMC:_____
POC and phone:_____

I. Computers/Printers/Software:

1. a. Do you currently use computer systems in your work operations?
Yes_____ No_____

b. How many by type:

386	486	PENTIUM	VT

2. Current Systems:
What programs/software do you currently use? Please provide as complete information as you are able. If you need additional space, please attach a separate sheet.

Program's Currently Being Used	**Yes**
AIMS (Advanced Information Management System)	
AlaCarte System	
ADS (Ambulatory Data System)	
AMEDDPAS (AMEDD Property Accounting System)	
ACTUR (Automated Central Tumor Registry)	
CaseTrakker System	
cc:Mail System	
CHCS (Composite Health Care System)	
CAPOC (Computer Assisted Practice of Cardiology)	
CEIS (Corporate Executive Information System)	
DCPS (Decentralized Civilian Personnel System)	

Automation Planning Document

Program's Currently Being Used	Yes
DBSS (Defense Blood Standard System)	
DDN (Defense Data Network)	
DEERS (Defense Eligibility Enrollment Reporting System)	
DMHRS (Defense Medical Human Resource System)	
DMIS-SS (Defense Medical Information System - Summary System)	
DMLSS (Defense Medical Logistics Support System)	
DMRIS (Defense Medical Regulating Information System)	
DRS (Dental Readiness System)	
DWRS (Dental Workload Reporting System)	
DAMIS (Drug and Alcohol Management Information System)	
STD (Epidemiology Disease Control - Sexually Transmitted Diseases)	
EAS (Expense Assignment System III)	
FormFlow	
HHIMS (Health Hazard Inventory System)	
HRA (Health Risk Appraisal)	
Healthwise System	
HEARS (Hearing Evaluation Automated Register System)	
HIV (Human Immunodeficiency Virus) System	
IMS (Inventory Management System)	
Lotus Notes Groupware	
MASS (Medical Analysis Support System)	
MARRS (Medical Automated Readiness Reporting System)	
MEPRS (Medical Expense and Performance Reporting System)	

Automation Planning Document

Program's Currently Being Used	Yes
MHCMIS (Medical Health Care Management Information System)	
MEDLINE (Medical Library Network)	
MODS (Medical Occupational Data Systems)	
MSRS (Medical Summary Report System)	
MSS (Medical Surveillance System)	
Nutrition Management System	
OHMIS (Occupational Health Management Information System)	
PASBA2 (Patient Administration Bio Statistical Agency)	
PERNET (Personnel Command Network)	
PROFIS (Professional Officer Filler System)	
QPRAC (Query For Practioners)	
RAPS (Resources Analysis and Planning System)	
RCMAS (Retrospective Case-Miz Analysis System)	
SWS (Social Work Services) System	
SIDPERS (Standard Installation/Division Personnel System)	
SPC (Statistical Process Control)	
SurgiServer System	
TACCS (Tactical Army Combat Computer System)	
TAMMIS (Theater Army Medical Management Information System)	
TPCS (Third Party Collection System)	
WWW Internet	
Other (specify):	
Other (specify):	

Automation Planning Document

Program's Currently Being Used	Yes
Other (specify):	
Other (specify):	

3. Planned Systems:

In addition to the software programs listed in item 3, what other software would you like to be able to use (e.g. patient education, on-line references, clinical information systems, etc...)? In addition is their any software that you would like to change as your primary preference (e.g. PowerPoint instead of Harvard Graphics)? Please provide as much information as possible for your area. If you have specific products in mind, please list them. If you require additional space, please attach a separate page.

Program	Yes
Clinical Information System - Inpatient	
Clinical Information System - Outpatient	
Digital Radiography - Diagnostic	
Digital Radiography - Consultative	
Patient Education Software (specify)	
Clinical References (specify)	
Administrative References (SOP's, etc...)	
Internet	
specify:	
specify:	
specify:	
specify:	
specify:	
specify:	

Automation Planning Document

Program	Yes
specify:	
specify:	
specify:	
specify:	
specify:	

4. a. How many computer workstations will you require to support your operations in the new facility? _____.

b. How many of your existing computers do you expect to move into the new facility? _____.

5. a. How many laser printers do you currently have in your area?_____

b. How many laser printers do you think you will need for the new facility?_____

6. Assume that all of the automation requirements in questions #3, #4, and #5 are available.

a. Given your new concept of operations for the new facility, how will automation improve your ability to conduct business?

b. What impacts would you expect if the automation resources were not available?

Automation Planning Document

II. Communications:

1. a. Do you currently use a fax machine in you operations?
Yes_____ No_____
If yes what is the make and model and age of your fax machine:
_____

b. Do you anticipate continuing to use or requiring new Fax capability in the new hospital? Yes_____ No_____

2. a. How many telephone extensions are in use in your area. A telephone extension is a separate number, not the total number of telephones. _____

b. How many telephone instruments do you currently have in your area.
_____--

c. Do you anticipate needing the same number of telephone lines in the new facility? Yes_____ No_____ If no, how many separate extensions do you require for your operation and the justification for additional lines:

3. a. How many pagers are in use in your area. _____

b. Do you anticipate needing the same number of pagers in the new facility?
Yes_____ No_____ If no, how additional pagers do you require for your operation and the justification for additional pagers:

4. a. How many copiers are in use in your area. _____

b. Do you anticipate needing a dedicated copier in the new facility?
Yes_____ No_____ If yes indicate your justification for a dedicated:

5. Do you anticipate using Video Teleconferencing in your operations in the new facility? Yes_____ No_____

How do you plan using Video Teleconferencing (VTC) or Telemedicine in the new facility? I.e. distance learning, consultations, conducting business.

III. Other:

1. If given an option in documenting patient care on a computer, would you prefer to do it in:
a. Outpatient: Exam Room_____ Office_____
b. Inpatient: Inside Patient Room_____ Outside the Patient Room___
Ward Team Centers_____ Ward Work Rooms_____,
Other(specify)_____.
Please check all choices which apply.

Any other comments related to electronic documentation of patient care.

2. Any other specific comments, questions, or specific requirements which you have in your area which have not been addressed previously?

Automation Planning Document

INFORMATION PAPER

SUBJECT: New Womack Army Medical Center, Equipment Planning Process

1. Purpose. To provide information and facts concerning equipment planning for the new Womack Army Medical Center.

2. Mission: To provide expert equipment planning and logistical support to the staff of Womack Army Medical Center during construction and transition to the new medical center.

3. Personnel: The Logistics Section is currently staffed with the following personnel:

Chief:	Mr. Richard W. Wagner
Log. Mgt. Specialist:	Mr.Dale J. Nuxoll
Logistics Specialist:	MSG Jerry W. Wilson
Contracting Specialist:	Ms. Gloria Carr
Equip. Rqmts. Mgr.	Mr. Lorenzo Harrison
Equip. Rqmts. Asst.	Ms. Lutricia C. Bradley
Logistics Assistant	Ms. Sonja T. Jones

Additionally, the TOC has a contract with Systems Research & Application Corporation of San Antonio, Texas to provide equipment planning services. SRA's multi disciplinary team of logistics professionals will not only help you determine your needs, they will even do your paperwork for you! All TOC employees, whether in-house or contractor are dedicated to providing you with the highest level of customer service at all times.

4. Process:

A. The Chief, Logistics (TOC) will determine the order your activity is reviewed for it's equipment needs. Currently, our priority for reviews is:

1. "B" Building Activities (Ancillary Areas)
2. "A" Building Activities (Clinic Areas)
3. "C" Building Activities (Nursing Tower)

B. To begin the process, we will call you and set up an appointment with you or your designated POC for equipment planning.

C. A representative from SRA will visit you at your activity. SRA will bring along a copy of the equipment list (as designed by the new facility architect), a current copy of your hand receipt, and a user drawing of your area in the new hospital. The SRA representative will go over your Concept of Operations with you and then go room by room in your new area to determine your equipment needs. Since our goal is to relocate as much good equipment as

possible to the new hospital, SRA will pay special attention to the equipment you currently have on hand. A metric we use in determining equipment relocation is, the equipment should have at least two years of useful life expectancy at the time of the move to the new facility. Be prepared to answer lots of questions during the review, your well thought out answers are the key to getting the best equipment for your needs. Since SRA is required to be vendor non-specific, be prepared to recommend a "preferred" vendor for each piece of equipment that you want to procure. SRA's equipment planners have extensive experience in planning equipment for both civilian and military hospitals. They can often tell you of products or vendors they know to be good as well as those to avoid, but remember, you have the final word on what you want.

D. When SRA completes the review, they compile the data and prepare the documents required to purchase or move your equipment. At a minimum, they will provide the TOC with the following:

1. A list of equipment recommended to be moved to the new facility
2. An Equipment Data List for each piece of equipment to be purchased
3. A Summary List of all equipment to be purchased for your activity
4. A MEDCASE Program Requirement (DA Form 5027-5028) for each piece of equipment to be purchased costing more than $100K unit price.

E. SRA will schedule a second visit with your POC to review and approve/sign the above lists/documents.

F. SRA will deliver the finalized documents to the TOC and we integrate that information into our equipment planning database. The equipment plan will be staffed through the hospital for approval (and to higher headquarters if required). The last step is to file them pending procurement.

G. If changes to mission or advances in technology necessitate changes to your equipment program, contact us for assistance. We recognize that changes are a necessary part of our business and will do everything we can to accommodate them. However, once we send your equipment requirements to contracting for purchase, and a contract is awarded, it is very difficult (and often expensive) to change.

H. We will prepare your procurement requests, assign a document number and forward your request to the appropriate contracting office. When the equipment is received, we will place it on the New WAMC Property Book, store it, and deliver it to the end location. Our Property Book Officer will work with your hand receipt holder at the appropriate time after the new facility is completed to transfer custody of the equipment.

I. We will plan some systems such as Physiological Monitoring, Office Automation (computers), etc. separately to ensure complete compatibility across the medical center. We will contact you to solicit your needs if your service or activity is a user of one of these systems.

5. Our goal is to provide you with the very best, most comprehensive, and certainly the most user friendly logistics planning services you have encountered in your Army Career. Point-of-contact for these issues is Mr. Richard W. Wagner at 432-2215/2315. If we fail to meet your expectations in any way, please do not hesitate to contact this office for a quick resolution to your problem.

Terri Sheckles/432-2359
3 December 1996

INFORMATION PAPER

SUBJECT: New Womack Army Medical Center, Furniture/Furnishing

1. Purpose. To provide information concerning the furniture/furnishings acquisition for the new medical center.

2. The furniture for the new hospital is categorized into two packages.

a. The palette furniture package is the "stand alone" type furniture. This type of furniture will be placed in HQ private offices, conference rooms, lounges, waiting areas and the dining area. The palette package is the method in which the Army obtains functional and procureable furniture for their medical treatment facilities. A palette workbook is issued from the Omaha Corps of Engineers, Interior Design Branch, to aid the project interior designer (Terri Sheckles, HFPO) in the selection and procurement of furniture. The palette process allows project input in the furniture selection and layouts. The project interior designer, rather than the actual user, is responsible for the selection of furniture from the palette submission. This is done for a number of reasons:

1) continuity of facility design

2) ensure quality of items

3) cost control.

4) timely procurement

5) flexibility

6) follow on with procurement technical experts

Much consideration will be given to the interior environment of the facility when selecting palette items. It is important to provide a professional and efficient atmosphere. An important factor in the palette furniture selections is the coordination of furniture finishes and upholsteries with the interior building materials and colors.

b. The IMMSS furniture package is the "modular" type furnishings. The Integrated Modular Medical Support System (IMMSS) will be utilized in exam rooms, single and multi-occupancy offices, work rooms and also includes nurse stations, lab, pharmacy and material handling

systems. IMMSS is a demountable and relocatable furniture, furnishings and equipment system composed of components that are panel/rail/wall support connected. IMMSS products can be relocated anywhere within the hospital. IMMSS provides maximum product integration and flexibility to accommodate changing medical technology and functional requirements. IMMSS is durable, flexible, has a professional appearance and is functional within a health care setting. IMMSS coordinates with and compliments the building design and the palette furniture selections.

3. The drapery requirements for the new hospital include patient rooms (except isolation and psych) and exterior office windows in the HQ block. The fabric of the patient room drapery will be multi-colored to coordinate with the cubicle curtain fabric used throughout the facility. Office area fabric will coordinate with the various furniture upholsteries. Windows in these areas have integral blinds, therefore, draperies will have a standard lining.

4. The artwork selected for the new hospital will compliment the interior building finishes and will include selections of poster art and photo art. Photo art will be located in public areas such as waiting rooms and main corridors. Poster art will be located in patient bedrooms, corridors and possibly exam rooms and offices.

5. Status and methods of procurement of the furniture/furnishing packages:

a. The selection of palette type items will be complete in late FY97 with actual placement and design to begin early FY98. User interviews will be held between the department furniture POCs and the HFPO interior designer. These will begin early in FY98. The users will provide input on function of their area, personnel, specific needs (filing, storage, etc), special equipment issues, etc. These interviews will take place later than and be separate from the IMMSS user interviews. These will include, but not limited to, conference rooms, lounges, waiting areas, HQ offices and locker rooms.

b. A contract was awarded 9 August 1996 for the IMMSS contract. Purchase orders have been initiated for design of the nurse stations with other areas to follow. A letter will be sent in January requesting a POC be designated who can make decisions to represent the department. This same POC will be contacted for the palette furnishing interviews. IMMSS areas will include, but not limited to, admin/office, nurse work rooms, exam rooms, material handling and carts.

c. The drapery package will be complete in early FY98.

d. The artwork package will be complete in mid FY98.

6. The POC for the furniture/furnishings selection and procurement is

Ms. Terri Sheckles
Interior Designer
Health Facility Project Office (HFPO)
432-2359 or 3340

432-6956 (fax)

18 September 1995

QUESTIONS & ANSWERS
Integrated Medical Modular Support System (IMMSS)

Users can become very interested in the furniture to be procured for their areas within the new facility. Several concerns and questions frequently surface pertaining to what is being ordered for them. Following are some familiar and repeated questions that are heard pertaining to the procurement of IMMSS.

Q: What is IMMSS?

A: The intent of IMMSS is to provide a quality interior furnishings system for the New Womack Army Medical Center, Ft. Bragg, North Carolina. IMMSS is a demountable and relocatable furniture, furnishings and equipment system composed of components, including but not limited to panels, rails and vertical and horizontal wall supports, work surfaces, storage units and electrical hardware, that are panel/rail/wall support connected and supported to provide work stations and combined to meet various functional requirements of the facility. These products shall enable the medical center to avoid product obsolescence due to changes of operation, equipment and personnel needs. The interior furnishings must respect this intent and provide maximum product integration and flexibility to accommodate changing medical technology and functional requirements. The products will be durable, flexible, safe, have a professional appearance and be functional within the health care setting. IMMSS shall coordinate with and compliment the building design and all the other furniture items specified for the facility.

The medical center has been designed to be space efficient and permit maximum internal flexibility which will facilitate cost efficient reconfiguration of space and traffic patterns. For example, examination rooms may be converted to doctor offices and vice versa as requirements change.

A wide selection of components shall be provided to meet clinical, administrative, pharmaceutical modules, lab systems, nurse station and material handling requirements. All products will be modular and capable of being relocated anywhere within the facility. Components will be specifically designed to accommodate material movement in areas of large material flow. The complete line of products will provide benefits to the entire organization from the multi-occupancy administrative offices to material handling and clinical need areas. The modular system provides the ability to relocate workstation components from one location in the center to another as functions change. The system relies upon an integrated infrastructure

allowing direct interchange of system components without facility modifications.

Q: When it pertains to admin areas, I hear that IMMSS is just a fancy way of saying that people work in little cramped cubicles and that no one really has their own space. What's the real story?

A: The real story is that IMMSS/systems furnishings provides a great deal more work surface area and vertical storage than the standard desk, chair and cabinet arrangement. The panels are made of acoustical material and absorb a great deal of noise. They provide work privacy, but make it easy for you to talk to your co-workers when you need to in a multi-occupancy office configuration. The designs will provide for shelving/bookcases, files, drawers, tackboards, paper management tools, task lights, etc. The stations will have power and telephone and computer drops. The storage areas, for the most part, will hang on the panels or on wall strips rather than rest on the floor.

Q: What size will my admin workstation be? What features will it have?

A: As a general rule, in a multi-occupancy configuration, clerical and admin people will have workstations at least 8-by-8 feet in dimension. Areas designed for technical and professional people are, for the most part, a single-occupancy office configuration and have dimensions of approximately 10-by-10 feet. See enclosed typical configurations for examples of a multi-occupancy and single-occupancy area. These drawings will give you some idea of what your area could possibly resemble.

Each workstation will have LAN drops for a PC, power outlets for electrical equipment, telephone jack, flipper door shelving units (concealed shelves), shelves, file drawer pedestals, chairs (number depending on configuration), pencil drawers, tackboards, tool bar for accommodating paper management tools. There are a number of other components available depending on function and other input from user interview.

The workstation components will be hung from wall strips or from panels depending on the room and the design configuration. Panel heights will vary depending on configuration and situations. For example, panels will be low in front of windows. The panels will be fabric covered and colors will be selected by HFPO based on recommendations from the Omaha Corps of Engineers, Interior Design Branch. Panels are usually light colored and fabric covered components within the configuration are darker and will contrast or blend with the panel color. Chair fabrics will also compliment the panel and component colors.

Q: What will my exam room look like?

A: The exam room components will be hung from vertical wall strips and horizontal rails.

Administrative, as well as, clinical/material handling components will be designed in the exam room configurations. A work surface, upper storage (flipper door), tackboard, keyboard tray, file drawers and paper management tools are the likely components to comprise the admin portion. A wall mounted large storage module with various shelves, drawers, and compartments is an option for material storage/handling. This module will have the capability of being transported via mobile cart for restocking, etc. The exam room most likely will feature a small mobile storage cart (L-Cart) which is configured with various drawers for storage and a work surface.

Q: Will everyone have IMMSS/systems furnishings?

A: Criteria is currently being developed to determine which areas/rooms will receive IMMSS furnishings. In the past, criteria included:

- multi occupancy offices (2 or more people)
- majority of single occupancy offices
- acoustical privacy is needed
- vertical storage is needed
- room layout is dysfunctional for traditional stand-alone furniture
- room has great potential for redesignation of function (i.e. doctor's office to exam room)
- excess traffic/major assembly point for staff (NCOIC/Wardmaster office)
- nurse stations
- nurse work rooms/areas

Single Occupancy
Office

Multi Occupancy
Office

Exam Room

INFORMATION PAPER

SUBJECT: Contracting Information

1. Contractor/Vendor Representatives are salesmen. Most salesmen are paid on a commission basis. They don't get paid unless someone buys, therefore, it is imperative that **no-one obligates or commits the government to any purchase without proper authority**. As part of the Transition Office, my mission and objective are as follows:

OBJECTIVES:
To ensure that no-one obligates the government without Contracting Officer Authority.
To ensure that all procurements are purchased utilizing the guidelines and regulatory requirements set forth in the Federal Acquisition Regulation (FAR).
To coordinate all procurement actions and assist users with acquiring desired equipment.
Oversee and plan all procurement actions.
Assist users with vendor presentations, thus maintaining high procurement integrity.

2. To assist you in providing correct information to vendor and contractors, Solicitation Mailing List Application (SF 129) has been attached. This form should be provided to any Contractor/Vendor that would like to be included on the mailing list for equipment procurement. The SF 129 when completed should be mailed to: Central Contracting Office MEDCOM, ATTN: MCAA CS BLDG 2015, 1105 Beebe Loop, Fort Sam Houston, TX 78234-6000.

3. Contact the TOC prior to accepting any products or equipment from contractors for the purpose of examination or demonstration. We will provide you with a Material/Demonstration/ Examination/Products Displays Letter. This letter serves as an agreement between the government and the contractor and protects both. It also establishes guidelines and limits the time that the government can evaluate the equipment.

4. Point-of-contact for contracting questions or issues is: Ms. Gloria Carr, Transition Office Contracting Specialist, at 2-2215/2315/2219.

INFORMATION PAPER

SUBJECT: Budget Documentation

1. Proper budgeting will allow all departments within this facility to continue to operate as normal and yet still meet the daunting requirement of transitioning into the new facility. This will include unusual and usually unexpected expenses, many of which will occur prior to the completion of the new hospital. Some of the items below may be eligible for Transition funding:

a. Travel/TDY for training on equipment/systems *DIRECTLY* related to the New Facility.
b. Moving costs related to relocating into or because of the construction.
c. Communication installation costs.
d. Some furniture costs.

2. The important criterium for any costs is that it must be *directly related* to the construction of the new hospital, *usually a one time occurrence*.

3. There will be instances where the cost may be borne by the activity. Resource Management Division and the Transition Office are working on a method to capture all of these costs in order to validate the necessity of increasing the annual Transition Office budget and/or reimbursement of these expenses.

4. The Transition sends out a letter once a year requesting information on the following fiscal year budget. It is imperative that this information is provided to the Transition Office, so that we may be better able to assist you (our customers). *Failure to do so may cause your activity to incur expenses that otherwise could have been paid by the Transition Office.*

5. Point-of-contact for budget questions or issues is: Ms. Kathryn Walls, Transition Office Program Analyst, at 432-2215/2315.

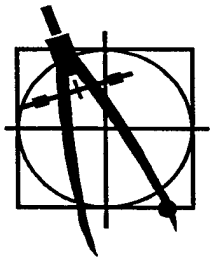
Transition Planning Checklist **Transition office Comples** **Womack Army Medical Center** **Fort Bragg, NC 28307-5000**	**ACTIVITY: ED Ambulance Section** **POC: Mr. Dan Ayers** **TELEPHONE: 2-7774**
Action: Date:	**Comments**
Initial Meeting: 27 August 97	**Draft to be submitted:** **Reviewed initiated:**
Follow-on Meeting:	
Follow-on Meeting	
Follow-on Meeting	
Follow-on Meeting	
Follow-on Meeting	
Referral to Automation:	
Referral to Equipment:	
Referral to Furniture:	
Summary Meeting :	
Referral to Procurement:	
Final Review:	
Briefing: Transition Committee	

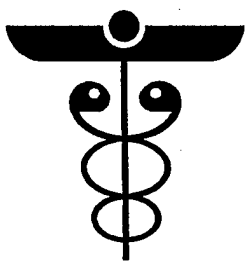
TOC TICKS

May 1998

Monthly publication of the Transition Office Complex. Purpose of this newsletter is to provide pertinent information about construction and transition activities of the NWAMC, Joel Health and Dental, and Clark Clinics.

What's Inside....





from the desk of the Chief,TOC

The New Telephone System

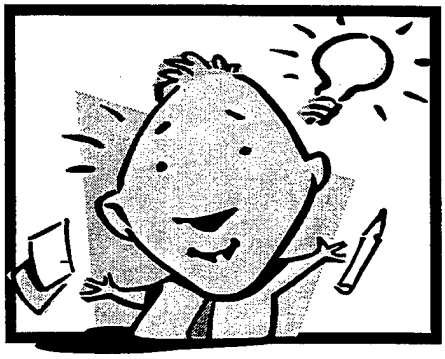
What is the value of telephone communication? As our world changes dramatically every hour, it is integrally important for us to communicate with each other telephonically, verbally, and by mail (ccmail, CHCS, postal, etc.). Each new medical facility will have single-line telephone system capability into its work area.

Imagine bringing the flexibility, accessibility, and convenience of your home phone into the office. The single line telephone at the office, the exam room, the receptionist's desk, will allow you to have immediate telephone line access coupled with voice mail and a service package of features (call forwarding, call transfer, call waiting, etc.)

As each activity completes its automation planning, telephone location and a standardized package of service must enhance your ability to communicate with your internal and external customers.

This operational change allows you (the user) to avoid a desk instrument with multiple lines. You will not have to wait until one line is free to make a call. If you are not using it, then you have a free line. Through the use of call groups, you can structure multiple numbers in your group that can be answered by multiple persons. Maximizing the single-line telephone features, telephone access should improve for our patients and staff. How will you maximize this change?

MAJ Don Brocker



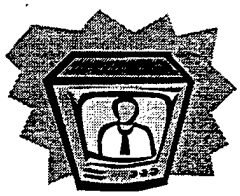
NWAMC TRIVIA !!!

1. How many bricks were used to build the NWAMC?
2. Who is driving the TOC Bus this month?
3. How many trees will be planted on the new hospital grounds?

ANSWERS:
1. 2 Million.
2. Rich Wagner
3. 1,60# plants (23 types)

Watch for TOC updates on Ft. Bragg Channel 7.

STAY TUNED...



TOC TICKS

Opening Dates!!!

⇒ ***Joel Health and Dental Clinic Opens Summer 1998 88.9% Completed***

⇒ ***Clark Clinic opens Summer 1999 47.7% Completed***

⇒ ***NEW WAMC opens Summer 1999 88.1% Completed***

Watch our TOC

Go Up the Mountain of Progress!!!

We now have a bulletin board near the dining facility describing the construction progress of the New Womack Army Medical Facility

CHECK IT OUT..... each month will feature a new driver. It could be your boss, a friend, **EVEN YOU!**

Be one of the first **five** people to call and tell me who is driving the bus this month and receive a **"Special Gift"** from TOC. Call Sande Barr, TOC Marketing, 432-2215/2219.

Updates from the Chief, HFPO-SE

The new Womack Army Medical Center is currently 88.9% complete. We are approximately 15 months from completion of the project. When you pass the construction on Reilly Road, you see that the majority of the exterior building work is completed. Within the structure the A building, Clinic Mall, is almost complete and we have begun to "punch out" the building which means we're checking for deficiencies that need to be corrected. The B building, Ancillary Building, has all studs in place and wall board is almost complete. The C building, Tower, stud work is completed to the 6th floor. the majority of the contractor work force is working on the interior of the building which will continue over the next 12-14 months.

How does this impact us? Tour traffic will have to be scheduled during non-peak work hours and tour group sizes will have to be limited. It is imperative that we do not impede the work progress of the contractor. The best time for tours will be during lunch hours 1100 - 1230 and after 1530 in the afternoons. The HFPO realizes the importance of getting the users out to see the site to see their future areas of operation and will work with the user to make this possible. Please schedule your tours at least a week in advance, POC's are MAJ Steele. CW3 Helms or Robbie Johnston, 432-2359/4077.

LTC Carmen Rinehart

Construction Area Safety!!!

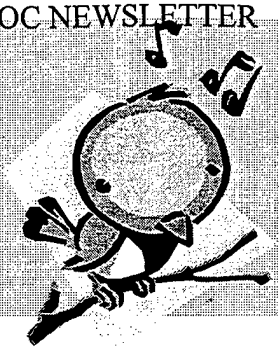
Construction areas are inherently dangerous require specific safety procures be followed when people enter a construction area. Recently some Womack staff visited the new buildings under construction without permission or escort. The visit may not seem dangerous or reckless, but it does expose the individuals to injury and the contractor to liability.

All visits to construction sites must be coordinated with the Health Facility Project Office (HFPO), an escort provided, and the required safety procedures followed (including clothes, equipment, briefing and liability release). You ***MAY NOT*** drive onto the site without permission. This procedure is for your safety and to insure the contractor takes appropriate measures to protect you while visiting the site.

If you have any questions, please contact the safety office at 432-4722 or HFPO at 432-3340/2359.

Thomas Archer, Safety, WAMC
Health Facility Project Office
Centex Construction Company

IMD in the NWAMC...

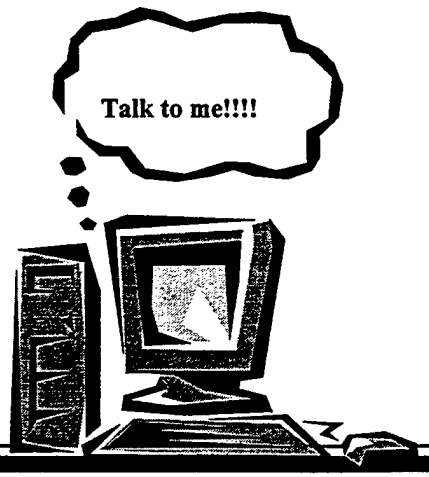


As many of you are aware computers and other information technologies have invaded healthcare. In New Womack Army Medical Center the presence of information technologies will be much greater than we see today. In this series of short articles I want to discuss what the Information Management Division is planning and what your role in that planning is.

Your role is to define how you will conduct business in the new facilities. What are your requirements? Please note that I did not ask you to tell me how fast a processor you need, how much disk space, how much memory, or what programs do you want. Your focus should be on the functions you perform in your job! The technology decisions should be the last step in the requirements analysis. If you define the solution first, then making the problem fit it, often leads to unresolved problems.

In defining your requirements you need to "think out of your box." Not, "I need to do word processing," but "I want to create memorandums by talking to the computer and automatically file them in the patient's records." This is a golden opportunity to bring in some technologies and processes as we transition to the new facilities. Don't look back at how we do it today, ask how can we do it better tomorrow.

MAJ Richard Stepanek
Chief
Information Management Division



Springtime Decor.....

As we have all noticed, Spring has arrived with the flowers and trees blossoming out in their various arrays of beautiful color. I have had inquiries about the planned landscaping of the new Womack. This past year at the Reilly Road entrance of the hospital, Saucer Magnolia trees were planted. These trees with their large flowers in early spring give a pleasing view upon entering the hospital grounds.

The hospital grounds cover 163 acres. The hospital is as big as Cross Creek Mall. Parking areas will have 2,500 spaces and 119 handicap parking. The remainder of the hospital area will be landscaped with the following:

Grass	50 acres
Ground cover	125,660 plants (13 types)
Shrubs	5,943 plants (17 types)
Trees	1,604 plants (23 types)
Seedlings	1,092 plants (5 types)

We will have our own "Botanical Gardens" right here on Ft. Bragg to enjoy. It will be a pleasure to watch these new plants grow and mature to their full beauty.

Not to forget the inside of the hospital, it will have 1,092 plants of 4 different varieties complimenting the interior design. Our beautiful state-of-the-art medical center will truly be a wonderful place to thrive.

Sande Barr, Editor

Loggie Notes:

On several occasions, I have been asked if furniture items can be moved from the old hospital to the new WAMC. The answer is sorry, no-can do. Have no doubts! The New Womack Army Medical Center is going to be ***the*** state-of-the-art medical care facility in the Department of Defense. Architects, engineers, and interior designers have spent literally thousands of hours planning the systems, furnishings, and equipment to make it the Army's premier healthcare facility. The area which has the biggest impact on the aesthetics of any facility is the furniture. It has to be tough enough to meet the rigors of the healthcare use. It must be functional, ergonomic, but most of all pleasing to the eye. During the planning process, great care was taken to keep the furniture consistent with the architectural intent of the facility. Colors, textures, and fabrics all work in harmony to provide a peaceful and calm environment for both patients and staff. To achieve this, we are purchasing all new furniture, furnishings, window treatments, artwork, and decorative plants. Even though your current furniture may be relatively new and in good shape, it is unlikely that it will be a perfect match. So plan on saying goodbye to it when you move.

Rich Wagner
Logistics C., TOC

May Showers bring May flowers!!!

INTERESTING BUILDING AND SITE FEATURES OF JOEL HEALTH AND DENTAL.....

The following are interesting building and site features we would like to 'bragg' about in the final article of this series.

Beginning with the flexible room design in Primary Care. Rather than design some permanent provider offices, and some permanent exam rooms, the clinic has maximized treatment capability by installing a sink in each room along the exam finger corridors and making these rooms convertible as an office or an exam. Each of these exam/office rooms has sufficient lighting, ventilation, power, and phone/data connectivity to support either exam equipment or office equipment. State-of-the-art computer connectivity is in every exam, dental treatment, office, and reception area. Conference rooms have connections in the floor for a presentation or other computer technology sitting on the conference room table. This precludes staff from triping over extension cords. Once you plug in, you reap the benefits of a speedy network, courtesy of IMD's design and installation efforts.

Dentist need good quality and a high level of lighting. At Joel, they get it The designed 5000k "color-matching" lamps score 90+ on the Color Rendering Index (specifically for areas where color discrimination is important) They are located in all dental treatment and oral hygiene rooms. The interior design has a special complimentary effect as well. The special patterned tile in front of all reception counters will give a visual clue to where they are. Waiting area for Primary Care has five raised-ceiling areas with recessed lighting to provide a more comfortable environment. Waiting areas for dental has a 'clerestory' which allows natural light to enter the large open space and reflect down pleasantly.

"Troop photographs" of various units served by the clinic will be posted in the main corridors and waiting areas.

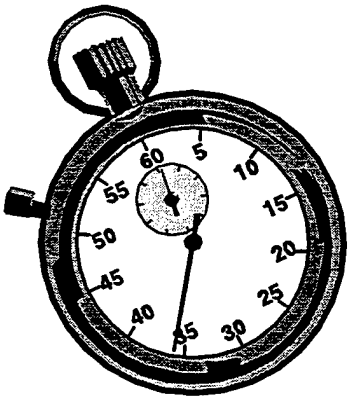
Sande Barr
Marketing & Editor

Staff News.....

TOC bids a fond farewell to the following individuals. Ms. Kathie McCracken and her husband are moving to the Washington D. C. area. LTC Louise Cuthbertson is retiring and will be returning to her family and home in Virginia. Good Luck to you both in your new adventures in life!

Welcome to our newest staff member, Roy Arne.

Watch our TOC Bus go up the Mountain of Progress!!!!!



Watch for the **BRIGHT ORANGE** monthly publication, **TOC TICKS**, for updates about the transition of Joel Health and Dental Clinic and construction updates of NWAMC and Clark Clinic. ✓

☛Watch Ft. Bragg Channel 7 for Transition Updates✓

☛ Check out the Ft. Bragg Home Page, HFPO-SE and TOC TICKS newsletter for construction progress updates. ✓

✆ Need additional information about Transition activities?
Call: Sande Barr, Marketing, 432-2219/2215, Fax 432-5869 or
EMAIL: SANDRA_BARR_AT_hfpose@ftdetrck-ccmail.army.mil

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