

[H.A.S.C. No. 111-109]

**THE NEW WALTER REED: ARE WE ON
THE RIGHT TRACK?**

JOINT HEARING

BEFORE THE

READINESS SUBCOMMITTEE

MEETING JOINTLY WITH

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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THE NEW WALTER REED: ARE WE ON THE RIGHT TRACK?

HOUSE OF REPRESENTATIVES, COMMITTEE ON ARMED SERVICES, READINESS SUBCOMMITTEE, MEETING JOINTLY WITH MILITARY PERSONNEL SUBCOMMITTEE, *Washington, DC, Wednesday, December 2, 2009.*

The subcommittees met, pursuant to call, at 10:02 a.m., in room HVC-210, Capitol Visitor Center, Hon. Solomon Ortiz (chairman of the Readiness Subcommittee) presiding.

OPENING STATEMENT OF HON. SOLOMON P. ORTIZ, A REPRESENTATIVE FROM TEXAS, CHAIRMAN, READINESS SUBCOMMITTEE

Mr. ORTIZ. The subcommittee will come to order. Today the Readiness Subcommittee and the Military Personnel Subcommittee meet in a joint session to discuss the Base Realignment and Closure (BRAC) realignment of Walter Reed and whether the final plans are sufficient to meet a world-class standard.

The realignment of the Walter Reed National Military Medical Center was one of the major decisions included in the 2005 Base Realignment and Closure process. Its overarching reach to close the Walter Reed Army Medical Center and relocate those activities to Fort Belvoir and Bethesda have not been without controversy or political carnage.

Because of the substandard conditions found at Walter Reed, the former Army Surgeon General and former Secretary of the Army were relieved of duty. At the heart of this controversy is the fundamental discussion as to what level of care should our wounded warriors receive. In my estimation this simple question deserves a very simple answer: the best.

What most intrigues me in this decision process is that I am not convinced that the Department of Defense (DOD) shares in this simple assessment. The Deputy Secretary of Defense indicated that “development of a world-class medical facility is not a destination, but rather a journey of continuous improvement.”

This seems to indicate that the Department cannot obtain a world-class medical facility as proposed in the BRAC process in the timeline provided. So where does this journey contemplated by the Department take us? It would provide us a medical facility capable of providing medical care to the military concurrent with the BRAC timeline, but it does not deliver the world-class expectation envisioned by the BRAC Commission or the Department.

The Defense Health Board (DHB) recently stated that the current design would not attain world-class. I find this unacceptable. This inability to obtain a world-class medical center seems to hide

the fact that 4 years have passed since the BRAC Commission reported its findings, and yet we still have a disorganized medical command, a disjointed funding authority, and an inconsistent construction design in support of a \$2.5 billion effort.

I have visited the Bethesda campus several times since the BRAC Commission finalized its deliberations. While I am convinced that the new construction is on the right path, I think that the overall requirements to provide the best care to our wounded warriors needs to be reassessed, and the full scope of work, including related repair work, needs to be reviewed.

I think the input provided by the Defense Health Board provides an excellent roadmap on issues to address. In the end I hope that this theory provides answers to the questions about what our wounded warriors deserve. I hope that at the conclusion of our deliberations, we will be united in saying that they do deserve the best.

The chair now recognizes the distinguished chairwoman from California, Mrs. Davis, for any remarks you would like to make.

[The prepared statement of Mr. Ortiz can be found in the Appendix on page 33.]

Chairman Davis.

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS. Thank you, Chairman Ortiz.

Well, here we are again. We are having a hearing about Walter Reed. And history, I think, to all of us is important. In 2004 the Military Personnel Subcommittee raised a number of concerns about how we were caring for our wounded warriors. The Department of Defense witnesses told us to trust them and that they would make sure that wounded warriors and their families were properly cared for. And our reward for that trust were the revelations of almost three years ago at Walter Reed.

Ladies and gentlemen, any response of "trust us" simply doesn't suffice. While the name "Walter Reed" is the same, I need to make an important distinction. What was revealed at Walter Reed almost three years ago was shameful. Wounded warriors and their families were allowed to fall through the cracks. They were often left to fend for themselves for administrative tasks such as pay and housing.

However, there is one thing that was never questioned during the scandal that had to do with the quality of medical care provided at Walter Reed. It was and remains excellent. One of our key concerns is that the current plan and the organizational structure are simply inadequate and that patient care, wounded warrior care, will suffer as a result. Chairman Ortiz said it perfectly. There is only one acceptable standard of care for our wounded warriors, and that is the best.

We have had concerns about the plans for the Walter Reed National Military Medical Center at Bethesda from the beginning. In hearings and meetings we have had Vice Admiral Mateczun tell us in effect not to worry, that everything is on track, but we have yet

to be convinced that that is true. And in fact, we have yet to be convinced that the Department takes our concerns seriously.

In last year's National Defense Authorization Act (NDAA), we required that an independent design review be done to validate the current plan, and that review was completed this last summer. And its results are simply unsettling. Among the troubling descriptions of the current plan are that it would not result in a world-class facility, that it would not meet joint commission accreditation standards and that it was ambiguous about the vision, the goals and expectations of the new century.

As disconcerting as the independent design review's findings were, however, they pale in comparison to the Department's response to those findings. And for example—and this was mentioned already—“development of a world-class medical facility is not a destination, but rather a journey of continuous improvement.”

World-class is most decidedly a destination, one that Congress expects its new facility to arrive at before the center opens its doors. The definition of world-class will no doubt evolve over time, but as the independent design review has indicated, the current plan does not meet today's definition, and that is unacceptable.

As Chairman Ortiz mentioned, four years have passed since the BRAC recommendations were reported. Two years have passed since the Joint Task Force Capital Medicine was established. Still we do not know exactly who has overall responsibility for this project. Key decisions about funding, staffing and the chain of command have yet to be made, and we do not feel that the plan meets all of the requirements spelled out in law and the BRAC recommendations.

And we have an independent design review that is highly critical of the current plan and organizational structure. Since this is our first hearing since the findings of the independent design review were released, I would like to hear how the Department plans to address the shortcomings identified.

I also look forward to hearing directly from the chair of the independent design review, Dr. Ken Kizer, and hope that we will have a productive discussion about this incredibly important topic. When the hearing ends today, it is my desire that we will leave with a better understanding of what needs to be done to ensure that the new Walter Reed National Medical Center at Bethesda becomes everything that it is supposed to be.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

Mr. ORTIZ. The chair now recognizes the distinguished gentleman from South Carolina, Mr. Wilson, for any remarks that he would like to make.

STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. WILSON. Thank you, Mr. Chairman. And thank you and Chairwoman Davis.

As I begin, I would like to move unanimous consent to introduce a statement from Ranking Member Randy Forbes of the Sub-

committee on Readiness. Congressman Forbes is currently at a markup of his Judiciary Committee.

Mr. ORTIZ. Without objection, so ordered.

[The prepared statement of Mr. Forbes can be found in the Appendix on page 37.]

Mr. WILSON. And I appreciate joining our good friends on the Readiness Subcommittee today led by Chairman Solomon Ortiz and Ranking Member Randy Forbes for our hearing on the progress of the Walter Reed National Military Medical Center.

I welcome the distinguished members of our witness panel. I believe that there is nothing more important than providing the outstanding members of our military, their families and our retirees world-class health care delivered in world-class medical facilities. There is no question in my mind they deserve nothing less.

Our family has experienced a quality of service with two grandsons born at Bethesda Naval Medical Center and a granddaughter born at Portsmouth Naval Hospital.

The Department of Defense has assured us on several occasions that merging Walter Reed Army Medical Center and the National Naval Medical Center at Bethesda, two icons of military medicine, would result in a single world-class medical center that would provide improved access to enhanced medical care for our troops and their families and veterans in the National Capital Region (NCR).

Now, I understand that the National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee of the Defense Health Board has issued a report that calls into question whether the Department's plan to merge these two facilities will result in a world-class facility. Further, I am aware that the Defense Health Board has expressed concerns regarding the Department of Defense's Corrective Action Plan published in response to the findings and recommendations of the board. It appears that there is still doubt about the new facility being world-class.

Before we hear testimony from our witnesses this morning, let me be very clear that the new Walter Reed National Military Medical Center opening as a world-class medical facility is not negotiable. We cannot accept anything less.

With that, I would like to thank our witnesses for participating today. I look forward to your testimony.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 40.]

Mr. ORTIZ. Thank you, Mr. Wilson.

Today we have four distinguished witnesses. Representing the Department of Defense, we have Mr. Al Middleton, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs; Dr. Dorothy Robyn, Deputy Under Secretary of Defense for Installations and Environment; Vice Admiral John Mateczun, Commander, Joint Task Force National Capital Region Medical; and Dr. Ken Kizer, Chairman, Defense Health Board, National Capital Region Base Realignment and Closure Health System Advisory Subcommittee.

And without the objections, the prepared statement that you may have will be accepted for the record. And hearing no objection, so ordered.

Mr. Middleton, welcome. And you may proceed with your opening statement whenever you are ready. Good to have you here.

And we are very honored to have an outstanding group of witnesses among us this morning. Thank you.

Mr. Middleton.

STATEMENT OF ALLEN W. MIDDLETON, ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

Mr. MIDDLETON. Thank you, sir. Mr. Chairman, Madam Chairwoman and distinguished members of the subcommittees, good morning. I am Al Middleton, the Acting Principal Deputy Assistant Secretary of Defense for Health Affairs. I am pleased to be here today to discuss progress in the implementation of the 2005 clinical BRAC recommendations for the National Capital Region.

As you know, the BRAC Commission report to the President released in November of 2005 directed the Department to close Walter Reed Army Medical Center in Washington and to realign the facility with the National Naval Medical Center in Bethesda, creating the Walter Reed National Military Medical Center, and to build a new community hospital at Fort Belvoir, Virginia, by the BRAC deadline of September 15th, 2011.

The Military Health System must fulfill a sacred responsibility to care for our Nation's service men and women, their families and those who have served before us. I am grateful for the many dedicated men and women who have answered the call to duty, and we are working to ensure that we create a health care facility that is well positioned to meet our service men and women, veterans and wounded warriors in the National Capital Region and throughout the country.

As principal advisor to the Secretary of Defense for the Department's health care program, the Office of the Assistant Secretary of Defense for Health Affairs maintains oversight of the clinical BRAC actions, including the transformation of the National Capital Region currently under way. I am pleased to report that we are on track to implement the BRAC recommendations by the statutory deadline of 15 September 2011.

However, we must acknowledge that completion of construction activities represents only part of the story. We sincerely appreciate the efforts of the Defense Health Board Subcommittee and acknowledge that their findings and recommendations can only help us in our quest to be world-class in the National Capital Region and throughout the Military Health System.

Addressing the complexity and resolving the challenges of BRAC transformation in the National Capital Region clearly necessitates the knowledge and the insight that the members of the health system advisors of the subcommittee possess.

Executing BRAC and creating an extraordinary health care delivery system in the National Capital Region in a relatively short period of time is certainly one of the most difficult undertakings in the history of the Military Health System. The Joint Task Force National Capital Region Medical (JTF CAPMED) was created to lead this clinical transformation in the National Capital Region.

Despite the challenges and complexities inherent in this task, we should not lose sight of the great progress that has been made to date. This single act of consolidating two medical centers into one, constructing a new robust community hospital in proximity to the majority of beneficiaries, is a major accomplishment.

The creation of the JTF CAPMED as the overarching market manager has been important to this effort, and I am confident that we are headed in the right direction and appreciate the Defense Health Board Subcommittee's detailed roadmap to achieve a world-class delivery system built upon world-class facilities at Bethesda and Fort Belvoir.

I look forward to working with the JTF CAPMED in the future and the military services and other stakeholders to implement the subcommittee's vision. Although our primary focus has been completing the BRAC recommendations before the deadline, we understand that creating outstanding health care facilities as a long-term commitment to improve beyond BRAC, and additional investments are required to achieve that end state.

We are prepared to support the JTF CAPMED and the military services in identifying additional non-BRAC requirements and to ensure that they are considered in the future budget requests. We continue to work to provide every man and woman in uniform with the best health care possible, and we appreciate this committee and the committee's continued support as we strive to excel in everything that we do.

Mr. Chairman, Madam Chairwoman and distinguished members of the subcommittee, I would like to thank you for the opportunity to address you today. I will be pleased to respond to any questions you may have in the ongoing dialogue that we will have to move us all closer to the jointly held goal of a world-class health system. Thank you.

[The prepared statement of Mr. Middleton can be found in the Appendix on page 42.]

Mr. ORTIZ. Dr. Robyn, you might proceed whenever you are ready. You can get close to the mic.

STATEMENT OF DR. DOROTHY ROBYN, DEPUTY UNDER SECRETARY OF DEFENSE, INSTALLATIONS AND ENVIRONMENT, U.S. DEPARTMENT OF DEFENSE

Dr. ROBYN. Oh, thank you. It helps to turn the mic on.

Chairman Ortiz, Chairwoman Davis, Congressman Wilson, Delegate Bordallo, distinguished members of these two subcommittees, I am honored to appear before you to discuss the question of the new Walter Reed—are we on the right track?

I am the Deputy Under Secretary of Defense for Installations and Environment (I&E). I have been in that position since July. My office is a major advocate within the Department of Defense for getting military facilities the budget they need in order to do their job effectively, mainly to support mission occupants. My office also oversees the BRAC process from start to finish.

The BRAC has, among other things, been a significant engine for re-capitalization of our enduring military facilities. Hospitals and other medical facilities in particular have received a significant

amount of funding as part of the latest BRAC round, the 2005 BRAC round.

To answer the question posed by this hearing—are we on the right track with respect to the new Walter Reed—it is helpful to recall how we got to this point. Specifically, several concerns about the state of medical care in the National Capital Region drove the 2005 BRAC decision.

First of all, there was a growing mismatch between the location of the eligible beneficiaries with active duty families concentrated in the southern part of the region and the location of the major medical facilities to the north. Second, Bethesda and Walter Reed had significant excess inpatient capacity.

And third, Walter Reed's infrastructure was deteriorating due to the combination of heavy use and chronic under-investment. It would have, by our estimate, cost hundreds of millions of dollars—between \$500 million to \$700 million—to renovate or replace the existing Walter Reed facility and would have taken between 6 and 15 years to accomplish that process.

By closing Walter Reed, and expanding and improving facilities at Bethesda and Fort Belvoir, the BRAC decision allows the Department to more effectively channel its resources. And in the Department's view, this reallocation of resources, combined with the shift to a joint service delivery approach in the National Capital Region, promises to transform medical care delivery in this area.

With less than two years to go, we are on schedule, and we are on track to deliver the promised benefits by the BRAC deadline of September 2011. The Defense Health Board Subcommittee provided an excellent roadmap, to use your words, Chairman Ortiz, for that transition, but they have in recent weeks suggested that the Department should possibly delay the BRAC construction process, pending further planning of additional improvements—improvements that are outside the scope of BRAC that the subcommittee believes are necessary to make the new Walter Reed world-class.

We fully agree with the need for additional improvements, but we think it is not necessary to halt the BRAC construction process. And we think to do so would jeopardize their benefits that this endeavor promises. And let me cite three reasons why I believe that.

Most important, without the discipline of the BRAC process, we could not have overcome the inertia and the impediments to change that created the problems that are described in the first place. But we need to keep the discipline of the BRAC process in place in order to solve that problem.

Second, we need to continue to operate the existing Bethesda Naval Hospitals even as we renovate and expand this facility. It is a little bit like building a new Woodrow Wilson Bridge while continuing to operate the existing bridge. We have to do both things at once. So there is a real limit to the amount of construction and activity that we can undertake there at one time.

And third, by and large the kinds of additional improvements being discussed to make the new facility world-class can be addressed separately and subsequently. Thus, continuation of the BRAC construction process will not result in wasted effort. By contrast, if we suspend the BRAC construction process, we will sub-

stantially delay and possibly jeopardize the benefits that this promises.

So in conclusion, it is a large, complex undertaking, as you have heard, but it represents a reasonable and balanced approach to combining the functions of the old Walter Reed with the new. And it will result in a delivery system that is superior to what we have now, and one on which we can continue to build in the future. My message is simple. This undertaking would not have been possible without BRAC, without discipline of BRAC. If we relax that discipline, we jeopardize those benefits with little, if any, offsetting benefit.

So in conclusion, my simple message is keep the pressure on. Let us stay the course. Thank you very much.

[The prepared statement of Dr. Robyn can be found in the Appendix on page 48.]

Mr. ORTIZ. Thank you.

Vice Admiral Mateczun, whenever you are ready with your statement, you can proceed, sir.

STATEMENT OF VICE ADM. JOHN M. MATECZUN, USN, COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL REGION MEDICAL

Admiral MATECZUN. Thank you, Chairman Ortiz, Chairwoman Davis, Ranking Member Forbes, committee members. Thank you for the opportunity to share with you the progress of the Department in realigning the medical assets of the National Capital Region to create the Military Health System's first fully integrated, jointly operated and staffed health care delivery system.

This transformation will allow the DOD and the military services to capitalize on their collective strengths, maintain high levels of readiness, provide world-class health care to our Armed Forces and their families, both active and retired.

I want to take the opportunity to thank the Military Personnel and Readiness Subcommittees for their continuous support and oversight. Your visit to Bethesda back in March was greatly appreciated, and the meetings that we have had since then have certainly provided the guidance and direction that we needed. I would like to commend Dr. Kizer and the Defense Health Board Subcommittee on the NCR for their work in defining world-class, and then their recommended steps to achieve that world-class.

The attributes that they talk about in the world-class institutions do not all exist in any one place that I know of in the world. They are goals that we must strive to achieve, and there are many of those attributes of world-class that exist today at Walter Reed—not just world-class, but best-in-class, best-in-the-world.

If you want amputee and prosthetics care, Walter Reed is the place that you want to be today. If you have an open traumatic brain injury, then Bethesda is the place that you want to be. Those are examples of some of the quality of care that is going to go on when we combine these two centers. There will be no diminishment of any of those attributes of world-class care that already exist today at Walter Reed or Bethesda.

Our goal now is to strive towards the rest of the attributes that Dr. Kizer's committee has so well put together. Now, Dr. Kizer's

getting ready to publish and make these guidelines available. They have been enacted into statute in the Fiscal Year (FY) 2010 NDAA and provide a new guideline for us. So as part of that evolution, as they have gone from BRAC to the post-February 2007 commitment to our wounded warriors, we now have a new standard just established within the last two months.

We have had the Defense Health Board report to be able to work on. We are not disagreeing with any of the recommendations that the Defense Health Board has made. We are committed to achieving world-class standards at the new Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital.

The Capital Region Medical BRAC projects and the journey to world-class are inextricably linked. The DHB required a master plan to be developed. And in fact, in the Fiscal Year 2010 NDAA, there is a requirement that the Department do that. This comprehensive master plan will synchronize the current efforts that are going on, both with the BRAC and then those other efforts that will be needed to achieve as many as possible of the attributes of world-class that the panel so well laid out.

That master plan will satisfy the requirements of 2714 of the Fiscal Year 2010 NDAA, which is required by the 31st of March. I would say that the Department is on schedule to meet the BRAC deadline. In our former briefs to you, I told you about our progress towards the initial outfitting and transition contract. That contract was awarded last week, and we have a highly competent group of general and subcontractors that will be performing that activity.

That was one of the last contractual pieces that we will have to meet in terms of the construction and outfitting to be able to achieve the BRAC deadline. And there are no data points, and I will reiterate again there are no data points that I know, that say we would be unable to meet the BRAC deadline.

Casualty care is my number one priority. We are committed not just to world-class care, but to the best care that can be provided anytime, anyplace, to the wounded that are coming to us from the theaters in Iraq and Afghanistan. And we will suffer no diminishment of care or patient safety during this transition to be able to achieve the goals that the Department has.

Chairman Ortiz, Chairwoman Davis, Ranking Member Wilson, committee members, thank you again for your interest and support in the transformation. We are committed to providing this health care not just to our wounded, but to all of our beneficiaries. Your support and oversight have made immeasurable contributions to this process. The Department will continue to work with the military services to make this integrated regional health care system the first in the country within the Military Health System.

We look forward to a fruitful and collaborative partnership with this committee. Thank you for the opportunity to be with you today.

[The prepared statement of Admiral Mateczun can be found in the Appendix on page 58.]

Mr. ORTIZ. Thank you, Admiral.

Dr. Kizer, whenever you are ready, sir.

STATEMENT OF DR. KENNETH W. KIZER, CHAIRMAN, DEFENSE HEALTH BOARD, NATIONAL CAPITAL REGION BASE REALIGNMENT AND CLOSURE HEALTH SYSTEMS ADVISORY SUBCOMMITTEE

Dr. KIZER. Good morning, Chairman Ortiz, Chairwoman Davis, Ranking Members Forbes and Wilson, distinguished members. Thank you for inviting me to make some comments this morning. Everyone here knows the history of how we got here this morning, so I will not take any time to make comments in that regard. And I thank you for including my written testimony in the record.

I would like to use my allocated time for comments to make two main points that will augment my written testimony.

First, in your consideration about the evolution of Walter Reed to become a world-class medical facility, it is important to keep in mind that the committee's work to date has reviewed only the design plans for the visible architecture of the new Walter Reed National Military Medical Center. That is, we have reviewed only the design plans for the physical structure of the facility. It is not yet possible to review the invisible architecture of the facility.

By "invisible architecture" I mean the values and the culture of the organization, the attitude or morale of the staff, and other less tangible design features of the new facility that will in the long run be the most important determinant of whether the new Walter Reed performs at a level of excellence that would make it world-class.

No matter how new or modern or sophisticated is the visible architecture of the facility, the physical structure alone can never make a world-class medical facility. More importantly, however, it can prevent the facility from becoming world-class.

The second point I would like to highlight is that, as has been commented on by others, that there does not appear to be any significant disagreement about the deficiencies that have been identified in the plan, nor about ultimately what needs to be done to correct them. The Department seems to agree with the subcommittee's findings—the subcommittee that I represent—and acknowledges that the current design plans will not produce a world-class medical facility.

We applaud their candor in this regard, and we recognize that the road getting us to this point has had some hills and curves, to use that metaphor. We also applaud the good work and the diligent efforts of many individuals to make Walter Reed the world-class facility.

And while the Department has stated that it is committed to achieving world-class status, and we commend this expressed commitment, its response to the committee's report does not provide sufficient detail or specificity to determine whether the planned corrective actions are on the right track or will be achieved in a reasonable time or at a reasonable cost, in my committee's judgment.

I believe that the committee would feel more confident that things were on the right track if the statements about commitment were accompanied by detailed plans for fixing the problems, if those plans had clear milestones and deadlines, and if it were clear that someone had the necessary authority and control to execute

those plans. Until these latter things are in hand, I do not see how we as an independent panel would feel confident that we are in fact on the right track.

I should perhaps clarify a bit a point made by one of the other witnesses, and that is that the Defense Health Board has not recommended that construction be delayed or suspended. We do believe that there is a limited time opportunity and a diminishing window of opportunity to fix some of the identified problems at a lower cost and with less disruption and inconvenience to patients and the staff, if these problems are fixed sooner rather than later.

In closing, let me say that I believe there are few issues more important to readiness in military personnel than our troops knowing that the best possible health care will be there for them when they are harmed in the defense of our Nation. I am reminded of this by frequent health care related questions from my daughter, who is currently on active duty as a recruiter with the Marine Corps. And her recruits often ask her about the health care that they will receive if they enlist or should they be injured on duty. And she not infrequently picks up the phone and says, "Dad, what about this?"

Frankly, when we send our children into harm's way, we have a responsibility to ensure that they have the peace of mind of knowing that they will have world-class medical care, should they need it. And anything less than that is simply not good enough.

Representing the committee that has produced the report that you are familiar with, we would urge that whatever action is necessary be taken to ensure that the new Walter Reed National Military Medical Center, and indeed our entire military health care system everywhere, is world-class. Thank you. I would be pleased to answer any questions that you may have.

[The prepared statement of Dr. Kizer can be found in the Appendix on page 63.]

Mr. ORTIZ. Thank you, Doctor.

Mr. Middleton, I have a question for you. I have read the Joint Task Force's issued statement that they are committed to establishing a world-class medical center at the hub of the Nation's premier regional health care system. Is the Department committed to obtaining this vision? I mean I think they are, but I would like to hear from you. When do you expect to obtain this capability, and at what additional cost? Maybe you can enlighten the committee on my question.

Mr. MIDDLETON. Thank you. Thank you for that question, sir.

I think directly the answer to your question is yes. There has been in my view no evidence that we are not committed to that vision, that every effort that was made into BRAC—and I think all of you are familiar with the additional resources that were added to enhance and to accelerate the BRAC construction in the National Capital area, both at Fort Belvoir and at Bethesda, where a big investment by the Department to bring that capability on board as soon as we possibly could.

The addition of warrior treatment centers, you know, the enhancements that we are making with centers of excellence at Bethesda, as you are well aware of, the involvement of the Fisher Foundation in putting in another Intrepid Center of Excellence

there as a donation to the government, I think all speak to that commitment that we have all made to make this world-class.

I think that what we have to do is realize that within the BRAC confinement of what we do in BRAC, we want to get that capability onboard as soon as we can. We know at Bethesda that is going to be 66 single rooms, for example, okay, modern, first-class rooms up there. We know that there's a lot of rooms out there that we are going to have to get back to and renovate. And as Dr. Robyn said, you can't tear the whole thing apart at one time.

We know down at Fort Belvoir we are building perhaps the finest community hospital that has been built in this country in terms of its capabilities, in terms of what is going to happen at that facility, and the facility itself. I think that the commitment is there.

But I am reminded of Dr. Kizer's comments about the six domains of world-class, only one of which is core infrastructure. There are other parts of being world-class, and there are plenty of examples in this country of operations that are not necessarily in first-class facilities, but are world-class operations. And so our commitment is to both.

We want to do the facilities at a time phase. We will have to go beyond the BRAC deadline in order to do some of these renovations up at Bethesda. That is part of our plan. And as Admiral Mateczun and the JTF folks put in their master plan for the National Capital area, we will see that time phasing, the BRAC phase, the concurrent phase, the phase that occurs during BRAC and goes after BRAC.

And then there are things we will have to do after BRAC—not go back and redo what we have done. We will have to use that space as a leverage point, then, to launch. If we had built a new Belvoir 10 years ago, we would have that at a leveraged spot that we could do, but we are going to get that all at the same time.

So once we get that platform done, then we can swing around and do the rest of the facility so that the plan is at the same time we have to work on those other five domains that are articulated in the subcommittee's report. So to answer you correctly, sir, directly we are committed to it—absolutely.

Mr. ORTIZ. There was another part to the question. Maybe you can touch on it—at what additional cost?

Mr. MIDDLETON. That has not been determined, sir. I mean it would be presumptive of me to give you a dollar figure, because I think as the master plan is built, as we build that master plan, you know, over the next few months, we will have a better articulation of, well, okay, what is it going to take, then, to go back and renovate this space?

You know, we need some demand analysis, too. We need to know precisely the number of beds and the kinds of beds—for example, new operating rooms (ORs). How many ORs do we need? We know that we have 17—16, 17—ORs that need to be renovated. Do they all need to be at 600 square feet? Or can some of them be procedure rooms? Do we need to have—those are all the things that have to come out in the master plan. And that will then inform the budget decision, sir.

Mr. ORTIZ. And I can understand Dr. Kizer saying that maybe we should try to do it all at the same time now. I am pretty sure

we are going to hear some complaints from some of our constituents, the families of the wounded warriors, when they are assigned to the new facility, the new operating rooms versus the old ones.

And I would not—I guess you ladies and gentlemen will be at the forefront to answer those questions to the constituents. Why in the world did I go to this 12, 15, old surgery rooms instead of going to the 2 or 3 new surgery rooms? I mean how are we going to address that? Do you think that might be a problem to any of you?

Admiral MATECZUN. Chairman Ortiz, let me talk specifically to the question of the operating rooms at Bethesda. When we came to brief the Deputy's response to the DHB report, we had a number of questions about the coordination of the renovation plan that the Navy is doing on the OR projects with the overall vision, taking that back, called everybody to the table. We were just out at the University of California-Los Angeles (UCLA) to take a look at the ORs of the future out there.

And our goal right now is to evolve those operating rooms as we go. So the three new operating rooms are certainly extraordinarily large. They were being built in a new construction. And we will arrive at a vision that will help us to move towards the world-class in terms of the operating rooms that currently exist and the renovations that are there.

That will potentially leave us with a shortfall of operating rooms. We can either make that up through changing the ORs' schedules. That is, start times can extend well into the day to do the same number of cases, or we can potentially look at new OR construction in the future.

But we are committed to moving ahead and moving towards that world-class standard at this point. I haven't made the final decision yet. I have to see what the cost is going to be. But we have taken that at your advice and tried to incorporate that into the movement towards world-class.

Mr. ORTIZ. When is that coming now?

Admiral MATECZUN. We should be finished this month with the review, the costing to the contractors, and arrival at a decision.

Mr. ORTIZ. This next month did you say? Did I hear correct?

Admiral MATECZUN. December—yes, sir.

Mr. ORTIZ. Yes. Okay.

I just have one more question, and then I am going to yield to my good friend, Chairman Davis.

But, Dr. Robyn, I understand that several fiscal accounts are being used to implement the BRAC recommendation of a premier medical center, including BRAC funds, Defense Health funds, and Operation and Maintenance funds. However, I am not convinced that all of these funding sources are being used to obtain the same vision. I can be mistaken now, but can you explain how the Department intends to synchronize these facility accounts and obtain a world-class medical center? Maybe you can bring everything together. How are we going to do that?

Mic.

Dr. ROBYN. As I said, we are focused on trying to take advantage of the discipline of the BRAC process to achieve the goals that were set out as part of the BRAC recommendation. And that will be de-

liver an integrated health care delivery system in the National Capital Region that is superior to what we have now.

It will not be everything that it can be and should be, and so it will be necessary to go beyond the BRAC process in order to achieve world-class and to use funding outside of the BRAC process.

How will that be synchronized? I mean I think that is where the master plan will guide us in terms of how much additional funding that would take. But we are using as much in the way of BRAC resources as it takes to achieve and go beyond the BRAC vision.

As you well know, we have gone well over the initial estimate of what the BRAC reconstruction renovation would take, the difference between. We have gone to \$2.4 billion. The national estimate was about \$800 million. That is not mostly inflation and construction costs. That mostly represents actual additional expansion, additional improvements, the kinds of things that Mr. Middleton talked about that were not originally part of the BRAC vision.

So I think the master plan will be the mechanism for synchronizing it. How much will it cost? We are still trying to figure that out.

Mr. ORTIZ. Chairwoman Davis.

Mrs. DAVIS. Thank you. Thank you very much.

I want to talk a little bit about the structure. And, Dr. Kizer, you mentioned in your comments that you would be confident if there were more detailed plans and whether or not you were certain that you could get there with the necessary authority and control.

And I wanted to turn to Mr. Middleton and ask about that, because part of the concerns have been around those issues. The Military Health System operates with the Assistant Secretary of Defense at the top. And that is the way it is structured today—not necessarily making a judgment about that, but that is the way it is structured.

How does the current arrangement with JTF CAPMED fit into that structure? Vice Admiral Mateczun reports directly to the Deputy Secretary of Defense, but there has really been a question about who is the arbiter when there is disagreement between Health Affairs and JTF CAPMED, between the services and JTF CAPMED. Who is the arbiter there? Does everything need to be handled by Deputy Secretary Lynn?

And then we go over to the staffing as well. Would the services still be responsible for programming and budgeting personnel for the facilities under the control of JTF CAPMED? Will JTF CAPMED assume this responsibility? I know that that has been a concern. Could you help us better understand that? And what have been the discussions to see whether in fact that is on the right track?

Mr. MIDDLETON. Thank you. It is a complex issue, as you articulated, Madam Chairman.

Well, a couple of points. We have established within the Department an integrated product team, a team that actually the Assistant Secretary or currently, Ms. Ellen Embrey, who is performing the duties of the Assistant Secretary, formerly Dr. Ward Casscells, and Dr. Robyn's predecessor, Wayne Army and now Dr. Robyn—an

Overarching Integrated Product Team (OIPT), we call it, in order to articulate the issues that come up, that arise.

What are the concerns? What are the issues? We haven't had that meeting for some time, because we haven't had a series of issues that require that. And that gets back to the authorities question. We have worked through last year—and I know Dr. Mateczun can articulate this better than I—a series of meetings in order to articulate the authorities over the personnel. And we worked on manning documents for the military personnel, and we have still an issue about the civilian personnel and which Title authorities that Dr. Mateczun would have over those folks.

There remains, I think, still the issue of the ultimate end state as to, okay, who is actually going to be responsible for the resources within that? On our side on the Health Affairs and TRICARE management activities side, we recognize the fact that in order to actually run the operation for the National Capital Area, they will have to have the authority over the resources.

What we can offer to Dr. Mateczun, and have offered to Dr. Mateczun and the JTF, is the ability to have transparency and visibility into all of the budgeting issues that occur within those facilities. You know, there are 37 facilities within the National Capital Area. That is a lot of facilities, and they cross three different accounting and finance systems. So this gets more complicated the deeper you get into it on how you actually do this. So what we have tried to do is provide him and his staff with all the transparency and where the resources occur.

In terms of the differences, I will tell you that there haven't been many differences between Health Affairs and the JTF CAPMED on moving forward with world-class vision, with getting all the authorities, with teeing up these issues so that Secretary Lynn can make the decision. I think that represents in some respects Secretary Lynn's deep interest in all this and wants to be informed, as did his predecessor.

So it is a very complicated matter, Chairwoman, that I don't think is yet resolved. I think that is what we are about to do in the next several months is to work through these thorny issues of the authorities.

We have a lingering issue as to what actually physically constitutes the Walter Reed National Medical Center, which buildings on the Bethesda campus belong to the National Medical Center versus which are infrastructural issues that belong to the Navy Medicine or what are the issues that belong to the Navy Installations Command. So we have to work through all of these issues.

Mrs. DAVIS. I think the concern is that we are so far down the line, and yet these issues still exist.

And, Dr. Kizer, you know, you have been looking at this as well. Does it make you feel any better to hear what Mr. Middleton just said?

Dr. KIZER. Well, on the one hand, it is a complicated issue. I acknowledge that. But on the other hand, it is also a very simple issue. Someone has to be in charge. And to make an integrated delivery system work, one entity has to be vested with both the operational and budgetary control. On an editorial note, I suppose the committee is a little perplexed that this foundational issue of au-

thority is problematic to resolve in a hierarchical organization like the Armed Forces.

Mrs. DAVIS. Is that part of the problem—that there are obviously multiple services here as well?

Mr. MIDDLETON. I think Dr. Kizer, you know, would say that. I think what Dr. Kizer is alluding to is the fact that it should be easy to make those decisions, because it is a hierarchical organization. Someone just needs to make the decision and do it.

Mrs. DAVIS. But there are several hierarchies.

Mr. MIDDLETON. There are several hierarchies and there's a lot of equities in this issue, you know, between the Surgeons General. They have authorities here, and they have responsibilities for these folks. And Dr. Mateczun will, and his office will, ultimately have some responsibilities and authorities as well. And we are just going to have to work through each one of those.

And we have worked through a couple of them. And we have worked through the military piece, the military personnel piece, last year. We are working now through the civilian personnel piece and the Title 5 authorities and those kinds of issues. We are working through those now.

Mrs. DAVIS. Could you give any kind of a timeframe, because there is a number of concerns about construction, and obviously personnel as well. But when do you think we appropriately should be able to say, okay, you know—

Mr. MIDDLETON. We are there.

Mrs. DAVIS. Yes, exactly.

Mr. MIDDLETON. Yes, yes. Anything I would say would be speculative on my part, because I am not sure I even fully understand all of the thorny contracting issues that go—the contentiousness that could occur. But I would hope that as we re-energize the OIPT here very soon, that we will be able to work through these in a fairly expeditious way.

And my commitment then would be that to both committees that we will report back on that, you know. We can report back on where we stand on these issues and articulate those to you in the weeks and months ahead, if that is reasonable for you.

Mrs. DAVIS. Is the master plan itself—I mean we have asked you to create the master plan. Are some of these decisions beyond the ability of the Department to make? Should somebody else help make them?

Mr. MIDDLETON. I don't believe that is true. I don't believe that is true. I think we have all the authorities we need to make these decisions. If there is a special—if there is something that I am unaware of, and I would refer that to Dr. Mateczun as well; he may know something—but I don't know of any authority that we don't have to make the decisions.

There are some matters around Title 5 authorities that get a little thornier—for instance, second and third order issues about auditing and things like that, but I think we have the authority to do it. But I defer that to Dr. Mateczun.

Admiral MATECZUN. Chairwoman Davis, as part of the master plan that is due back, the authorities issue is one of the threads that we are interweaving. We have a group that is working specifi-

cally on all authorities issues, and as far as I know, there are none that are outside the authorities of the Department.

Mrs. DAVIS. Congress, you know, had asked for this master plan. Do you think that kind of work would have gone on irrespective of that request?

Admiral MATECZUN. Yes, ma'am, absolutely. In fact, two of those are—actually, three of them are pending decisions left for the Deputy Secretary that we have had identified. We had the manpower and civilian personnel issues. The other three that are still pending are the force mix between the two hospitals, the resources—how do the resources flow, which is highly technical, and we will come to an answer on that.

And then ultimately, what is the governance of the JTF? So these are identified issues that that Defense Health Board, you know, sees this issue as foundational. We agree. It is a difficult thing to struggle with, to think about aligning authorities in a different way than they exist today in the Department.

Mrs. DAVIS. Thank you. I appreciate that.

Thank you very much, Mr. Chairman. I have some additional questions, but I want to be sure everybody has a chance to ask. Thank you.

Mr. ORTIZ. Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman.

And thank you, Madam Chairwoman, too.

For the panel, thank you for being here today.

And in particular, Secretary Middleton, I appreciate your work with TRICARE. This is crucial for our military, for their families, for our veterans, and for survivors. So your stewardship is greatly appreciated by me.

As we proceed today, Dr. Kizer, the advisory committee reported several findings and recommendations that would bring the new Walter Reed closer to the goal of being a world-class medical facility. Which of the recommendations that you feel DOD did not adequately address in their assessment is the most critical to delivering safe, quality patient care, and why?

Dr. KIZER. I think there are several levels that one could address that. I think the issues that the committee views as paramount at the moment is the authority issue, which we have talked about some already, the alignment of funding streams, which continues to seemingly be at the root of many of the issues related to the master plan, which I would put as the third critical issue.

And when I speak of the master plan, there are, again, several types of master plans that are needed. Ostensibly, they would all roll into one master plan, but there is the master plan for the Walter Reed facility itself. There is a need for a master plan of the Bethesda campus, where the Walter Reed facility is co-located or approximate to multiple other facilities that it will work with on an intimate basis. And then there is the need for a master plan for the entire National Capital Region and the more than 30 different medical commands that reside within that multi-state area.

Now, beyond that there are a number of other issues relating to operating rooms and surgical pathology and a number of other things, which we had detailed, and I would defer to my written testimony and other comments that were made already about those.

But I think fundamentally until the authority issue is resolved, we really can't deal with the—or at least it is hard to understand how you are going to deal with the funding issue. And until the funding issue is dealt with, it is hard to understand how you are going to deal with the master plan issue. And then you get into all of the specifics about operating rooms and then single rooms and information technology (IT) systems, et cetera, et cetera.

Mr. WILSON. And you brought up about authority.

And, Admiral Mateczun, you are facing such extraordinary challenges, so best wishes trying to—in your position. And what authority do you currently have to direct the funds to resolve the design and construction issues that have been raised by the Defense Health Board?

And, of course, there has been a reference several times, and again just a second ago, about the situation of two patients to a room instead of one, particularly in light of the concern that everyone has about the rise of infections in hospitals in the United States.

Admiral MATECZUN. The monies that have been needed to correct these deficiencies are all working within the Department, and the funds are identified, not programs yet, not allocated completely, but each of the issues that Dr. Kizer identified in terms of the current construction and the deficiencies we have been able to work with.

There is a question of whether or not there will need to be new construction that we have to do in the master plan. There are going to be 52 double patient rooms left at Bethesda. Part of the Department's change in 2007 in enhance and accelerate was to start renovation of those rooms and conversion into single patient rooms. Still, 54 will remain at the—or 52 will remain at the end of BRAC.

And the question is what to do with those rooms, not disagreeing with, you know, the need and the movement in the country as the country is moving towards a single patient room standard. That will require renovation of those remaining rooms. And since there is no space in the construction left, that would likely require new construction.

We are also taking a look at the fundamental demographics of the population and their demands as we work towards an integrated delivery system to validate the—the number of beds that we would need and integrate that into the master plan as well.

Mr. WILSON. And I hope again that—and I know you are looking into that. And as I visit hospitals, I frequently find that they have quickly been rearranged for a single patient.

And, Dr. Kizer, a final question for me. The Army has indicated they will be managing 400 warriors in the transition at the new Walter Reed and needs 300 barracks rooms for the soldiers. Please explain the plan for accommodating not only the Army Warrior Transition Unit (WTU) population, but the Navy and Marine recovering wounded warriors as well. In addition, please explain the plans for accommodating the families of the wounded warriors at the Bethesda campus.

Dr. KIZER. Well, sir, I don't think I am the right person to answer that question, since those are questions that frankly we raised in our report, were issues like that, as to how they would

in fact—a number of these other services that need to be provided, how they would be, because it was not apparent from the plans that we saw. And this is, of course, part of what is needed in the master plan.

I would just add to—on the prior question—to the response that Admiral Mateczun gave that one of the findings of the committee was the need for current and prospective forward-looking demand analysis for the services. The current capacity and design of the facility was based on a 2004 retrospective, backward-looking demand analysis. Things have changed. The population has changed. Technology has changed. Care practices have changed. And we really need a more forward-looking demand analysis to guide the master plan and as a design piece.

Mr. WILSON. And to conclude, Admiral Mateczun, I think it was passed to you. If you could comment, that would be very nice.

Admiral MATECZUN. Yes, Mr. Wilson. Thank you. This is additionally one of those—partially, one of those instances of changing requirements. The Army is taking a hard look at how it manages the warrior transition and in particular the non-medical attendants, as well as family members.

And so each of the services has a different requirement generations mechanism that they use to take a look at that. We are at this moment combining all of those requirements. The Center for Army Analysis has done a study on that requirement. We will be incorporating those. Admiral Mullen has a specific interest in this, and I believe we will come to resolution on that issue very quickly.

Mr. WILSON. Well, we appreciate your efforts.

Thank you, Mr. Chairman.

Mr. ORTIZ. Before I yield to Mr. Taylor, I would like for the record to include a statement from our good friend, Chris Van Hollen, for the record. Hearing no objection, so ordered.

[The information referred to can be found in the Appendix on page 85.]

Mr. ORTIZ. Mr. Taylor.

Mr. TAYLOR. Thank you, Mr. Chairman. And thank you for having this hearing.

Admiral Mateczun, I am going to shift gears just a little bit, but I don't get to see you that often. Over the past couple of years, the different service secretaries have been very cooperative. Let me backtrack. It seems that every young amputee that I have met with expresses a very strong desire to—to continue to serve. They have paid a terrible price for their participation on the team. They want to stay on the team.

And one of the ways that I would think that we could help them to stay on the team and do something meaningful would be to have them assigned to the different service academies either as assistant coaches or squad level officers, plumbers, carpenters, whatever, depending on what their Military Occupational Specialty (MOS) was and what they did in the private sector before they joined the service.

And to the best of my knowledge, every one of the service secretaries have signed onto this. But also to the best of my knowledge, very few have actually been assigned to the service academies. It has also been the intention of Chairman Skelton to expand this to

the different Reserve Officer Training Corps (ROTC) programs, with the thought being that the service academies are limited to Colorado and New England states, whereas the ROTC programs are in every state. So again, they would be doing meaningful work, in the case of the ROTC programs, closer to home.

There is a Capitol Hill guide. I regret that I don't know his name, but every week he brings wounded warriors to the Capitol. Every week we stop and say hi to them, and every week I ask these kids if they have been told about this program. And not one of them is aware of it.

Again, I know you have got a million things on your plate, and I can only imagine how difficult your job is. But how can we do a better job of making these opportunities available to folks so they can stay on the team, do meaningful work for their nation, continue to wear the uniform, and do something worthwhile for their nation, which is what their desire is, and give them a seamless transition, should their decision be to go back to the private sector, a seamless transition back to the private sector and buy them some time. What could we do to get that word out?

Admiral MATECZUN. Thank you, Mr. Taylor. It is, you know, a wonderful thing that is going on now. We moved into a rehabilitation, capabilities-based rehabilitation model in the services that really didn't exist before these current operations in Iraq and Afghanistan. And so based on the capabilities that the individuals have, the limbs that they have lost and where they might be able to go, I know that almost everybody would like to have them work in their areas and work with them.

One of the opportunities that we will have at the Walter Reed National Military Medical Center is an area where we will jointly be able to provide information to all those folks. Since all of the amputees as they go through rehabilitation will be at Walter Reed, we will be able to disseminate that through each of the service mechanisms in a more comprehensive and joint way. We are committed as well to making sure that they understand all of the opportunities that they have.

Mr. TAYLOR. Well, Admiral, this has been policy for well over a year. And again, not one of these young people that are taking tours of the Capitol has been made aware of it. And so again, I do understand that you have a heck of a lot of responsibilities, but I would make this request of you face-to-face, that your organization do a better job making this available.

And if there are some impotence either administratively or in the code that are keeping this from happening, let us know so we can address it in next year's session. And I will just give you one for instance. Merchant Marine Academy Captain Ebbs is our chief staffer for the Seapower Subcommittee—just came back.

They have barracks that don't have hot water. For \$30,000 worth of plumbing equipment and the properly skilled people in that building to fix that, we could fix that tomorrow. And I have got to believe that you have got some injured Seabees who could be doing that job or Army people from the Army construction battalions.

Again, I do see some opportunities to provide these young people with meaningful work while they stay in the service. We are miss-

ing them somehow. And I would hope that you would get back to me on how we are going to correct that.

Admiral MATECZUN. Yes, Mr. Taylor. I will take that back.

[The information referred to can be found in the Appendix on page 89.]

Mr. TAYLOR. Okay. Thank you very much, Admiral.

Thank you, Mr. Chairman.

Mr. ORTIZ. Dr. Fleming.

Dr. FLEMING. Yes, thank you, Mr. Chairman.

I would like to ask the panel to elaborate on the concept of world-class medical facilities as it applies to what would emerge from this merger, if you will.

Admiral MATECZUN. Dr. Fleming, thank you. You know, we are headed towards an integrated delivery system for the first time within the Military Health System. The National Capital Region is the largest concentration of military medical forces and beneficiaries that we have in the country—500,000 beneficiaries, 300,000 enrolled in the TRICARE Prime program that we have.

As we move towards this integrated delivery system, we are working, trying to come to our master plan on how to integrate both specialty and primary care into that integrated delivery system. What you will see at Bethesda will be one of the premier quaternary medical centers that we have in the country in the end state. And what we need to do—it will be both the referral medical center and a specialty medical center for the area.

The community hospital at Fort Belvoir will provide general specialty services to what is now the majority of the area's population, which is shifting south over the last couple of years. And so those things will come together as part of the integrated delivery system.

In terms of the vision itself for what will not be happening at Walter Reed, we are taking a look at integrating not just the current terrific capabilities for amputee care, traumatic brain injury. There is also the National Intrepid Center of Excellence, which is going to be there for Traumatic Brain Injuries (TBI) and Post Traumatic Stress Disorder (PTSD), working with Dr. John Niederhuber from the National Cancer Institute (NCI) in a collaboration where we will start moving towards a comprehensive cancer center with NCI designation for all of our beneficiaries. That will be the first within the Military Health System.

And in each of the areas that we are moving towards, we are looking towards achieving world-class. We are in a particularly good location. We are right across the street from the National Institute of Health, and we have a medical school right on our campus. As part of the strategic plan, we are looking at how to bring together the medical center and medical school in a new model for academic medicine for the country. So those are some of the things that we are doing. I don't know if that answers your question, sir.

Dr. FLEMING. Let me follow up, and then I will open it back up to the panel. When you say "integration," do you mean assigning Air Force physicians or providers to Navy facilities and vice versa? Are we looking at integrating all providers into one service? What—can you elaborate on that?

Admiral MATECZUN. The facilities themselves will be—the personnel will be jointly assigned—that is, that personnel from all of

the services will be at both of the facilities. In terms of the integration, from the patient perspective what we are looking at is having them see an integrated delivery system. They will see joint providers, providers from all the services. But what we are really working towards is what they will see as the integrated delivery of care across all the services that we have.

Dr. FLEMING. And will this tend to happen in facilities around the world? Will you begin to see this jointness? Or are we talking about just in this area here?

Admiral MATECZUN. No, there are only a few areas in the country where there is more than one service hospital. The National Capital Region and San Antonio are the two biggest, so it is unlikely that you will see much of this anywhere else.

Dr. FLEMING. I see.

Others?

Mr. MIDDLETON. Jointness is not unprecedented. We have had Air Force staff working in the hospital in Landstuhl for a number of years. We will do the same endowment as we close the Wilford Hall Medical Center down in San Antonio. Much of that staff is going to go to the Brooke Army Medical Center, and that will be a jointly staffed hospital.

I think the integration also speaks to the way in which patients flow through the system seamlessly so they can move from the primary care setting that we have around the area to our secondary and tertiary care facilities as well. So I think the integration piece and how information flows seamlessly, I think that is all part of the world-class vision.

So talking about around the globe, we want to make sure that information flows along with the patient. So whether it is a serviceman injured in Iraq or Afghanistan that is coming back to Landstuhl, or whether it is someone who gets in a motorcycle accident outside St. Louis, they are moved through the process as seamlessly as we can.

Dr. KIZER. If I might make two comments, one just to amplify a little bit on what Vice Admiral Mateczun said, that at least when I was a naval officer 30 years ago or so, the nature of my work was such that I not infrequently was assigned to both Army and Air Force units and had the opportunity to delve into all these. And I would say that there are very different cultures in the services, and integrating into a single joint Armed Forces medical culture is not an easy task, and we recognize the challenges here.

The second point I would make is the Congress is very clear, and the Department certainly agrees, that the facility should be world-class, but the Congress did not provide much operational definition for what world-class should be taken to mean. So much of the work of the subcommittee that I chaired and the report that we issued actually had to do with defining in operational and functional terms what world-class would mean. And there are many pages detailing that in 6 different domains and 18 conditions.

But perhaps, if I might just state in perhaps a different way than what was said earlier, I think the subcommittee views a world-class medical facility as one that goes above and beyond compliance with the professional accreditation and certification standards, where there is a palpable commitment to excellence.

A world-class facility is one in which highly skilled professionals work together with precision and passion as practice teams within an environment of inquiry and discovery and in one that creates an ambience or an atmosphere that inspires trust and communicates confidence.

I think a world-class facility constantly envisions what could be and goes beyond the best-known medical practices to advance the frontiers of knowledge and to pioneer. Improved processes appear so that the extraordinary becomes ordinary, and the exceptional becomes routine. So perhaps that is a different way of operationalizing or thinking about this concept of world-class.

Dr. FLEMING. Sure. I know I am out of time, but I don't know how much—I would like to follow, if I could, one other question, Mr. Chairman?

Mr. ORTIZ. Go ahead.

Dr. FLEMING. The issue of electronic medical records (EMR), which is a wonderful thing—it is a wonderful—I am a strong believer as a physician myself. My medical clinic had an EMR since 1997. I am also very familiar with the challenges, and certainly a worldwide system that then has to integrate with the Veterans Affairs (VA) system is an unbelievable challenge. But I do hear complaints about the functionality of the system.

Obviously, as you integrate and you have more jointness and all these things, that is going to become even more critical. Do you have plans to improve that? Or I understand that the platform is really an old platform which may limit how much you can improve it. Can you elaborate any on those points?

Admiral MATECZUN. Yes, Dr. Fleming, thank you. It is a great challenge. You know, we have probably one of the world's largest databases for the Military Health System in the central data repository, where we have tremendous amounts of information, so we do have some expertise. Our platform is sometimes not user-friendly. We are working at changing that.

We are committed to arriving at the Administration's mandate for interoperability between the VA and the DOD. Particularly, we are working right now on an inpatient system to cross over the two systems and then interoperability between the two platforms, which are Armed Forces Health Longitudinal Technology Application (AHLTA) and Veterans Health Information Systems and Technology Administration (VistA) that are out there today.

Mr. MIDDLETON. If I could help there, too, as you know, sir, we have our system. The VA has their system. We have a mandate from the Administration to put together the virtual lifetime electronic record for our veterans, a huge challenge.

The VA system, and I know Dr. Kizer knows it as well as anyone in this room, also has its challenges in its old architecture and things like that. We recognize that in our own. We and the Department are working on the way ahead for a new architecture. We are in the process of that now, actually picking folks to be part of that team to move forward with that.

We have a commitment from the Department to help us in that endeavor in terms of not only the expertise, but in some resources as well. So we think we are on our way to a different place with electronic health record. That is not to say that the health record

we have today hasn't served us very well for a number of years, but it is time for a change.

And as I am sure you are familiar, we now also have the national standards, the National Health Information Network (NHIN) standards that are evolving. We are going to do some programs, some pilot programs, perhaps with some civilian activities, to see if we can share information between the Departments as well as civilian activity. So there's a lot of exciting things coming in electronic health record, but it is a huge challenge—absolutely, sir.

Dr. FLEMING. Thank you.

I yield back, Mr. Chairman.

Mr. ORTIZ. Thank you.

Mr. Middleton, you know, I find it troubling that we have programmed \$2.5 billion for the realignment of Walter Reed, but we still have so many fundamental issues outstanding. We have programs that will cost almost another \$5 billion in other medical centers.

And do you think that our inability to manage the Capital Region will also have an impact at other locations in the United States? And how do we ensure that lessons learned are incorporated to other sites? And I think somebody questioned on Brooke Medical Center in San Antonio. So how are we going to implement some of those lessons learned today and through this process of realigning Walter Reed and Bethesda?

Mr. MIDDLETON. Thank you, sir. I think the first is to articulate some of the lessons that we have learned. I think that is an important issue. And, of course, those lessons are always ongoing.

One key area is acquisition strategy. There's multiple ways in which you get buildings acquired. One of those is design-build. One is integrated design-bid-build. We are actually testing that out. Frankly, the way we are doing it in Bethesda has allowed us to actually meet these timelines. Had we gone through some traditional methodologies, we would have been struggling. So we have been fortunate in that.

I think we have to learn the lesson of how we deal with our agents, the Corps of Engineers and the Naval Facilities Engineering Command (NAVFAC) in an effective way. We have, I think, built a strategy. What we learned in Bethesda is how we can sit down with the I&E, Dr. Robyn's staff, our staff, JTF CAPMED staff, to make sure that we are identifying the requirements as early as we can.

We have over the last couple of years built a series of criteria for evidence-based design, which is sort of the buzzword for the kinds of facilities that we want to build. And so back in 2007, we put together a package that articulated what those design features ought to be.

And we held a conference in 2008 with civilian activities to articulate those kinds of world-class facilities issues around evidence-based design—things like natural light and enhanced privacy for infection control, as Mr. Wilson talked about in single rooms, patient safety features that are built-in, the way in which we observe the patients in the rooms, and the way in which hand cleaning has occurred, and the kinds of technology that we can advance.

All of those are part of where we go in the future, so everything that we do at Fort Belvoir particularly, because it was a greenfield site, are things that we tend to want to extrapolate, so when we go to build the new Fort Hoods of the world and the Fort Bliss of the world or the new Air Force base hospitals, where we are building those new design features into that, and we are learning that based on what we are learning in Bethesda.

We have seen also there are some negative lessons. We know how difficult it is to build and operate the facility at the same time. You know, this is much akin to the old analogy of flying the airplane while you are fixing it, only we are doing it at hypersonic speed. And that is a big lesson.

So where we don't have to do that in the future, that may be a lesson that we want to learn as well—how difficult this can be to operate a really first-class medical facility at the same time you are trying to renovate it and enhance it at the same time.

So all those will be built into our building strategy, our acquisition strategy, our world-class strategy. And I think where the Defense Health Board Subcommittee has helped to articulate those other six domains, not just the core infrastructure, we do need to talk about the leadership processes of care, and we need to talk about performance, how we are doing knowledge management.

And to that end we are having our conference. Our main Health and Human Services (HHS) conference in January is going to—basically, the theme is going to be knowledge management, how we share information, because we don't want Bethesda to become—we want it to be a center of excellence, but we don't want it to become an island of excellence. That is not the only place where excellence needs to occur. Many years ago I commanded a small hospital in South Dakota, and I want that place to be as excellent as well for the care that they can provide at that facility. So those are all the lessons that we are trying to learn to build the future, sir.

Mr. ORTIZ. Chairwoman Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

I wanted to ask about one of the issues that I think Dr. Kizer raised about the kind of invisible structure and the concern, I think, that there may not have been or—and part of my question is is there an ongoing process for clinician input into the communities of interest, essentially, that occur within hospitals?

And one of the concerns is with—the amputee community today I know is together, and that provides, you know, some great benefits that I think that a number of the clinicians think is a good idea. We also know for breast cancer patients, for example, that they are also together.

It is my understanding that some of the organization, and there are different philosophies about that, you know, whether it is more related to acuity or it is more related to the particular kind of issues that patients are working with and perhaps have an ability to share.

So what are we seeing within that structure? And have we resolved all those issues? Is there still opportunity for clinicians to be able to present their points of view around that? Where are we?

Admiral MATECZUN. Chairwoman Davis, on that, a couple of examples just on end-user input into design, we are still accepting

some of that. As recently as two weeks ago, we were at meeting on some of the rooms at Fort Belvoir. And we can't do big design changes, but we are working still with end-user input to make sure that we are able to on the design phase do as much as we can.

In terms of the delivery of care, there are differences of opinion on organization. When we made a move towards a comprehensive cancer center, there were a number of desirable attributes of that form of care—for instance, the consolidation of cosmetic services, the consolidation of psychological counseling for cancer members that sometimes seemingly conflicted with the independent provision, for instance, of breast care centers.

And so we have been working with the clinicians about that. They are still providing input. And we are continuing to do that. We have got a meeting coming up with all of the cancer chiefs, where we will be continuing to work with those questions about organization to make sure that they feel they are able to provide the best care, but that our patients are getting integrated care across the system.

One of the problems that we have is that as we focus in an individual lane like breast care, then we sometimes lose focus on the integrated delivery of care for the other problems they may or may not have. So we are struggling with that, and I think we will come up with a good model.

Mrs. DAVIS. All right. I would appreciate that, because I think that certainly the people that have created what we know is to be an exceptional care for our wounded warriors particularly, we need to continue to have that kind of input, I think.

Admiral MATECZUN. The amputee care will be organized exactly as it is today so that that whole part of the organization is getting imported. And one of the questions I frequently get is, well, is that an Army structure? Actually, it is a tri-service structure today. So it will come over intact. The way that they deliver care will be preserved.

Mrs. DAVIS. Thank you. I wanted—two quicker questions to just pick up on a few issues that were raised. One of those have to do with Section 1635 of the FY 2008 NDAA. It required the interoperability between the DOD and the VA. And Health Affairs had briefed our staff—I guess this is to Mr. Middleton—that you have fulfilled the requirements of 1635, and yet we just heard today that it sounds like it is, you know, a work in progress.

Mr. MIDDLETON. I think there's two things. I think there is meeting the requirements, which is the interoperability, our ability to transfer information. I am sure we have been over and talked before about bi-directional information and one-directional information with the Veterans Administration. I think we have articulated and can prove that we can do that.

I think the bigger question that I alluded to before is what is the backbone like? What does the architecture look like going forward, as both departments have to modernize their facility? And we have come a long way from the architecture that we built this with many, many years ago.

Modern technology, the Internet, there's all kinds of things now that afford us an opportunity to make it better and make it even more interoperable. And I think that is what I wanted to make

sure that you understood is that we think we meet the requirements of your—but we need to do better.

I mean we could, for example, we can push a lot more information right now than the Veterans Administration can absorb at one time because of some architectural issues within their system. So we need to solve that collectively. We don't necessarily have to have the same system. We have to be able to make sure that a larger system is more interoperable, and I think that is where we want to go, as well as modernize our own system.

Mrs. DAVIS. Thank you.

Admiral Mateczun, you mentioned earlier that funds had been identified to address and fix the concerns of the independent review, and I just wanted to turn to Mr. Middleton and Dr. Robyn. And is that true? I mean as far as you know, have those funds been identified that can address the concerns of the review?

Admiral MATECZUN. Let me clarify, Madam Chairwoman. The funds that are identified were with the ongoing construction. For anything that required new construction in the master plan, those funds have not been identified. So all of the deficiencies within the current construction are certainly there. Things like single patient rooms and achieving those or new ORs, should they be needed, funds have not been identified.

Mrs. DAVIS. Funds have not been identified for those. All right. You would agree with that. All right. Thank you.

Mr. ORTIZ. I think we have had some wonderful testimony today, and me personally, I think I have learned a lot from your testimony. And we need to stay ahead of the curve. If we do send—the President recommended that we send 30,000 soldiers to Afghanistan, which means that—and I pray to God that we don't have any more casualties or, you know, young men and women coming back with injuries.

And we are just going to have to be ready for whatever comes between now and then. And I know that, you know, you and I and this committee, we have huge obligations and responsibilities to our warriors. They have done a great job. Some of them just came back from Landstuhl this last week, and we visited some of the soldiers deploying from Italy and Germany back at their—who are there now, because they left two or three days ago.

But I know that all of us mean well. I mean we are a team sitting in different locations, but we want the best for our warriors. I just want to thank each and every one of you for your testimony today. And hearing no more questions, this joint hearing we had today stands adjourned. Thank you so much.

[Whereupon, at 11:30 a.m., the subcommittees were adjourned.]

A P P E N D I X

DECEMBER 2, 2009

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

DECEMBER 2, 2009

Opening Statement by Chairman Solomon Ortiz
Readiness and Military Personnel Subcommittees Joint Hearing
Medical Military Construction
December 2, 2009

Today, the Readiness Subcommittee and the Military Personnel Subcommittee meet in a joint session to discuss the BRAC realignment of Walter Reed and whether the final plans are sufficient to meet a world-class standard.

The realignment of the Walter Reed National Military Medical Center was one of the major decisions included in the 2005 Base Realignment and Closure process. Its overarching reach to close the Walter Reed Army Medical Center and relocate those activities to Fort Belvoir and Bethesda have not been without controversy or political carnage. Because of the substandard conditions found at Walter Reed, the former Army Surgeon General and former Secretary of the Army were relieved of duty.

At the heart of this controversy is a fundamental discussion as to what level of care should our wounded warriors receive. In my estimation, this simple question deserves a simple answer: the best. What most intrigues me in this decision process is that I am not convinced that the Department of Defense shares in this simple assessment.

The Deputy Secretary of Defense recently indicated that "development of a world-class medical facility is not a destination but rather a journey of continuous improvement." This seems to indicate that the Department cannot obtain a world-class medical facility as proposed in the BRAC process in the timeline provided. So where does this journey contemplated by the Department take us?

It will provide us a medical facility capable of providing medical care to the military concurrent with the BRAC timelines. But it does not deliver the world-class expectation envisioned by the BRAC commission or the Department. The Defense Health Board recently stated that the current design will not obtain world class. I find this unacceptable.

This inability to obtain a world-class medical center seems to hide the fact that four years have passed since the BRAC commission reported its findings, and yet we still have a disorganized medical command, a disjointed funding authority, and an inconsistent construction design in support of a \$2.5 billion effort.

I have visited the Bethesda campus several times since the BRAC commission finalized its deliberations. While I am convinced that the new construction is on the right path, I think that the overall requirements to provide the best care to our wounded warriors needs to be reassessed and the full scope of work, including related repair work, needs to be reviewed.

I think the input provided by the Defense Health Board provides an excellent roadmap on issues to address. In the end, I hope that this hearing provides answers to the questions about what our wounded warriors deserve. I hope that at the conclusion of our deliberations, we will be united in saying: they deserve the best.

Today, we have four distinguished witnesses representing the Department of Defense. We have; Mr. Al Middleton, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs, Dr. Dorothy Robyn, Deputy Under Secretary of Defense for Installations and Environment, Vice Admiral John Mateczun, Commander, Joint Task Force National Capital Region Medical, and Dr. Ken Kizer, Chairman, Defense Health Board National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee.

Without objection, the witnesses' prepared statements will be accepted for the record.

**Statement of Chairwoman Susan Davis
Joint Readiness and Military Personnel Subcommittees
Hearing on “The New Walter Reed: Are We on the Right Track?”**

“History is important here. In 2004, the Military Personnel Subcommittee raised a number of concerns about how we were caring for our wounded warriors. The Department of Defense witnesses told us to trust them. That they would make sure wounded warriors, and their families, were properly cared for.

“Our reward for that trust were the revelations of almost three years ago at Walter Reed.

“Ladies and gentlemen, any response of ‘trust us’ simply will not suffice today.

“While the name ‘Walter Reed’ is the same, I need to make an important distinction. What was revealed at Walter Reed almost three years ago was shameful. Wounded warriors and their families were allowed to fall through the cracks. They were often left to fend for themselves for administrative tasks such as pay and housing.

“However, one thing that was never questioned during the scandal had to do with the quality of medical care provided at Walter Reed. It was and remains excellent.

“One of our key concerns is that the current plan and organizational structure are simply inadequate, and that patient care, wounded warrior care, will suffer as a result. Chairman Ortiz said it perfectly, there is only one acceptable standard of care for our wounded warriors, and that is the best.

“We have had concerns about the plans for the Walter Reed National Military Medical Center at Bethesda from the beginning. In hearings and meetings we have had Vice Admiral Mateczun tell us in effect, ‘don’t worry, everything is on track.’ We have yet to be convinced that is true. In fact, we have yet to be convinced that the department takes our concerns seriously.

“In last year’s National Defense Authorization Act, we required that an Independent Design Review be done to validate the current plan. That review was completed this past summer, and its results were simply unsettling.

“Among the troubling descriptions of the current plan were that it would not result in a world-class facility, that it would not meet Joint Commission accreditation standards, and that it was ambiguous about the visions, goals, and expectations of the new center.

“As disconcerting as the Independent Design Review’s findings were, however, they pale in comparison to the department’s response to those findings. For example, ‘...development of a world-class medical facility is not a destination but rather a journey of continuous improvement...’

“World-class is most decidedly a destination, one that Congress expects to new facility to arrive at *before* the new center opens its doors. The definition of ‘world-class’ will no doubt evolve over time, but as the Independent Design Review has indicated, the current plan does not meet today’s definition, and that is unacceptable.

“As Chairman Ortiz mentioned, four years have passed since the BRAC recommendations were reported. Two years have passed since Joint Task Force-Capital Medicine was established. Still, we do not actually know who has overall responsibility for this project. Key decisions about funding, staffing, and the chain of command have yet to be made. We do not feel that the plan meets all of the requirements spelled out in law and the BRAC recommendations. And we have an Independent Design Review that is highly critical of the current plan and organizational structure.

“Since this is our first hearing since the findings of the Independent Design Review were released, I would like to hear how the department plans to address the shortcomings identified. I also look forward to hearing directly from the chair of the Independent Design Review, Dr. Ken Kizer, and that hope that we will have a productive discussion about this incredibly important topic.

“When this hearing ends today, it is my sincere desire that we will leave with a better understanding of what needs to be done to ensure that the new Walter Reed National Military Medical Center at Bethesda becomes everything it is supposed to be.”

**Statement of Ranking Member Randy Forbes
Subcommittee on Readiness**

**Joint Readiness and Military Personnel Subcommittee Hearing
on the New Walter Reed: Are We on the Right Track?**

December 2, 2009

I thank the chairman. I also thank the witnesses and appreciate their being here.

Nothing we do is more important than providing for the health care of our troops, their families, and retirees. As you know and Congress has declared as a matter of policy and law, the creation of a new Walter Reed National Military Medical Center at Bethesda is an opportunity to establish a world class facility that will deliver the highest standards of care. An integral part of this world class health care system for the National Capital Region is the new Fort Belvoir Community Hospital in the Commonwealth of Virginia.

With full understanding of the difficulty of the task, I am distressed about the lack of progress in a number of areas. It's extremely troubling that these problems persist despite Congress' clear and consistent emphasis on the importance of this project. We have continually asked about whether world class facilities are truly being constructed and whether more time is needed to accomplish that goal, and are now told that that standard only applies to the BRAC related portion of the new facility. We have been asking about properly integrated staffing and budgeting processes, only to find that very little, if any progress, has been made on these issues.

While I am very glad to receive Dr. Kizer's forthright report on the deficiencies of the Department's approach, I remain perplexed how responsible outside observers can come to such different conclusions from the Department of Defense officials responsible for implementing these programs.

I have noted Congress' persistent concerns. I should also highlight the professional qualifications of the Defense Health Board members who unanimously approved Dr. Kizer's report questioning the DOD plan in a number of areas. The Defense Health Board core board members include a wide range of medical

luminaries and eminent former Pentagon officials, including the Honorable Togo West, former Secretary of the Army and Secretary of Veterans' Affairs; General Richard Myers, former Chairman of the Joint Chiefs of Staff; and General Richard Cody, former Vice Chief of Staff of the Army. I take the recommendations of these officials very seriously.

We understand that it is very difficult to merge two busy major medical centers with separate budgets and separate military cultures, but are most concerned that the Department remains unresponsive in the face of consistently expressed reservations by Congress and the Defense Health Board. I hope our witnesses today will provide specifics on how the Department intends to address these real facility, organizational, and budgetary issues.

We want to help you succeed. The only way we can do that is with honest communication. Please help us help you create a world class health care facility and organization. America's wounded warriors deserve the best we can provide.

Again, thank you Mr. Chairman for scheduling this hearing.

**Opening Remarks – Congressman Wilson
The New Walter Reed: Are We on the Right Track?
Joint Readiness/Military Personnel Subcommittee
Hearing
December 2, 2009**

Thank you Chairwoman Davis. I appreciate joining our good friends on the Readiness subcommittee today, led by Chairman Solomon Ortiz and Ranking Member Randy Forbes, for our hearing on the progress of the Walter Reed National Military Medical Center (WRNMMC). I welcome the distinguished members of our witness panel.

I believe that there is nothing more important than providing the outstanding members of our military, their families and our retirees with world class health care delivered in world class medical facilities. There is no question in my mind that they deserve nothing less. Our family has experienced the quality service with two grandsons born at Bethesda National Naval Medical Center and a granddaughter born at Portsmouth Naval Hospital.

The Department of Defense has assured us on several occasions that merging Walter Reed Army Medical Center and the National Naval Medical Center at Bethesda, two icons of military medicine, would result in a single world class medical center that would provide improved access to enhanced medical care for our troops and their families in the National Capital Region (NCR).

Now I understand that the National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee of the Defense Health Board (DHB) has issued a report that calls into question whether the Department's plan to merge these two facilities will result in a world class facility.

Further, I am aware that the Defense Health Board has expressed concerns regarding the Department of Defense's corrective action plan

published in response to the findings and recommendations of the Board. It appears that there is still doubt about the new facility being world class.

Before we hear testimony from our witnesses this morning, let me be very clear that the new Walter Reed National Military Medical Center opening as a world class medical facility is not negotiable. We can accept nothing less.

With that, I would like to thank our witnesses for participating in the hearing today. I look forward to your testimony.

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PREPARED STATEMENT

OF

ALLEN W. MIDDLETON,
ACTING PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR
HEALTH AFFAIRS

BEFORE THE

SUBCOMMITTEE ON READINESS

AND

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE COMMITTEE OF THE ARMED SERVICES

JOINT HEARING ON NCR BRAC TRANSFORMATION

DECEMBER 2, 2009

NOT FOR PUBLIC RELEASE UNTIL RELEASED BY COMMITTEE

Madame Chairwoman, Mr. Chairman and distinguished members of the Subcommittees. Good morning. I am pleased to be here today to discuss progress in the implementation of the 2005 Clinical BRAC Recommendations for the National Capital Region (NCR). As you know, the BRAC Commission Report to the President, released on November 9, 2005, directed the Department of Defense to close the Walter Reed Army Medical Center (WRAMC) in Washington, DC and realign the facility with the National Naval Medical Center (NNMC) in Bethesda, MD, creating the Walter Reed National Military Medical Center (WRNMMC), and to build a new community hospital at Fort Belvoir, VA (FBCH) by the BRAC deadline of September 15, 2011.

The Military Health System (MHS) fulfills a vital responsibility: to care for our nation's Servicemen and Women, their families, and those who have served before. In these challenging times, the men and women of the MHS work tirelessly to provide the best possible medical care to those who protect our country. We are grateful for the many dedicated men and women who have answered the call to duty and are working to ensure that we create healthcare facilities well-positioned to meet the needs of our Servicemen and Women, veterans, and Wounded Warriors in the NCR and throughout the country.

As the principal advisor to the Secretary of Defense for the Department's healthcare program, the Office of the Assistant Secretary of Defense for Health Affairs maintains oversight of the clinical BRAC actions, including the transformation of the NCR currently underway. The BRAC 2005

Recommendations proposed a transition from a legacy Service-specific medical infrastructure into a premier, modernized joint operational medicine platform. We are making great progress, and I am pleased to report that we are on track to implement the BRAC recommendations by the statutory deadline of September 15, 2011.

However, we acknowledge that completion of construction activities represents only part of the story. While our intention all along has been the transformation of all health care operations within the NCR, the Health Systems Advisory Subcommittee of the Defense Health Board has articulated a vision of world class and shared their perspectives on how we may be more effective in translating that vision into reality. We sincerely appreciate the efforts of the Subcommittee and acknowledge that their findings and recommendations can only help us in our quest to be "world-class" in the NCR and throughout the MHS. Addressing the complexity and resolving the challenges of BRAC transformation in the NCR clearly necessitates the knowledge and insight that the members of the Health Systems Advisory Subcommittee possess.

Executing BRAC and creating a world class care delivery system in the NCR in a relatively short period of time is certainly one of the most difficult undertakings in the history of the MHS. The Joint Task Force (JTF) CAPMED was created to lead this clinical transformation in the NCR.

Despite the challenges and complexities inherent in this task, we should not lose sight of the great progress that has been made to date. The single act of

consolidating two medical centers into one and constructing a new robust community hospital in proximity to the majority of beneficiaries is a major accomplishment. The creation of the JTF CAPMED as the overarching market manager would have been unimaginable just a few years ago. I am confident that we are heading in the right direction and appreciate the Subcommittee's detailed roadmap to achieve a world class delivery system built upon world class facilities at WRNMMC and FBCH. I look forward to working with the JTF CAPMED, Military Services, and other stakeholders to implement the Subcommittee's recommendations.

I monitor on a monthly basis the progress of the implementation of the Clinical BRAC recommendations as part of our shared journey to create truly "world-class" medical facilities at the WRNMMC and the FBCH. While performing the duties of the Principle Deputy, my staff and I have provided policy oversight of clinical BRAC actions and have served as a focal point for resolution of issues. Health Affairs has also provided budgeting and programming guidance for Clinical BRAC actions and has validated and submitted the annual BRAC and non-BRAC budget and program requests in support of the construction and integration of the medical facilities in the NCR. Additionally, we have provided guidance and direction to the JTF CAPMED, U.S. Army Corps of Engineers, and Naval Facilities Command regarding each of the hospital construction projects.

Over the past several years, I have been consistently impressed with the dedication of the individuals working on BRAC to rise above the many challenges

inherent in such a transformation and deliver a final product that will be the standard for military healthcare in our country. With less than two years remaining until the BRAC deadline, we have a comprehensive plan to meet the BRAC deadline with minimal risk to patient safety. I am pleased to report that new construction is over 60 percent complete at the new WRNMMC, which includes new inpatient and outpatient additions, as well as a parking garage. Additional construction is beginning for a Wounded Warrior Lodging, Messing, and Administrative complex as well as a Gym, and Parking Garage complex. The FBCH is over 50 percent complete and will provide a total replacement of the existing community hospital.

The Fallen Hero Foundation is also building a National Intrepid Center of Excellence (NICoE) for the diagnosis, treatment planning, research, family-centered education and long-term follow-up for military personnel with Traumatic Brain Injury (TBI) and Psychological Health (PH) conditions.

The Intrepid Fallen Heroes Fund is funding the construction and major equipment costs for NICoE, which will be gifted to the government upon completion. Future maintenance and operation costs will be funded by the government. We will continue working with all stakeholders to monitor the program through the duration of the BRAC deadline and beyond to ensure a premier, modernized joint operational medicine platform is provided in the NCR.

Although our primary focus has been completing the BRAC recommendations before the deadline, we understand that creating "world-class"

healthcare facilities is a long-term commitment to improvement beyond BRAC and that additional investments are required to achieve that end state. We are willing to support the JTF CAPMED and the Military Services to identify additional non-BRAC requirements and ensure they are considered in future budget requests. We are also incorporating the world class attributes identified in the DHB report in our DoD design and construction criteria where appropriate and are applying “lessons learned” from NCR BRAC to other MHS construction projects where feasible. We continue working to provide every beneficiary with the best healthcare possible, and we appreciate your continued support as we strive to be "world-class" in everything we do.

HOLD UNTIL RELEASED
BY THE COMMITTEE

STATEMENT OF

Dr. Dorothy Robyn
DEPUTY UNDER SECRETARY OF DEFENSE
(INSTALLATIONS AND ENVIRONMENT)

BEFORE THE
SUBCOMMITTEES ON MILITARY PERSONNEL AND READINESS
OF THE
HOUSE ARMED SERVICES COMMITTEE

December 2, 2009

Chairman Ortiz, Congressman Forbes, Chairwoman Davis, Congressman Wilson, and distinguished members of these Subcommittees: I am honored to appear before you to discuss the Department of Defense's effort to improve medical facilities in the National Capital Region (NCR).

Introduction

I am the Deputy Under Secretary of Defense for Installations and Environment, a position I assumed in July. I am responsible for overseeing the Department's building and installation portfolio, which is valued at some \$700 billion. My office is the advocate for getting our facilities the investment necessary to allow them to operate effectively to support their mission occupants.

I also oversee the BRAC process. My office has helped to develop the Department's proposed actions in the various BRAC rounds, and we oversee the implementation of the final BRAC recommendations. Among other things, BRAC has been a significant engine for the recapitalization of our enduring military facilities. The 2005 BRAC process has channeled a significant amount of money into such facilities across the board, but hospitals and other medical facilities have been among the biggest beneficiaries.

My office has also become a champion for the establishment of multi-service, or "joint," installations, as a result of the BRAC 2005 decision to "merge" a number of bases that

are located in close proximity. The goal is to improve the efficiency and effectiveness of these bases by broadening their utilization in support of the overall military mission.

The initiative to consolidate and realign medical care delivery in the NCR is of particular importance to my office, because of its basis in BRAC and its focus on transforming medical care through a joint delivery system. My staff and I work closely with the people who have direct responsibility for planning and executing the construction necessary to implement BRAC in the NCR: VADM John Mateczun, the Commander of the Joint Task Force National Capital Region, and my colleagues in the Office of the Assistant Secretary of Defense for Health Affairs and in the TRICARE Management Activity office.

Basis for and Execution of the BRAC 2005 Action

To decide whether we are on the right track with respect to “the new Walter Reed” hospital, it is useful to recall how we got where we are. The BRAC 2005 decision reflected four major concerns about medical care in the NCR. First, there was a growing mismatch between the location of eligible beneficiaries and that of major medical facilities: although active duty families were becoming increasingly concentrated in the southern part of the region, the two largest facilities (Bethesda and Walter Reed) were located just 6.4 miles from one another in the north. Second, for that reason among others (*e.g.*, the trend toward outpatient services), Bethesda and Walter Reed had

significant excess inpatient capacity. For example, Walter Reed was using only about 200 beds—less than one-sixth of its design capacity (1230 beds). Third, Walter Reed’s infrastructure was deteriorating due to the combination of heavy use and chronic under-investment in maintenance and repair. Estimates at the time indicated that it would cost \$600-700 million to replace or renovate Walter Reed and that, under existing budget assumptions, the work would take many years to complete (6-8 years for replacement, 10-15 years for renovation). Finally, while medical care in the NCR was of superb quality, the Service-specific and facility-specific approach to delivery lacked the virtues of a more modern, integrated system.

In response to these concerns, the 2005 BRAC Commission endorsed the Department’s proposal to consolidate and realign medical care delivery in the NCR. Consistent with the BRAC directive, and in compliance with the BRAC deadline of September 15, 2011, the Department will:

- Close Walter Reed and move some of its activities to the Bethesda Naval hospital, creating the consolidated Walter Reed National Military Medical Center.
- Move other Walter Reed activities to a newly built community hospital at Ft. Belvoir, VA.
- Close the inpatient wards at the medical center at Andrews Air Force Base, leaving an ambulatory clinic, the Malcolm Grow Surgical Center.

The BRAC decision recognized that renovation of the aged and deteriorating Walter Reed facility was not the best use of our resources. By allowing us to channel these resources to the remaining hospitals, BRAC addressed long-standing healthcare facility needs.

In the Department's view, this restructuring has the potential to transform medical care delivery in the NCR. The strategic relocation of facilities and the related expansion of outpatient services will give eligible beneficiaries more proximate and convenient healthcare. The reduction of excess capacity and related overhead will free up scarce personnel and resources to meet the changing needs of wounded warriors, active duty families and retirees. And the shift from a legacy medical platform to a modernized, joint operational system will provide a host of benefits, ranging from enhanced recruiting and personnel retention to an improved ability to incorporate and capitalize on evolving methods and trends in healthcare delivery.

Now, with less than two years to go before the BRAC deadline, we are on schedule and on track to provide these benefits. We are spending \$2.4 billion at Bethesda and Ft. Belvoir to help reach the goal of world-class facilities. By our September 2011 deadline, we will have constructed, re-constructed, and renovated the Bethesda and Ft. Belvoir facilities to accommodate a staff of 9,000 with more than 3 million square feet of clinical and administrative space, supporting 465 inpatient beds (345 at Bethesda and 120 at Ft.

Belvoir). This is an enormous and complex undertaking, as the statistics on what we will deliver by September 2011 illustrate:

- More than 682,000 square feet of world-class inpatient and ambulatory medical center additions to Bethesda's final footprint;
- More than 300,000 square feet of alterations to the existing medical center at Bethesda;
- 700,000 square feet of administrative space, enlisted quarters and facilities provided in support of the Warrior Transition Services at Bethesda; and
- More than 1.2 million square feet of construction at Ft. Belvoir to build an innovative, state-of-the-art hospital that will be an exemplar of Evidence-Based Design.

The Defense Health Board's Independent Design Review

The July 2009 Defense Health Board Subcommittee report, *Achieving World Class: An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital*, is an extremely important document that will inform our decisions on medical facilities now and over the long term. The report's utility is not limited to the NCR: it will be a guide for *all* medical facility planning in the United States and overseas. We are enormously grateful to the DHB Subcommittee for this signal accomplishment.

That said, we take issue with more recent suggestions by the Subcommittee that the Department should possibly delay BRAC construction pending further planning of additional work—work outside the scope of BRAC—that it believes is necessary to make the new Walter Reed world-class. The Subcommittee itself said in its July report that a construction halt “would be very costly and highly demoralizing and should be avoided if at all possible.” We agree with that assessment. Although our undertaking is large and complex, we have made course corrections as appropriate and are on track to deliver significant improvements. We believe we are striking the right balance by holding to our BRAC deadline while planning for further, post-BRAC improvements to these facilities.

Construction Timeline

The BRAC authority provided by Congress allowed us to improve health care in the NCR in a holistic way by closing facilities that had outlived their usefulness and replacing them with new and significantly improved facilities. Without the discipline of the BRAC process, we could not have overcome the inertia and impediments to change that created the problem in the first place. Thus, we believe strongly that the timeline imposed by BRAC is working for us.

In the case of Ft. Belvoir, geography (ample land) and the more limited burden of constructing a replacement “community hospital” permitted the kind of clean-sheet effort

that the DHB Subcommittee favors. Bethesda has been more challenging, however. We have had to continue to operate that superb facility even as we carried out the expansion and renovation effort. Thus, we face a very real limit to the amount of construction that we can undertake there at one time.

Moreover, in our view, the kinds of beyond-BRAC improvements being discussed can be addressed separately and subsequently. Thus, continuing with the BRAC construction will not result in wasted effort. By contrast, halting BRAC construction will impose significant costs and—no less important—delay or jeopardize the promised benefits. In short, we think it is critical to stay the course.

Funding and Costs

The DHB Subcommittee's July report stated that the BRAC funding process "entails a number of constraints and limitations that ...[represent] a major impediment to designing the new WRNMMC to be a world-class medical facility." This statement reflects some misunderstanding of how this congressionally authorized process works. To elaborate, the BRAC process provides flexibility in the authorization and appropriation of projects necessary to implement BRAC decisions. Essentially, BRAC funds are authorized and appropriated as a lump sum that can be used for BRAC purposes only. However, that does not mean that we cannot use multiple funding streams where BRAC and non-BRAC

purposes align. In fact, we are doing this at Bethesda, where we are using non-BRAC funds to renovate operating rooms and other facilities.

Separately, some have criticized us for the substantial increase in the amount of BRAC funding needed for the construction work at Bethesda and Belvoir. The increase has indeed been substantial: the original estimate was \$1 billion; as noted earlier, we have spent about \$2.4 billion. Nevertheless, we think that is appropriate. Aside from the substantial inflation experienced by the entire construction industry over much of this decade, the increase resulted from our efforts to enhance and accelerate construction at Bethesda and Ft. Belvoir based on i) lessons learned and ii) the recommendations of the *Independent Review Group (IRG) on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Co-Chaired by former Secretary of the Army Togo West and former Secretary of the Army and Congressman Jack Marsh). The IRG's April 2007 report recommended measures to improve medical care and called on DoD to accelerate BRAC projects in the NCR. In response to the report and lessons learned directly from combat, the Department committed to create Warrior Transition Unit facilities at Bethesda to enhance wounded warrior care, especially for the outpatient convalescent phase. The Department also committed to enhance inpatient facilities at both Belvoir and Bethesda.

Conclusion

In closing, I want to thank you for this opportunity to highlight the Department's efforts to improve our medical facilities in the NCR. This is an extraordinarily complex undertaking but one that will deliver major benefits. My message is straightforward. This undertaking would not have been possible without BRAC. If we relax the discipline that the BRAC process provides, we jeopardize those benefits with little if any offsetting benefit.

The construction now underway should go forward. It represents a balanced and reasonable approach to combining the functions of the old Walter Reed into the new. The result will be a medical delivery platform far superior to what we have now – and one on which we can continue to build. We are managing this process carefully, and we will keep you fully informed. Let us stay the course.

NOT FOR PUBLICATION UNTIL RELEASED BY THE HOUSE COMMITTEE ON ARMED SERVICES

PREPARED STATEMENT
OF
VICE ADMIRAL JOHN MATECZUN, MC, USN
COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL REGION MEDICAL

BEFORE THE

HOUSE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEES ON READINESS AND MILITARY PERSONNEL

DECEMBER 2, 2009

NOT FOR PUBLICATION UNTIL RELEASED BY THE HOUSE COMMITTEE ON ARMED SERVICES

Chairman Ortiz, Chairwoman Davis, Ranking Members Forbes and Wilson and committee members, thank you for the opportunity to share with you the progress the Department of Defense (DoD) is making in realigning medical assets in the National Capital Region (NCR) to create the Military Health System's (MHS) first fully integrated, jointly-operated and staffed, healthcare delivery system. This transformation will allow the DoD and the Military Services to capitalize on their collective strengths, maintain high levels of readiness and provide world-class healthcare to our armed forces and their families active and retired. This committee's oversight and support have greatly enhanced the Department's efforts throughout this process.

2005 Base Realignment and Closure Law

The 2005 Base Realignment and Closure (BRAC) Commission recommendations constituted the largest realignment and transformation in the history of the MHS in the NCR. It consolidated the inpatient services of four Medical Treatment Facilities (MTFs) into two. It did this by establishing the Walter Reed National Military Medical Center (WRNMMC), in Bethesda, Maryland, and a robust community hospital at Fort Belvoir, Virginia (FBCH). It relocated existing functions at the Walter Reed Army Medical Center (WRAMC), in Washington, District of Columbia, to those two facilities and established Malcolm Grow Medical Center at Andrews Air Force Base as an ambulatory surgical center.

Joint Task Force National Capital Region Establishment and Mission

In September of 2007, the Department established the Joint Task Force, National Capital Region Medical (JTF CAPMED) as a fully functional Standing JTF located on the National Naval Medical Center (NNMC) campus and reporting directly to the Secretary of Defense (SECDEF) through the Deputy Secretary of Defense (DEPSECDEF). JTF CAPMED reached Initial Operational Capability (IOC) on October 1, 2007, and Fully Operational Capable (FOC) status on September 30, 2008.

JTF CAPMED is executing its standing mission to oversee the effective and efficient consolidation and realignment of military healthcare delivery in the NCR Joint Operating Area (JOA). To accomplish this mission, JTF CAPMED is coordinating with the NCR medical components of the Army, Navy, and Air Force to integrate processes and ensure the best utilization of resources available to eliminate redundancies, enhance clinical care, promote health professions education and joint training, and enhance military medical research opportunities. JTF CAPMED has also been directed to oversee the implementation of the 2005 Walter Reed BRAC recommendation as well as any other missions assigned.

As required by law, continued access to quality healthcare will not be affected throughout this transformation process and overall medical capabilities of the regional end state will remain equivalent to what existed prior to the BRAC. In addition, JTF CAPMED will coordinate Health Service Support (HSS) missions in the NCR as a functional medical component of JTF NCR when activated, significantly simplifying the planning process for events such as the National Special Security Events, such as the Presidential Inauguration, State Funerals, or responding to potential influenza outbreaks.

The NCR Joint Operating Area (JOA), as defined by the forces assigned, stretches as far north as New Jersey, skirts West Virginia and extends south to Bowling Green, VA. It has 37 MTFs, including what will become the largest Medical Center in the military (WRNMMC), as well as over 12,000 military and civilian employees. The region encompasses over 545,000 eligible beneficiaries and 282,000 MTF enrollees.

2005 NCR Medical BRAC Projects and Transition

While the NCR Medical BRAC construction and initial outfitting & transition (IO&T) timeline for Bethesda and Fort Belvoir is aggressive, the Department, through integrated program and project management, has developed comprehensive milestone schedules and a transition of operational plans as part of its Master Transition Plan (MTP) for the Walter Reed transition. In addition, firms in the private sector retain hospital transition activities as a core competency and the IO&T contract that was just awarded will leverage that competency.

The MTP was delivered to Congress on September 30, 2009, and covers all aspects of the transition from WRAMC to WRNMMC and FBCH and lays out the sequence and timing of service moves (clinical and others). It details all of the individual actions required to ensure success at each step of the transition. The plan is dynamic in nature and will be regularly updated as it continues to evolve across the duration of the BRAC execution timeline.

As informed by the MTP, the Department is currently on schedule to complete the BRAC projects and Walter Reed transition by the September 15, 2011 deadline. There is minimal schedule risk left in the construction at Bethesda and Fort Belvoir and the IO&T contract for both hospitals has been awarded. Both WRAMC and NNMC pose inherent operating risks during BRAC that the Department is mitigating. At WRAMC, it will be important to maintain the civilian workforce to preserve current capability and to staff both of the new hospitals. The Department is working to identify a military force mix for WRNMMC and FBCH by the end of the year. This will allow for the completion of the JTD manning document and identifications of locations for individuals in the end state by Spring 2010. At NNMC, the Navy must continue to provide healthcare while renovations require the relocation of many functions. During the actual movement of patients from WRAMC to WRNMMC and FBCH, direct care system patients will be appropriately offloaded to the private sector or other military hospitals temporarily to allow for the transition.

Development of the BRAC Projects at Bethesda and Fort Belvoir

The NCR Medical BRAC projects at Bethesda and Fort Belvoir have matured between May 2005 and the present due to several factors. While capabilities in the NCR will remain the same after the completion of BRAC, the 2005 original estimate for transitioning operations at WRAMC to Bethesda, MD and Fort Belvoir, VA did not include adequate funding for non-medical treatment aspects of the WRAMC recommendation which also encompass moving various research and support functions from WRAMC to other locations.

Between May 2005 and September 2006, the DoD performed detailed requirements and cost analysis for the healthcare needs associated with the WRAMC BRAC actions in the NCR. These refinements resulted in almost doubling the required floor space.

The remaining modifications occurred in two main parts: additional MILCON at both WRNMMC and FBCH resulting from decisions to primarily enhance and also accelerate construction in support of wounded warriors as well as additional construction projects (including traffic mitigation/additional parking) and IO&T funds for both hospitals.

DoD's First Jointly Governed Hospitals

On January 15, 2009, the Department directed the WRNMMC and FBCH to be established as the Department's first jointly governed and staffed hospitals in the MHS. Both hospitals will be Joint commands subordinate to JTF CAPMED, and the manpower document providing their billets will take the form of a Joint Table of Distribution (JTD). This will greatly enhance interoperability, achieve economies of scale, provide for patient safety and ensured clinical standardization.

DoD also approved a single civilian manning model for the medical personnel in NCR, creating the potential for new leadership and executive roles as well as expanded career progression for MHS civilians. This will be accomplished through the realignment of Army, Navy and Air Force civilians from the Military Services to DoD civilians. The Department is also reviewing the appropriate delegation of Title 5 authority needed to manage and direct civilian employees consistently across the region.

Bethesda's final footprint will include world-class inpatient and ambulatory medical center additions of more than 682,000 sqft. Current alterations to the existing medical center are estimated to exceed 300,000 sqft, will include some 700,000 sqft of administrative space, enlisted quarters and facilities in support of the Warrior Transition Services. Fort Belvoir will have an innovative state-of-the-art community hospital (FBCH) of over 1.2M square feet, which will be the leading exemplar of Evidence Based Design in this country. At the conclusion of BRAC, WRNMMC and FBCH will be staffed with over 9,000 individuals; more than 3 million square feet of clinical and administrative space and provide 465 beds of inpatient capability (345 at WRNMMC and 120 at FBCH).

World Class Vision for Bethesda and Fort Belvoir

In July 2009, the NCR Base Realignment and Closure (BRAC) Health Systems Advisory Subcommittee of the Defense Health Board (DHB) provided the Department of Defense (DoD) with its review of plans and designs for the new Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). The DHB panel is to be commended for the review and its efforts to better describe the attributes necessary to define a world-class medical facility, which Congress codified under section 2714 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010.

After careful consideration, the Department submitted to Congress its plan to actively address the DHB panel's findings and recommendations. It has initiated the development of a comprehensive master plan for the NCR Medical that will realize a common world-class vision and, among other items, effectively synchronize non-BRAC and BRAC funding streams to achieve that vision. This plan will include additional non-BRAC MILCON and renovation projects at Bethesda as well as inform the non-BRAC projects required to achieve conformity among the older structures on the installation with the new construction. The plan will also be

used to satisfy the requirements under section 2714 of the NDAA for FY 2010 and is due to Congress by March 31, 2010. The Department may request non-BRAC funds to begin to implement this plan as early as FY 2011; however, the majority of the execution will likely occur following the completion of the BRAC projects to minimize disruption to patient care and maintain existing schedules.

The DHB panel identified the authorities issue in the NCR Medical as “foundational” and recommended empowering a single official with complete organizational and budgetary authority in the NCR. In its plan the Department stated that, “[organizational] authority issues regarding the relationship between the two hospitals and the installation Commanders remain under development, particularly in accountability for establishing and executing sustainment, restoration and modernization (SRM) and the alignment of medical support services.” The Department is reviewing the appropriate delegation of organizational and budget authorities to effectively implement a common world-class vision for the NCR Medical and understands the urgency in resolving this quickly.

Wounded Warriors

Maintaining the capability to serve as America’s primary casualty reception site and caring for those casualties remains my number one priority. This includes Warrior Transition Services, which will be established to consolidate care and support requirements for the most seriously wounded, ill or injured service members from WRAMC and NNMC who will receive care at WRNMMC. The Department provided for significant warrior care enhancements at Bethesda, which go well beyond the BRAC requirements.

Each Service employs comparable care models and administrative processes for providing wounded warriors with inpatient/outpatient care, non-clinical support, personnel benefits and medical disability/administrative separation proceedings. JTF CAPMED is working with NSA Bethesda to thoughtfully design support services for these wounded warriors while maintaining the command and control equities that the Services see as essential.

Conclusion

Chairman Ortiz, Chairwoman Davis, Ranking Members Forbes and Wilson and committee members, thank you all for your interest and support in NCR Medical transformation and the efforts the Department is taking to constantly improve its healthcare and healthcare support. JTF CAPMED is committed to providing wounded service members, their families and all MHS beneficiaries with world-class medical care and support.

Your support and oversight have made immeasurable contributions to this process. The Department will continue to work with the Military Services to deliver the finest, most robust, integrated regional healthcare system in the country. JTF CAPMED looks forward to a fruitful and collaborative partnership with this committee and I thank you for this opportunity to be with you today.

STATEMENT OF
KENNETH W. KIZER, M.D., M.P.H.,
CHAIRMAN, NATIONAL CAPITAL REGION BASE REALIGNMENT AND
CLOSURE HEALTH SYSTEMS ADVISORY SUBCOMMITTEE OF THE DEFENSE
HEALTH BOARD
TO A JOINT HEARING OF THE
ARMED SERVICES SUBCOMMITTEES ON READINESS AND MILITARY
PERSONNEL,
UNITED STATES HOUSE OF REPRESENTATIVES

December 2, 2009

Good morning Chairman Ortiz, Chairwoman Davis and Members of the Subcommittees. Thank you for inviting me to testify before you this morning concerning the new Walter Reed National Military Medical Center.

I appear before you representing the National Capital Region (NCR) Base Realignment and Closure (BRAC) Health Systems Advisory Subcommittee (HSAS) of the Defense Health Board (DHB), which was convened in the summer of 2008 to advise the Department of Defense about the integration of the more than 30 separate medical commands in the NCR as the Department seeks to establish a joint armed forces integrated healthcare delivery system in the NCR. The NCR BRAC HSAS was later additionally asked by the Assistant Secretary of Defense for Health Affairs to advise about the design and construction plans for the new Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH) pursuant to the Congressional directive contained in Section 2721 of the National Defense Authorization Act for Fiscal Year 2009 (NDAA FY09, Public Law 110-417), requiring an independent review of the design and construction plans for these two new medical facilities.

As a preface to my further comments, I should note that the NCR BRAC HSAS was convened per the Federal Advisory Committee Act and the terms of all but one member of the group have expired. The status of the Subcommittee's reappointment is unclear, and the work of the group essentially came to a halt some months ago.

Background

In 2005, the Defense Base Realignment and Closure Commission (BRAC) directed that the Walter Reed Army Medical Center be closed and its activities realigned and relocated to a new facility that would be constructed on the grounds of and combined with the National Naval Medical Center (NNMC) in Bethesda, Maryland, and a new military community hospital to be constructed at Fort Belvoir in Virginia.

In 2007, the Joint Task Force Capital Medical (JTF CAPMED) was established by the Department of Defense to provide oversight for the National Capital Region (NCR) Medical BRAC realignments and integration of healthcare delivery in the NCR. Apparently, the JTF CAPMED was not granted actual operational or budgetary authority over the many separate medical commands located in the NCR, nor the ability to integrate BRAC funding for new construction with other military construction funding sources to accomplish needed renovation of the NNMC that was to be part of the new combined joint armed forces medical facility.

In the NDAA FY 2009, Section 2721, the Congress directed that an panel be convened to conduct an independent review of the design plans for the new WRNMMC and FBCH and to advise the Secretary of Defense whether these plans were those of a *world class medical facility*, as was the intent of Congress. The NCR BRAC HSAS of the DHB, augmented with additional medical facility design experts, was charged with completing this review.

After reviewing many documents and hearing numerous briefings regarding the design plans for the WRNMMC and FBCH, and conducting several meetings and conference calls, the NCR BRAC HSAS determined that the plans for the new WRNMMC were not those of a world class medical facility and made multiple suggestions for how those plans might bring the new facility closer to this goal. These findings were detailed in a report entitled *Achieving World Class, An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital*. The NCR BRAC HSAS's findings were presented and discussed in open session at multiple meetings of the Defense Health Board between November 20, 2008 and May 7, 2009. The report was finalized at the end of May 2009 and formally presented to the Department of Defense by the DHB on July 2, 2009. It is my understanding that copies of this report were shared with the Congressional defense committees last July.

Among other things, the NCR BRAC HSAS:

(1) developed an operational definition for a *world class medical facility*. This definition has since been codified in the National Defense Authorization Act for Fiscal Year 2010 (Section 2714, PL 111-84);

(2) identified an exigent need to consolidate organizational and budgetary authority for the new Walter Reed National Military Medical Center, along with the

other medical facilities in the National Capital Region, in one entity. The Committee does not believe that an integrated delivery system in the NCR nor a joint armed forces medical facility can be developed without this alignment of authority.

(3) identified a need to integrate and align the BRAC and other construction funding sources in order to complete both the new construction and renovation of the existing National Naval Medical Center. The goal is to have a single well-functioning integrated medical facility, but the funds needed to accomplish this goal come from multiple sources under disparate control.

(4) identified a critical need for a master facility plan for the new Walter Reed National Military Medical Center, a master installation plan for the Bethesda campus where the new WRNMMC will be located along with other related facilities, as well as a master plan for the entire National Capital Region Integrated Delivery System.

(5) identified numerous other deficiencies and problems needing corrective actions.

A copy of the executive summary of the NCR BRAC HSAS's report is appended to these comments (Appendix 1).

Section 2721 of PL 110-417 also directed that, not later than 30 days after submission of the report of the independent review, the Secretary of Defense should respond to the report, including, if needed, a corrective action plan. On October 15, 2009, the Department's response to the report was delivered to the Congress.

While technically no longer existent, the NCR BRAC HSAS reviewed the Department's response and found it disappointing in many ways, as was subsequently detailed in a memo from me to the Co-Vice Chairs of the Defense Health Board. The full DHB reviewed these concerns in open session on November 13, 2009, and unanimously concurred with the NCR BRAC HSAS's observations and formally transmitted those observations with its own comments to the Department on November 23, 2009. The DHB memo is attached to these comments as Appendix 2.

Key Concerns at Present

The House Armed Services Subcommittees on Readiness and Military Personnel have convened this hearing to consider whether plans for the new Walter Reed joint armed forces medical facility are on the right track. The NCR BRAC HSAS is concerned that they are not.

The Department has stated that it agrees with the NCR BRAC HSAS's overall assessment and specific findings, as conveyed in its report last summer, and it

acknowledges that the current plans for the WRNMMC will not produce a world class medical facility. However, the Department has not presented a meaningful plan for addressing those findings and recommendations, nor a cost estimate for the needed corrective actions.

The NCR BRAC HSAS recognizes and commends the diligent work of many dedicated individuals, but is very concerned that multiple circumstances are impeding efforts to make the new Walter Reed a world class medical facility. We believe that failure to very quickly address the identified deficiencies that have been publicly discussed for over a year will result in substantial additional and avoidable expense, unnecessary future disruption of services, untoward effects on personnel morale, and possible harm to patients.

Construction of the new portion of the WRNMMC is moving forward quickly and is reported to be ahead of schedule. Normally this would be reason for applause; however, in this case it is cause for further concern since it means that the window of opportunity to take corrective action is even less than it was several months ago when the NCR BRAC HSAS completed its report.

The NCR BRAC HSAS believes that it is imperative that resolution of the authority issue, alignment of funding sources, and the master plan(s) be accomplished very quickly. The NCR BRAC HSAS also believes that the funding and master planning problems, as well as the numerous other identified deficiencies, cannot be adequately addressed until the needed consolidation of authority occurs.

Conclusion

In closing, I want to acknowledge that the NCR BRAC HSAS understands that the Department is currently dealing with multiple high visibility, important and challenging issues. Nonetheless, we believe that few issues are more important to readiness and military personnel than their knowing that the best possible healthcare will be there for them when they step into harm's way. We urge that you take whatever action is necessary to ensure that world class healthcare is available to those who have committed themselves to the defense of our nation.

That concludes my prepared testimony. I would be pleased to answer any questions that the Committee might have.

APPENDIX 1

Achieving World Class - An Independent Review of the Designs Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. Prepared by the National Capital region Base Realignment and Closure Health Systems Advisory Subcommittee. May 2009.

EXECUTIVE SUMMARY

REPORT PURPOSE

The National Capital Region (NCR) Base Realignment and Closure (BRAC) Health Systems Advisory Subcommittee (HSAS) of the Defense Health Board (DHB) was convened in May 2008 to advise the Department of Defense (DoD) on the planned integration of military medical facilities in the NCR service area. In response to the National Defense Authorization Act for Fiscal Year 2009 (NDAA 2009, Public Law 110-417; Appendix A), in September 2008, the NCR BRAC HSAS was further charged to review the design and construction plans for the new Walter Reed National Military Medical Center (WRNMMC) and the new Fort Belvoir Community Hospital (FBCH) to determine if they were being designed and constructed to be *world-class medical facilities* and, if not, what should be done to remedy any perceived deficiencies. This report responds to this latter charge.

FINDINGS

Based upon its review, the NCR BRAC HSAS finds that:

A. The integration of the Walter Reed Army Medical Center (WRAMC), the National Naval Medical Center (NNMC) and other military medical commands in the NCR is likely to better serve the area's active duty and retired military personnel and their dependents.

B. Congress specified that the new WRNMMC and FBCH should be designed and constructed to be *world-class medical facilities*, and indicated that this should be taken to mean that they incorporate "...the best practices of the premier private health facilities in the country as well as the collaborative input of military healthcare professionals into a design that supports the unique needs of military personnel and their families". This verbiage conveys Congressional intent, but it does not provide operational or functional details about the meaning of the term *world-class medical facilities* that would support completion of the review required by the NDAA 2009.

C. To date, no recognized body has established an operational definition of *world-class medical facility*. Based on a review of relevant reports and other literature, the HSAS's collective experience and judgment, and extensive review by prominent healthcare leaders, a definition of *world-class medical facility* was developed and used as a yardstick for this review (Appendix B).

D. The creation of a *world-class medical facility* must begin with a clear vision. This vision is realized through integrated facility design and operational plans, skilled and appropriately empowered leadership, and the provision of necessary funding and other resources, among other things. If funding and other resources come from more than one source, they must be integrated to match the integrated facility design and operational plan.

E. The BRAC funding process entails a number of constraints and limitations that do not support the creation of a comprehensive plan and construction strategy, particularly for renovation of existing facilities. These limitations have been, and continue to be, a major impediment to designing the new WRNMMC to be a *world-class medical facility*.

F. The Service-specific and facility-centric cultures of the Army, Navy and Air Force medical commands

conflict with the needs of an IDS, and there is no evidence of a concerted, organized effort to engineer the new integrated military healthcare culture needed to achieve and sustain a joint Armed Services IDS that provides *world-class* medical care.

G. Many dedicated individuals have worked diligently to achieve what they have perceived to be the goals of the regional integration effort; however, there are multiple circumstances beyond their control that have impeded, and continue to impede, their efforts. Among these are Service-specific and facility-centric military healthcare cultures, a *confusing* and redundant chain of command, and ambiguity about the vision, goals and expectations for the future NCR IDS and the WRNMMC. There is an urgent need to clarify the vision, goals and expectations for the future NCR IDS, especially for the WRNMMC, and to consolidate organizational and budgetary authority in a single entity.

H. A comprehensive, forward-looking demand analysis that includes the capability to accommodate surge needs has not been completed for the WRNMMC.

I. There does not appear to be a comprehensive "master plan" for the WRNMMC that includes the combined and augmented assets of the WRAMC and NNMCM and that integrates the Uniformed Services University for the Health Sciences (USUHS), the Joint Pathology Center (JPC) and other specialized centers or institutions on the grounds of or proximal to the WRNMMC.

J. Significant input from frontline clinicians and other stakeholders does not appear to have been incorporated into the current plans for the WRNMMC.

K. The current plans for the WRNMMC are not those of a *world-class medical facility*. Significant deficiencies exist, especially with regard to the existing NNMCM. The final facility design will more likely be able to achieve world-class status if the deficiencies detailed below are addressed and if the definition of *world-class medical facility* detailed in Appendix B is used to guide further work.

The following specific issues need to be addressed in the design and construction plans for the WRNMMC:

1. Several areas are not in conformance with the Joint Commission's hospital design standards.
2. The current bed plan does not provide for broad conversion to single-patient rooms.
3. The design of the surgical suite has several problems.
 - a. It appears that after construction and renovation there will be too few operating rooms (ORs) and that the ORs will be too small to accommodate current and expected future surgical technologies.
 - b. The frozen section/surgical pathology space is to be located in an area remote from the surgical suite. Such an arrangement is problematic because it "designs in" inefficiencies and could lead to patient safety problems.
 - c. It is unclear whether the post-anesthesia care unit (PACU) will be used for services unrelated to post-anesthesia care. Any decision in this regard should be informed by analyses of the demand for PACU services and of the experience and skills of PACU staff relative to the skills needed to properly care for other potential PACU patients.
4. Plans for observation care are unclear. The capability to provide observation care is important, especially for emergency patients, and should be specifically designed and planned for in accordance with the projected need for this level of care.
5. On-site simulation labs for surgery, cardiac catheterization, gastrointestinal endoscopy and pulmonary endoscopy are not included. Provision of these labs in an off-site location will likely create barriers to the utilization of these important resources.

6. Information management and information technology (IM/IT) support and services are absolutely essential to the operation of a *world-class medical facility*; however, the plans for these essential services appear to be incomplete:

- a. It is unclear whether the IM/IT infrastructure needs (e.g., fiber optic cabling, wireless technology) are being addressed.
- b. Plans for the electronic health record do not appear to have addressed significant issues such as inter-system interoperability, ease of physician use, transportability and use of open source software.
- c. Plans to support the transfer of medical records from WRAMC into the new facility are inadequate.

7. The new facility design does not seem to account for expansion of support services (e.g., food service, day care, community services, medical records, materiel management) to accommodate the anticipated growth in staff, patients and families.

8. Parking limitations imposed by the National Capital Planning Commission (NCPC) appear likely to have a detrimental impact on the operations of the WRNMMC.

9. The new WRNMMC facility design locates the dialysis unit above several environmentally-sensitive areas of the hospital. The rationale for this is not obvious.

10. There does not appear to be a strategic technology master plan for use of advanced diagnostic and treatment technologies.

L. The plan for the new FBCH is well conceived and incorporates many important evidence-based design (EBD) features; however, the current plan would benefit from addressing the following specific issues:

- 1. There does not appear to be a plan to evaluate the impact of incorporating EBD features into the facility's design. Such an assessment would be valuable for informing plans for future federal hospital construction.
- 2. FBCH representatives have talked about a "facility-based master plan", but the existence of this master plan could not be documented.
- 3. More complete plans should be created for IM/IT and for diagnostic and treatment technology along the lines as those outlined for the WRNMMC.

M. The BRAC timeline required an accelerated process for designing and building these two new facilities. Since different processes were used, it would be instructive to evaluate the two different processes to determine their relative value in an effort to inform planning for the design and construction of future federal medical facilities.

N. There is no need to halt construction of the new facilities if a properly devised master plan can be developed to ensure that backfill renovations can be accomplished in a timely manner. Halting construction would be very costly and highly demoralizing and should be avoided if at all possible.

RECOMMENDATIONS

A. Further planning for the new WRNMMC and FBCH, as well as development of the NCR IDS, should be guided by the definition of *world-class medical facility* detailed in Appendix B of this report.

B. One official should be empowered with singular organizational and budgetary authority and staffed appropriately to manage and lead the healthcare integration efforts and operations in the NCR. This should be accomplished as quickly as possible, and this official's authority should extend over all DoD healthcare facilities and resources that impact healthcare operations within the NCR.

This official should *not* have day-to-day operational responsibility for any individual facility in the NCR, so that his/her primary concern is always the operation of the integrated system.

The selected official should give high priority to:

1. developing a shared vision and a clear mission statement for the NCR IDS and the WRNMMC;
2. creating a comprehensive master plan for both the NCR IDS and the WRNMMC;
3. engineering a culture that will support the NCR IDS and *world-class medical facilities*;
4. developing a strategic technology master plan for the WRNMMC, FBCH and NCR IDS;
5. ensuring that all further planning is informed by user groups and reflects input from patients and their families and frontline clinicians (e.g., physicians, nurses, pharmacists); and
6. implementing a mechanism for the ongoing independent review of the design and construction of the new WRNMMC.

C. Deficiencies in the current plans for the WRNMMC should be corrected and the funding needed to correct these deficiencies should be identified as soon as possible. Specifically:

1. All design and construction plans should be in conformance with the Joint Commission's standards, at a minimum.
2. The bed plan should be reconsidered so that single-patient rooms are the norm throughout the facility.
3. Plans for the surgical suite should be reconsidered, addressing especially the specific concerns identified in this regard. A model of the perioperative process and a demand analysis should be developed and used to guide further planning for the surgical suite.
4. Plans for patients requiring observation should be further considered and clarified.
5. Plans for on-site simulation laboratories should be developed and funded.
6. The IM/IT infrastructure plan should be further considered. Funding and other resources to ensure that the facility will have a forward-looking IT infrastructure should be ensured and electronic health record-related issues of inter-operability, ease-of-use, open-source applications and portability should be addressed.
7. Current plans should be reviewed for their adequacy to address expected increased needs in support services such as food service, day care, parking, medical records processing and storage, and materiel management, among others. Modifications to current plans should be made based on this review.
8. Placement of the dialysis unit in the new WRNMMC should be further considered.

D. A plan to assess the outcomes, benefits and return on investment, among other things, of the design processes used for the new WRNMMC and FBCH, as well as the benefits of incorporating EBD principles in these facilities, should be developed, funded and implemented.

E. New construction should proceed as currently planned, assuming that the needed master plans are developed in a timely manner. Going forward, modifications should be made as needed.

Backfill renovation should be deferred until it can be coordinated with and, if necessary, redesigned in conjunction with the master plan and the recommendations detailed in this report.

APPENDIX 2

DEFENSE HEALTH BOARD
 FIVE SKYLINE PLACE, SUITE 810
 5111 LEESBURG PIKE
 FALLS CHURCH, VA 22041-3206

NOV 23 2009

DHB

MEMORANDUM FOR: ELLEN P. EMBREY, DASD (FHP&R)
 PERFORMING THE DUTIES OF THE ASD (HA)

SUBJECT: World-Class Military Medical Facilities in the National Capital Region

1. The DHB recognizes the vital importance to the Armed Forces of having the highest quality healthcare and healthcare delivery systems for its warriors and their families. The Board understands that Congress shares that sense of importance and duty and thus directed that Walter Reed National Military Medical Center be a world-class facility.
2. Unanimously, the DHB believes that the Department's described current course of actions will not achieve that status.
3. During the DHB open session meeting on 13 November 2009, Dr. Kenneth W. Kizer, who chaired the NCR BRAC Health Systems Advisory Subcommittee (HSAS) of the DHB when it produced the "Achieving World Class" report, advised the DHB of the subcommittee members' urgent and critical concerns with the DoD response to Congress. Dr. Kizer submitted a memorandum to the Board detailing these concerns. In general the Department's corrective action plan in response to the report lacks specific details and portrays an absence of timelines and milestones. Particular concerns include the following.
 - o The HSAS report clearly recommended that continuing construction should be contingent upon the Department's rapid response and correction of deficiencies identified in the HSAS report. Despite the HSAS recommendation, construction has continued without an affirmative response to the significant concerns expressed in the HSAS report, thus creating the potential for considerable risks and liabilities for DoD. The Board holds that the WRNMMC facility as currently designed lacks necessary capabilities to deliver world-class care.
 - o Several critical benchmarks have not been attained, thus elevating the Board's concern that such deficiencies may have a significant deleterious impact on the quality of care delivered as well as adversely impacting patient safety, especially at the WRNMMC facility. Examples include 1) absence of a master facility plan, 2) location of surgical pathology units at sites not adjacent to operating rooms, 3) operating room designs that appear to be undersized by current standards, 4) lack of a clear plan for addressing information management/information technology, 5) lack of a singular authority for decisions, priorities, resource requests/allocation, 6) lack of evidence that final design plans are reviewed by critical clinical staff for acceptability (e.g., infection control).

SUBJECT: World-Class Military Medical Facilities in the National Capital Region - DHB 2009-09

- The Board believes the Department has allocated insufficient funds to appropriately build the Congressionally-mandated world-class medical center. DoD faces two overlapping requirements: realignment of Walter Reed Army Medical Center to WRNMMC and FBCH through BRAC, and the Congressional directive to establish a world-class medical center. The disparate timetables and funding streams require both flexibility and additional resources beyond those already identified.
 - Cultural realignment to a joint service perspective would overcome continuing clashes/problems with multiple and often service-specific cultures thereby allowing energies to be spent on improving warrior and family care.
4. The DHB Core Board unanimously concurred with Dr. Kizer's memorandum to the Board (TAB A) that was presented and discussed on 13 November 2009. This memorandum addresses the Board's concerns with the Department's course of actions following receipt of the May 2009 HSAS report.
 5. The DHB recognizes the complexities and potential challenges that may arise as DoD proceeds to accomplish the BRAC initiatives and to address its congressionally-mandated obligation to meet the standards of a world-class facility within various current constraints, including fiscal limitations. The DHB, consistent with its mission and charge, remains positioned and willing to assist the JTF CAPMED Commander and DoD in their efforts to construct and operate a world-class facility. In this regard, the DHB unanimously approved and offers the following recommendations.
 - Due to the time-sensitive nature of this issue, DoD is advised to pursue immediate action to decisively address the concerns raised by the Board, particularly given the present advanced stage of construction.
 - The DHB requests a substantive progress report from DoD by 15 February 2010. This report should identify and detail specific efforts undertaken and progress manifested by that date to address the critical deficiencies of the Department's current report plus a review of the Master Plan. These efforts should include strategies undertaken for procurement of funding and resources necessary to meet the Congressionally-mandated standards for these facilities.
 6. The DHB believes that DoD has a unique opportunity not only to set a precedent within the Department, but also to leave a lasting legacy for future delivery of care for wounded Service members. Facilities of such merit will serve as models on both a national and international scale, but most importantly will enable DoD to meet its obligation and duty to provide the highest quality care and support for Wounded Warriors and their families.

SUBJECT: World-Class Military Medical Facilities in the National Capital Region -
DHB 2009-09

7. The DHB strongly supports the men and women in military medicine and believes in their ardent dedication to practice the highest caliber of medicine whether in tents, on ships or in state-of-the-art facilities. The Board knows that it can best serve these men and women by assisting the Department in creating the plans, gaining necessary resources, and holding itself and the Department to the high standards necessary to achieve a world-class medical center.
8. The DHB appreciates this opportunity to examine various issues pertaining to the establishment of world-class facilities at WRNMMC and FBCH, and in particular, to provide a definition of world-class that allows the construction of a healthcare facility of appropriate merit, reflecting the standard and level of healthcare and service quality worthy of our Wounded Warriors and their beneficiaries.
9. The DHB looks forward to assisting the Department in meeting requirements as mandated by Congress and providing future recommendations as developments arise that could facilitate the Department's efforts to provide optimal care for Service members.
10. References:
 - a. P.L. 111-84 111th Congress, National Defense Authorization Act for Fiscal Year 2010, §2714, 28 October 2009.
 - b. Department of Defense, Response to: Achieving World Class, An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital, 15 October 2009.
 - c. National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee of the Defense Health Board, Achieving World Class: An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital, May 2009.
 - d. P.L. 110-417 110th Congress, National Defense Authorization Act for Fiscal Year 2009, §2721, 14 October 2008.
 - e. Defense Base Realignment and Closure Commission, Final Report to the President, 08 September 2005.
 - f. Memorandum, Deputy Assistant Secretary of Defense, 12 September 2007, Establishing Authority for Joint Task Force – National Capital Region/Medical (JTF CapMed) and JTF CapMed Transition Team.

SUBJECT: World-Class Military Medical Facilities in the National Capital Region -
DHB 2009-09

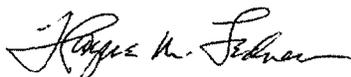
11. Background:

- a. In their Final Report dated 2005, the Defense Base Realignment and Closure Commission (BRAC) directed a repositioning of the Walter Reed Army Medical Center to the Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH).
- b. In a memorandum dated 12 September 2007, the Deputy Secretary of Defense established the Joint Task Force Capital Medical (JTF CAPMED) as a standing operational entity that would directly report to the Secretary of Defense through the Deputy Secretary of Defense, with a critical mission to provide oversight for the National Capital Region (NCR) Medical BRAC realignments and integration of healthcare delivery in the NCR.
- c. As stipulated in § 2721(b) of the National Defense Authorization Act for Fiscal Year 2009 (NDAA FY09) an expert panel was requested to be established to conduct an independent review of the design and plans for the new WRNMMC and FBCH facilities and to subsequently advise the Secretary of Defense whether they would meet the standard of world-class facilities. The DHB was assigned responsibility for that review by the Assistant Secretary of Defense for Health Affairs in a memorandum dated 20 October 2008.
- d. The NCR BRAC Health Systems Advisory Subcommittee (HSAS) of the DHB held several meetings between November 2008 and January 2009, during which the members received numerous briefings regarding the construction and design projects at both the WRNMMC and FBCH facilities. The HSAS deliberations and findings resulting from its independent review were submitted to the DHB for deliberation in open session during the Core Board meetings held on 20 November 2008, 15-16 December 2008, 9 March 2009, and on 7 May 2009, when the Core Board voted and approved by unanimous consent the HSAS report, entitled: "Achieving World Class, An Independent Review of the Design Plans for the Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH)". The report was subsequently provided to DoD on 2 July 2009.
- e. DoD formally responded to the HSAS report in its submission of a report to Congress that addressed the HSAS findings and recommendations.

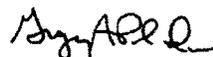
SUBJECT: World-Class Military Medical Facilities in the National Capital Region -
DHB 2009-09

- f. The HSAS definition of a world-class medical facility was codified into law (P.L. 111-84) on 28 October 2009, when President Obama signed the NDAA FY2010 (PL 111-84). In addition, the law mandates that DoD develop a Master Plan to address deficiencies identified by the HSAS by 31 March, 2010.

FOR THE DEFENSE HEALTH BOARD:



Wayne M. Lednar, M.D., Ph.D.
DHB Co-Vice-President



Gregory A. Poland, M.D.
DHB Co-Vice-President

Attachment
TAB A, Dr. Kenneth W. Kizer memorandum

Distribution List
ADASD (FHP&R)
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Strategic Communications, OASD(HA)
DHB Members and Consultants
Surgeon General of the Army
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Surgeon General of the Air Force
Commander, JTF CAPMED
Joint Staff Surgeon
Library of Congress

TAB A
(Memorandum from Dr. Kizer)

November 12, 2009

TO : Wayne M. Lednar, M.D., Ph.D., Co-Vice President
Defense Health Board

FROM: Kenneth W. Kizer, M.D., M.P.H., Chairman
NCR BRAC Health Systems Advisory Subcommittee

SUBJ : DoD Response to NCR BRAC HSAS Report, *Achieving World Class, An Independent Review of the Design Plans for the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital*

The NCR BRAC Health Systems Advisory Subcommittee (hereafter referred to as the "Committee") thanks the Department of Defense ("Department") for responding to its review of the design plans for the new Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH) that was completed earlier this year in fulfillment of Section 2721 of Public Law 110-417. The Committee appreciates the Department's general agreement with its findings and the Department's candor in acknowledging that the current plans for the WRNMMC will not produce a world class medical facility.

The Committee also commends the Department for beginning to transition the Military Health System from its Service-specific, facility-centric approach to service delivery to a more modern integrated service delivery model that has become the norm in the other major federal healthcare system and is becoming increasingly prevalent in the private sector as well.

Based upon a careful analysis of the Department's plan of action espoused in Tab A that was attached to Deputy Secretary Lynn's letter to Subcommittee Chairman Murtha dated October 15, 2009, the Committee has identified a number of concerns that warrant the attention of the Defense Health Board. These concerns have been grouped as "general" and "specific" for presentation here. The issues detailed in the following paragraphs should be viewed as illustrative but not inclusive of all of the Committee's concerns.

General Concerns

First and foremost, the Committee is concerned that the Department may not have fully understood some of the Committee's recommendations or the essentiality of taking corrective action in a timely manner. The Committee is particularly concerned about the lack of specific details contained in the Department's corrective action plan and the absence of time lines and milestones. What is not said in some instances conveys a sense of uncertainty about both direction and commitment.

The Committee is not reassured that timely course correction will be accomplished based on the number of matters that are "under review," "under development," "under study" or similarly unresolved. The lack of specificity contained in the Department's response is especially troubling in light of the amount of time that the Committee's findings and recommendations have been available. Likewise, the Committee is not confident that the NCR OIPT that is identified in the Department's response as a primary

NCR BRAC HSAS Memorandum
November 13, 2009

vehicle for issue resolution will actually resolve the identified problems considering its longstanding existence and inability to resolve key problematic issues so far. Overall, the Department's response does not convey a sense of commitment to correcting the identified deficiencies and organizational problems that were identified by the Committee.

The Committee philosophically agrees with the Department that "...development of a world-class medical facility is not a destination but rather a journey of continuous improvement..." but the Committee expected, as probably does the Congress, that the effort would be less of a work in progress by this time, and definitely less so than appears will be likely by September 2011, unless significant course corrections are made soon.

The Committee is dismayed by the Department's assertion that the Committee concluded that the WRNMMC design plans were "...sufficiently close to the newly defined standard to recommend that the construction projects should continue." This statement is a misrepresentation of what was stated in our report.

To be clear, the Committee did not suggest that either the new construction or the total design plan as presently laid out would result in a world class medical facility. The Committee clearly stated that the current plans were not those of a world class medical facility.

Nevertheless, recognizing the high cost and disruption that would be associated with halting new construction, the Committee recommended that construction be continued as needed renovation projects were carefully but quickly reviewed and incorporated into a master plan.

Foundational to the Committee's recommendation that new construction continue was the expectation that its recommendation to realign and consolidate organizational and budgetary authorities would be quickly operationalized. The Committee believes that this must occur in order to achieve world class performance and support integrated service delivery in the NCR.

While the Department appears to embrace this recommendation it also suggests that no change is imminent - or at least no decision will be made any time soon. The Committee views indecision or equivocation in this regard as highly problematic.

Failure to resolve the organizational and budgetary authority problem in the near term portends for serious problems and a substantial negative impact going forward.

We wish to underscore, as was repeatedly expressed during the Committee's deliberations, the recommendation that new construction continue was contingent on necessary corrective actions being completed in a timely manner. After reading the Department's plan of action, the Committee is less confident that new construction should not be halted.

Specific Concerns

Cultural Realignment. The Committee recommended that problems with the multiple and often conflicting Service-specific cultures be urgently addressed in the hope that this

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would lead to a needed new patient-centered collaborative joint Armed Forces healthcare culture. The Department's plan of action provides insufficient detail to know whether this important transformation is likely to occur in the foreseeable future.

BRAC-Related Funding Constraints. During its deliberations, the Committee was repeatedly advised that a master facility plan had not been developed due to funding-related constraints of the BRAC law. The Committee is pleased to now hear that, apparently, this is no longer the case and that the BRAC funding process would not restrict the Department's ability to create a comprehensive facility master plan.

Surge Capability. While the Committee agrees that an analysis of surge capability is important, the Committee recommended that a forward-looking "demand analysis" be performed to better understand the future care needs of active duty, retired and dependent personnel in the NCR. Changes in the demographics of the region, the prevailing types and extent of morbidity and advances in medical care technology and methods of service delivery, among other things, need to be assessed in this demand analysis to assure that the service delivery infrastructure will be both appropriate and adequate.

NCR Integrated Delivery System Master Plan. The approved master plan for the Bethesda installation does not appear to be adequately focused on the medical facilities that are currently present and which will be needed in future years. A comprehensive facilities master plan is needed to inform decisions going forward and ensure that the most effective use of the campus occurs. Implementation of the master plan may continue well past September 2011, but it needs to be completed as soon as possible if it is to serve as the basis for the renovations that are contemplated.

Strategic Technology Master Plan. While pleased that the Department will develop an information technology master plan, the Committee had recommended that a strategic technology master plan be developed that addressed all needed technology. This would include diagnostic imaging, radiation oncology, patient monitoring, surgical equipment, emergency and life support, laboratory, and the myriad other technologies utilized in a modern tertiary care hospital. With the rapidly changing medical care environment and the explosion of new technologies, such a plan is vital for the prudent expenditure of public funds, as well as the delivery of high quality care.

End-User Clinician Input. The Department's response suggests that no further clinician input will be considered until planning for post-BRAC construction. The Committee reaffirms its recommendation that multidisciplinary end-user input be continuously sought and used to inform design plans.

Single Patient Rooms. The Committee was surprised to see single patient rooms characterized as a newly defined standard. This is hardly the case. Single patient rooms have been a well established basic hospital design standard for some time. Single patient rooms are especially important for infection control, which is a particular concern among OEF/OIF wounded warriors.

The Committee believes it would not be unreasonable to maintain a few two-bed rooms for military-specific care-related purposes, but it does not view renovating just one floor to have single patient rooms as being adequate. Quite simply, the facility would not be state-of-the-art, to say nothing of world class, if the preponderance of rooms were not

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November 13, 2009

designed for single occupancy, albeit with the capability for conversion for double occupancy if needed for temporary additional surge capacity.

The Committee recently has been advised that the Executive Medical Service at the current Walter Reed Army Medical Center may need to occupy space on the one floor planned for single patient rooms, which would substantially reduce the available single occupancy rooms. This would be problematic. The Subcommittee reaffirms its recommendation that all but a select few rooms be designed as single patient rooms

Operating Rooms. While the three new operating rooms appear as if they will meet current size and infrastructure requirements, the Committee remains concerned that the other seventeen operating rooms will be substandard in many ways. The Committee does not view the Department's plan of action in this regard to be adequate.

On Site Simulation Laboratories. The Committee is pleased to learn that there will be on-site simulation laboratories, contrary to the information previously provided. The Committee hopes that all procedural skills will be available, including surgery, cardiac catheterization, GI endoscopy and pulmonary endoscopy, and that the chosen site permits ready access for both trainees and staff 24 hours a day, 365 days a year.

Dialysis Unit. The panel continues to believe that locating the dialysis unit where planned will be problematic. The multiplicity of risk mitigation measures that are being incorporated into the design of the space is reassuring on one hand, but affirms the Committee's fundamental concern on the other hand.

Surgical Pathology. The Committee understands that the frozen section/surgical pathology area will be incorporated into the clinical pathology space substantially remote from the operating rooms. The Committee did not have the benefit of discussing this matter with the surgeons who will be affected by this choice, but it is hard for the Committee to believe that they were supportive of this design.

Based on what it knows about the matter, the Committee does not support this design plan. If the decision is made to proceed with this unusual design, then it strongly encourages that rigorous patient safety and infection control policies and procedures, among others, be developed for surgical staff traveling to and from the surgical pathology space since the surgeon, with the tissue specimen in hand, will be traveling from the sterile operating room through public areas to the clinical pathology space located two floors down, causing the surgeon to become contaminated and needing to rescrub on returning to the surgical suite. These things will require that the patient be kept under anesthesia longer than would otherwise be the case (i.e., if the surgical pathology space were more proximate to the operating rooms as is customary). In light of these patient safety concerns, as well as the hassle factor for the surgeons, we would again recommend that this design plan be re-evaluated.

Post Anesthesia Care Unit. The Committee understands from the Department's plan of action that the PACU now may be used for the placement of regional anesthetic blocks, electroconvulsive therapy, and wound dressing changes for OIF/OEF wounded warriors requiring sedation. Each of these potential uses has multiple design requirements that were not reflected in the PACU design presented to the Committee. The Department's plan of action is silent about how the various specific design needs for these services will be incorporated into the final PACU design.

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November 13, 2009

Information Management/Information Technology. The Committee found the Department's plan of action for addressing identified deficiencies of the IM/IT infrastructure to be very unclear. For example, while it is stated that a \$50 million "procurement package" for IM/IT infrastructure has been "prepared" no information is provided about when, and if, the "package" will be operationalized or whether the \$50 million is actually available. The Committee was previously told by several representatives of the Department that funding for IM/IT was not available. Nothing in the Department's plan of action leads the Committee to believe that this situation has changed.

Other Issues. The Committee has additional concerns about the Department's plan of action relating to parking, support services, medical records maintenance, evaluation of the design processes, and the ongoing independent review of the design plans for these facilities, among other things, but these concerns are generally in line with those already expressed, so I will defer expressing those for now.

Conclusion

The Committee wishes to reaffirm its previous perspective that addressing the identified deficiencies of the current WRNMMC design plans will not necessarily ensure the new facility will be world class, but it is a certainty that it will not be world class if needed corrective actions are not taken in a timely manner.

The Committee hopes these concerns can be resolved in the near term, and if it would be helpful in this regard for representatives of the Committee, or the Committee as a group, to meet with appropriate Departmental officials, then we would be pleased to do so at the earliest possible mutually agreeable time.

DOCUMENTS SUBMITTED FOR THE RECORD

DECEMBER 2, 2009

CHRIS VAN HOLLEN
9th DISTRICT, MARYLAND

COMMITTEE ON
WAYS AND MEANS

COMMITTEE ON OVERSIGHT AND
GOVERNMENT REFORM

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December 2, 2009

The Honorable Ike Skelton
Chairman
House Armed Services Committee
2120 RHOB
Washington, DC 20515

Dear Chairman Skelton:

As the Member of Congress representing the new Walter Reed National Military Medical Center (WRNMMC) in Bethesda, MD, I share your commitment to building a world class medical facility for our nation's wounded warriors and write to commend you and the committee for convening today's hearing entitled "The New Walter Reed: Are We on the Right Track?"

As you know, the consolidation of the Walter Reed Army Medical Center and the National Naval Medical Center into the new Walter Reed National Military Medical Center was mandated by the 2005 Base Realignment and Closure (BRAC) process. Since that time, many dedicated individuals both inside and outside the Department of Defense have been working diligently to make the transition to the new facility a success.

Consistent with that objective, as well as Congress' oversight responsibilities, the 2008 Defense Authorization bill required the Secretary of Defense to develop a transition plan with sufficient resources to ensure no degradation of patient care and no net loss of capacity at the consolidated installation. The 2009 Defense Authorization bill went further to mandate an independent review of the design plans for the future facility, and the 2010 Defense Authorization bill enacted into law earlier this year called for the creation of a detailed master plan to provide world class military medical facilities across the National Capital Region.

Notwithstanding these efforts, the "Achieving World Class" report released by the National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee of the Defense Health Board in May of this year concluded that "the current plans for the WRNMMC are not those of a world class medical facility." Furthermore, issues related to traffic congestion and community impacts must be more fully addressed if we are to declare this relocation a success. We will be doing a disservice to our wounded warriors, their families and the medical personnel that assist them if they are unable to access the facility because of gridlock.

It is my hope that today's hearing will give Congress, the Department of Defense and all other stakeholders an opportunity to take stock of the work done to date, identify and eliminate any impediments to the progress we know we must make, and recommit to building the world class military medical facility the Walter Reed National Military Medical Center can and must be.

Sincerely,



Chris Van Hollen
Member of Congress

THIS STATIONERY PRINTED ON PAPER MADE OF RECYCLED FIBERS

**WITNESS RESPONSES TO QUESTIONS ASKED DURING
THE HEARING**

DECEMBER 2, 2009

RESPONSE TO QUESTION SUBMITTED BY MR. TAYLOR

Admiral MATECZUN. Each of the Military Services has programs to provide wounded, ill, or injured Service members who remain in the military opportunities for meaningful work. At the Office of the Secretary of Defense level, the Operation Warfighter program helps connect recovering wounded warriors with meaningful employment activities outside of the hospital environment. Operation Warfighter allows wounded warriors to explore employment interests, develop job skills, build a resume, and gain valuable work experience as interns with Federal agencies in the National Capital Region. It provides valuable assistance to wounded warriors transitioning back to the military or into the civilian community and workplace. [See page 21.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

DECEMBER 2, 2009

QUESTIONS SUBMITTED BY MR. ORTIZ

Mr. ORTIZ. Walter Reed Army Medical Center (WRAMC) was essentially closed by Base Realignment and Closure (BRAC) 2005 and the functions principally realigned to Bethesda, MD, and Fort Belvoir, VA. BRAC-related costs have increased significantly and the Department will be challenged to meet the September 2011 BRAC deadline. What steps is the Department pursuing to limit cost and schedule growth? Will the Department be able to meet the BRAC statutory deadline of September 2011? What are the biggest challenges that will need to be addressed in order to meet the BRAC statutory deadline?

Mr. MIDDLETON. The Department utilizes a well established vetting and approval process to limit cost and schedule growth. The Deputy Secretary of Defense is the final approval authority. As a result, the Department is on schedule to meet the BRAC statutory deadline. The biggest challenges facing the Joint Task Force, National Capital Region Medical (JTF CAPMED) and the Department are not related to construction but include governance, financial management, potential workforce attrition, and transition to the new facilities.

The scope of the transformation in National Capital Region (NCR) Medical has evolved since the original BRAC recommendations. Per the Naval Facilities Engineering Command and the Army Corps of Engineers, the Department is currently on schedule to complete the NCR Medical BRAC transfer of functions by the September 15, 2011 deadline. As such, there is minimal schedule risk left in the construction at Bethesda and Fort Belvoir. JTF CAPMED, via its Project Management Office, is overseeing the Walter Reed transition and has awarded the Initial Outfitting & Transition contract for both hospitals as well. This contract brings together the industry leaders to ensure that outfitting the buildings and transition of patients and staff will occur safely by September 15, 2011. To maintain schedule, the Department is working with the contractors to find efficiencies so it can mitigate potential delays should they occur.

The Department is putting to bear all its available resources to mitigate inherent operating risks both WRAMC and the National Naval Medical Center (NNMC) pose during BRAC. At WRAMC, it will be important to maintain the civilian workforce to preserve current capability and to staff both of the new hospitals. The Department has identified a military force mix for Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). It is also working to finalize the manning document to make notifications to employees of their locations in the end state by spring 2010. At NNMC, the Navy must continue to provide healthcare while renovations require the relocation of many functions. During the actual movement of patients from WRAMC to WRNMMC and FBCH, direct care system patients will be appropriately transferred to the private sector or other military hospitals temporarily to allow for the transition.

Bethesda—The Department continues to apply a wide range of acquisition and construction strategies, tactics, and techniques to limit cost and schedule growth while performing complex construction and renovation work on the active Bethesda campus. Significant customer input was collected both during concept development and early in the Design-Build process to create the schedule which supports the BRAC statutory deadline. The dialogue with end-users is still being maintained throughout each design stage and the ongoing construction phases. Once the requirements were determined, agreements were developed with all stakeholders to maintain the aggressive schedule, and to control cost for fixed scopes of work. The Defense Contract Audit Agency was used to perform contractor audits, which established reasonable market rates for design and construction needed to meet customer requirements. While maximizing patient safety, construction phasing for the renovation areas was organized to temporarily relocate functions, coordinate patient versus construction boundaries, and reduce the number of phases. All these Department efforts have maximized efficiency by reducing cost and shortening the schedule.

Fort Belvoir Community Hospital—The FBCH was contracted under the fast track, Integrated Design Bid Build process. This method operates in a cost-reimbursable mode during design development and is then converted to a firm, fixed price once the design is substantially completed. The design is complete and the De-

partment is currently in negotiations with the contractor to make the contract definite.

During the design phase of the project, risk of cost and schedule growth was significantly higher than it currently is. During the design period, the project team spent an extensive amount of energy and time coordinating with the Army's Health Facilities Planning Agency, JTF CAPMED, and Assistant Secretary of Defense for Health Affairs to ensure optimal design incorporating evidence-based design components and met the needs of the medical mission by providing a "world-class" medical facility. Since the design is now complete, the risk of additional cost and schedule growth beyond what has already been identified is significantly reduced. However, the entire project team must remain vigilant to minimize changes to the final design so the risk of additional costs and delays are minimized. In the event a change to the final design is identified, it will be scrutinized by management of all major stakeholder organizations to assure that it is absolutely essential and steps will be taken to mitigate cost and schedule impacts to the greatest extent practicable. To ensure that the Department is paying a fair-market price for this facility, it has engaged Defense Contract Audit Agency early in the project and is currently auditing the Contractor's proposal to assure all costs identified by the contractor are allowable and allocatable.

Evolution to World Class—The Department is committed to achieving world-class standards, as defined and directed under the law, at Bethesda and Fort Belvoir Community Hospital. However, completion of NCR Medical BRAC projects and the evolution to world class standards at Bethesda are two separate and necessarily sequential efforts. The Department is developing an NCR Medical Comprehensive Master Plan, as required by Section 2714 of the National Defense Authorization Act for Fiscal Year 2010, which will synchronize both of these efforts to maximize the effective use of resources while maintaining patient safety.

Mr. ORTIZ. Much progress has been made to improve the diagnosis and treatment of the so-called "silent wounds of war"—traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). However, medical practitioners at the National Naval Medical Center (NNMC) currently use somewhat different tools and approaches for the detection and treatment of TBI and PTSD compared to their counterparts at the Walter Reed Army Medical Center (WRAMC). What measures will be needed to reconcile diagnostic and treatment differences for these conditions? To what extent will findings from the Defense Centers of Excellence for TBI and PTSD be relied upon to standardize the diagnosis and treatment for TBI and PTSD at the NNMC? To a large extent, the NNMC and WRAMC have become specialized in different medical disciplines—the NNMC in brain injury and neurosurgical procedures and WRAMC in amputation and physical rehabilitation. In the future at a merged NNMC, will the Navy and Army largely continue to maintain these specializations? If so, how will this affect the organization, staffing, and management of medical treatment at the NNMC?

Mr. MIDDLETON. In the future, world-class medical care in each of these specialties will be available at the new facility. Clinical expertise in the Navy's brain injury and neurosurgical procedures and the Army's amputee care and rehabilitation programs will be merged and integrated at the new Walter Reed National Military Medical Center (WRNMMC). The complexity of TBI and psychological health requires specialized care that crosses a multitude of specialties. Unified leadership across these specialized services will ensure comprehensive holistic care throughout the continuum of care within the military and veterans' health care system. The TBI services will soon become one integrated service combining the concept of operation and assets from both the NNMC and the WRAMC. Access to TBI services will be at a single site in the clinical building at WRNMMC. There, the clinical screening teams, case managers, and multidisciplinary treatment teams will meet the patients and family members in one defined location. With a fully integrated staff, all members of the WRNMMC staff required in the management of patients with TBI will be appropriately trained and utilized regardless of their Service affiliation.

Amputee care and physical rehabilitation will be available as part of the Orthopedic and Rehabilitation Department. Space allocations and personnel resources have been dedicated to support all of these programs. Medical, nursing, and support staff will be fully integrated, appropriately trained, and utilized in the management of amputee care and rehabilitation regardless of their service affiliation.

Mr. ORTIZ. Congress has appropriated more than \$5 billion to support ongoing construction and renovation over the past three years. What are the current lessons learned from the ongoing realignment of Walter Reed? How will the lessons learned be incorporated into future military construction contracts at other ongoing construction locations? Will elements of a world-class and premier military treatment

facility be incorporated into future designs? What is the goal of Department of Defense (DoD) Health Affairs in military construction?

Mr. MIDDLETON. At this point, it is premature to fully evaluate the success of the different acquisition strategies utilized at Bethesda and Fort Belvoir. A full assessment of both will be conducted in conjunction with the U.S. Army Corps of Engineers and the Naval Facilities Engineering Command upon completion of both projects. The assessment will not be limited to simply cost and schedule metrics, but will also evaluate the degree to which key stakeholders, including patients, families, and staff, feel these new facilities provide patient-centric healing environments. The aggressive design/build and integrated design/bid/build strategies utilized by the design/construction agents were necessary and allow the Department to achieve the Base Realignment and Closure deadline set by law. The standard design/bid/build process would not have done so. Lessons learned will be incorporated into future military construction contracts at other locations where appropriate. This will be done through updates to current DoD Directives and adjustments to acquisitions strategies by our design/construction agents.

The key tenets of "world-class" infrastructure identified by the Defense Health Board are already included in current DoD guidance for hospital design and construction and are being incorporated into future designs.

The goal of OASD (Health Affairs) in military construction is to design and build health facilities that meet the tenets of "world-class" and promote a patient-centric healing environment while employing evidence-based design principles.

Mr. ORTIZ. Wide discretion is provided to the Department to implement design standards. However, this leads to a significant disparity in the quality of facilities and in the case of the Bethesda Naval Medical Center, a significant difference between the new construction and the rest of the medical center.

- In determining the construction/renovation criteria of a construction contract, does the Department seek to obtain the latest construction standard or does the amount of funding determine the scope of construction?
- What is being done to ensure adequate housing and support services for the families of patients receiving extended inpatient and outpatient care at the National Military Medical Center? In addition, are there plans to improve the accommodations of Mercy Hall at NNMC to the level now found at the Malogne House on the WRAMC campus?

Dr. ROBYN. [The information was not available at the time of printing.]

Mr. ORTIZ. DUSD (I&E) has indicated their intent to limit further BRAC investments and defer further renovation investments until after BRAC so that Service O&M funds can be obtained.

- Will the strategy of limiting Service O&M investments until after BRAC achieve the vision of a world-class medical center?
- Does the current construction plan require BRAC appropriations to renovate the remaining Bethesda campus? Will the responsible services then be required to renovate these areas again using Operation and Maintenance appropriations?

Dr. ROBYN. [The information was not available at the time of printing.]

Mr. ORTIZ. According to the Defense Health Board report: "The BRAC funding process entails a number of constraints and limitations that do not support the creation of a comprehensive plan and construction strategy, particularly for renovation of existing facilities. These limitations have been, and continue to be, a major impediment to designing the new WRNMMC to be a world-class medical facility. The BRAC 2005 appropriation limits use of these funds." Later on the report states that there is no need to halt construction of the new facilities if a plan can be developed to accomplish backfill renovations in a timely manner.

However, there has been some discussion between DOD and the Defense Health Board about whether or not to halt construction while a master plan is developed and whether or not the BRAC law and funding process would permit development of a Master Plan using BRAC funds.

- Is the Defense Health Board recommending a halt to construction while a master plan is developed? If so, how likely is DOD to meet the statutory deadline of September 15, 2011 for completion of this BRAC recommendation?
- What is the timeline for DOD to create a comprehensive facility master plan?
- How will development of a master plan affect DOD's ability to complete construction by the September 15, 2011 deadline?

Dr. ROBYN. [The information was not available at the time of printing.]

Mr. ORTIZ. The Army and the Navy's approach to support to wounded warriors and their service members vary significantly. With this merger of these two cultures at the military's premier medical center, there has been a clash of military cultures.

- What is being done to ensure adequate housing and support services for the families of patients receiving extended inpatient and outpatient care at the National Military Medical Center? In addition, are there plans to improve the accommodations of Mercy Hall at NMMC to the level now found at the Malogne House on the WRAMC campus?

Dr. ROBYN. [The information was not available at the time of printing.]

Mr. ORTIZ. Bethesda National Military Medical Center Transition. The Joint Task Force has advocated for the transition of the Walter Reed Army Medical Center to occur after all construction is complete and during an abbreviated timeline of a few days in August 2011. This timeline raises the risk to maintaining patient care and has the potential for inducing a significant disruption. Will patient care suffer during the accelerated transition period?

Admiral MATECZUN. While the NCR Medical BRAC construction and initial outfitting & transition (IO&T) timeline for Bethesda and Fort Belvoir is aggressive, the Department, through integrated program and project management, has developed comprehensive milestone schedules and a transition of operational plans as part of its Master Transition Plan (MTP) for the Walter Reed transition. JTF CAPMED's BRAC Transition Program Management Office (PMO) is coordinating transition planning across all three facilities (Walter Reed Army Medical Center, National Naval Medical Center and Dewitt Army Community Hospital) and developing risk management plans to ensure patient safety and patient care is maintained during all phases of the transition. In addition, firms in the private sector retain hospital transition activities as a core competency and the IO&T contract that JTF CAPMED just awarded will leverage that competency.

Patient care will not suffer during an accelerated transition period. This notion is supported by industry standards from world-class institutes such as UCLA, which transitioned all hospital services over 14 day time period, including 342 patients which were moved in a five hour period.

The key to maintaining patient care and ensuring patient safety during all phases of the BRAC transition is proactive and comprehensive transition planning. The Department provided its initial MTP to Congress on September 30, 2009, as part of its response to section 1674(a) of the National Defense Authorization Act (NDAA) for Fiscal Year 2008. The MTP, an iterative document, explained in February 2009, the Joint Task Force, National Capital Region Medical (JTF CAPMED) held a Transition War Game to commence the initial transition planning among the NCR Medical stakeholders. At this War Game, group consensus was services should not transition from Walter Reed Army Medical Center (WRAMC) to Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) until all critical activities are completed at the Bethesda campus or appropriate mitigation strategies have been instituted. One key trigger activity is ensuring all essential clinical and supporting services are in place and fully functional. Several facilities, including clinics, staff parking garages and the Warrior Transition Center Complex, are not expected to be ready for occupancy until late summer 2011. The consensus of the group was that it is an unnecessary risk to attempt to transition patients and staff when the necessary facilities may not be fully operational. Following completion of these critical activities, the Department is prepared to execute a well orchestrated, consolidated transition of staff and patients from WRAMC will occur.

To ensure industry standards and best practices are incorporated into our transition plans, JTF CAPMED conducted an in-depth study on seven major medical centers that have relocated to new facilities in the past three years. The findings of this study support the Transition War Game recommendation for transitioning inpatients over a consolidated period of time, as was done at major tertiary care facilities such as Catholic Health Initiatives: St. Joseph's Medical Center in Reading, PA. This 200 bed teaching hospital relocated eight miles with all in-patients transferred in six hours. The key to a successful move with patient safety maintained is assembling a transition team to develop a move plan, ensure training and orientation of staff prior to the relocation, and executing a phased move of all non-patient essential functions early when space permits.

The Department maintains that conducting a well-planned, abbreviated transition is the least risky option for it patients.

Mr. ORTIZ. The Army incorporated a single-patient room standard at Fort Belvoir. The Navy has elected to retain the vast majority of patient rooms at two per room. The Independent Design Review panel has indicated that a single-patient room

standard is general practice for most medical facilities. Why did the Department include different patient room standards at Bethesda and Fort Belvoir? What is the industry standard? Did costs limit the ability of the Department to implement a consolidated standard? Why does the Department provide such latitude in construction standards?

Admiral MATECZUN. The American Institute of Architects guidelines mandate single-patient rooms only for new hospital construction. There is no mandate to retrofit existing facilities, although application of this standard will be considered when undertaking major renovations of existing facilities. The Department's standard mirrors that of the industry and is being applied to all new hospital construction in the Department. As a result, Fort Belvoir includes all single-patient rooms and Bethesda does not. The Department did provide additional funds to incorporate single-patient rooms for our Wounded Warriors at Bethesda, so cost was not a factor in that decision. The Department will consider the need for additional single-patient rooms post Base Realignment and Closure as part of the ongoing master planning effort at the Bethesda campus.

Mr. ORTIZ. It has been reported that the Joint Task Force is not accepting any additional clinician input into the design process. Will the Department continue to accept clinician input into the design and construction process? Will these suggestions result in changes into the overall layout?

Admiral MATECZUN. Clinician as well as patient input has been integral to ensuring the design of the new Walter Reed National Military Medical Center, and the Fort Belvoir Community Hospital will meet all future mission requirements and provide an unparalleled standard of care for this Nation's most deserving patients. However, as the construction process moves forward and in some portions of the project nears completion, there is less flexibility in adjusting designs without significantly delaying delivery of the buildings, incurring an unacceptable increase in cost, or violating contractual agreements.

Regardless of these obstacles the Department continues to evaluate clinician and patient input. Also, where it is prudent to preserve the safety and quality of patient care, it has sought additional funding to incorporate these changes. Some of these changes have significantly changed the interior designs of the wards and clinics but have not impacted the exterior design of the buildings. The revised design of the Cancer Center and the improved design of the Optometry Clinic are indicative of the changes the Department has made during the construction process.

The Department continues to compile inputs from clinicians to appropriately implement in the non-BRAC projects that the Department identifies are required to achieve "world-class" standards, as defined under section 2714 of the National Defense Authorization Act for fiscal year 2010.

Mr. ORTIZ. Medical Care and Facilities Merging. The impending merger has produced a high degree of anxiety among many medical and non-medical staff. Some staff report that they have been informed that their positions will be terminated; some have been told that staffing plans have been changed and that they will be retained after all; some are in limbo. What is being done to ensure adequate housing and support services for the families of patients receiving extended inpatient and outpatient care at the National Military Medical Center? In addition, are there plans to improve the accommodations of Mercy Hall at NNMC to the level now found at the Malogne House on the WRAMC campus?

Admiral MATECZUN. Medical Centers within the Department of Defense are always constructed to meet current and future mission requirements by using the most up-to-date standards. All medical projects at Walter Reed National Military Medical Center (WRNMMC) and at Fort Belvoir are designed based upon standards as described in the Unified Facilities Criteria (UFC) 4-510-01, "Design: Medical Military Facilities" issued by the Department of Defense. The UFC is developed and maintained by DoD medical engineering and design experts based upon the "best practices" in industry. As such, DoD medical projects have always been required to meet, if not exceed, industry standards. Currently, the Department is developing a Comprehensive Master Plan for the NCR Medical that will identify the requirements to achieve "world-class" standards, as defined and directed under section 2714 of the National Defense Authorization Act for fiscal year 2010, at Bethesda.

The Department is utilizing existing assets and construction donated by private entities to provide housing for families of patients receiving extended inpatient and outpatient care at the WRNMMC. Currently, existing Navy Lodge, Fisher Houses, and Visiting Officer Quarters are available to provide temporary housing for families of patients. Those facilities will be augmented by three (3) new Fisher Houses which are currently under construction and will provide an additional 60 family suites. At present, there are no plans for additional renovation of Mercy Hall. Mercy Hall was built in 1968 and renovated to current Americans with Disabilities Act

(ADA) standards in 2008, providing 98 fully ADA compliant single occupancy rooms. The Hall is sited near inpatient and certain administrative services for wounded warriors and has proven to be an excellent facility in which to house wounded warriors that require close proximity to these services and require additional supervision to function as an outpatient. There is no intention to use Mercy Hall as temporary family accommodations. However, the Department is working diligently to define additional temporary housing requirements for the families of patients that will receive care at the new WRNMMC.

Regarding support services, there are already plans in place to expand support services on the Bethesda Campus. The Navy Exchange (NEX) will start construction of its new facility in Calendar Year 2010. The new NEX will be more than triple the size of the current NEX and will allow the NEX to carry a broader array of goods tailored to meet the needs of wounded warriors and their families. The Department will also provide a great number of services for Warriors in Transition (WIT) to include a physical fitness center that will be sized to properly accommodate the space and access requirements of the WRNMMC WIT population and allow them to exercise alongside other Warriors and caregivers. This will support integration and re-integration of WITs into their community, and the reestablishment of the warrior/athlete ethos. Additionally, Commander Navy Installations Command (CNIC) is proactively seeking to significantly expand child care services. These services are not currently available on the Campus.

Mr. ORTIZ. Medical Care and Facilities Merging. The impending merger has produced a high degree of anxiety among many medical and non-medical staff. Some staff report that they have been informed that their positions will be terminated; some have been told that staffing plans have been changed and that they will be retained after all; some are in limbo. What is being done to facilitate a successful merger of the NNMC and WRAMC personnel? What is being done to maintain morale before, during, and following the merger? In addition, what are the current and planned post merger staffing by department or function at NNMC and WRAMC? If changes are planned post merger, why are these changes needed and what will be the impact on the provision of needed medical care?

Admiral MATECZUN. At Walter Reed Army Medical Center (WRAMC), it will be important to maintain the civilian workforce to preserve current capability and to staff both of the new hospitals. Extensive planning has been accomplished to implement the Department mandated Guaranteed Placement Program (GPP) for WRAMC hospital personnel and to effectively merge Army and Navy employees into a single workforce of civilians at the new Walter Reed National Military Medical Center (WRNMMC). Leadership representatives from the four National Capital Region hospitals are members of the Civilian Human Resources Council, a group chartered to ensure placement of employees who remain at WRAMC through closure. In order to meet the dual goals of the GPP commitment and the creation of a "world-class" workforce, the Council will identify Service best practices to develop the new National Capital Region Medical culture of the future. The Council members are working collaboratively to modify current position management and hiring processes at WRAMC and the National Naval Medical Center (NMMC) in order to maximize the placement of WRAMC employees in their location of choice in 2011. The Department plans to begin notifying individuals of their work locations in the end-state in Spring/Summer 2010, after the final validation of the new hospital staffing plans is complete.

The Department's civilian workforce is a center of gravity. It strives to maintain morale by communicating updates on the BRAC Integration and Transition progress to employees using venues such as monthly Town Hall meetings, electronic, and print media. This type of communication will continue after the BRAC integration to facilitate ongoing dialogue needs of employees. A detailed plan has been developed to guide the transition and integration of employees from WRAMC to WRNMMC and Fort Belvoir Community Hospital (FBCH). Beginning with the approval of a Joint Table of Distribution (JTD), it seeks to align the current workforce using workforce planning techniques that optimize the assignment of employees, coordinate efforts by civilian Human Resources Specialists (HR), and establish standardized policies/processes that will ensure quality HR support in the future.

Mr. ORTIZ. What recommendations can be offered to ensure that the construction designs obtain a world-class standard?

Dr. KIZER. The National Capital Region Base Realignment and Closure Health Systems Advisory Subcommittee (NCR BRAC HSAS) of the Defense Health Board has made many specific recommendations for what needs to be done for the design of the new Walter Reed National Military Medical Center (WRNMMC) to more likely achieve world class status. These recommendations were detailed in our report

last June, copies of which, I understand, were provided to the House Armed Services Committee by the Department of Defense last July.

In viewing our recommendations it should be remembered that this is not a static process and that as design changes and renovations are made additional concerns or issues may arise. Also, as noted in our report and in my testimony, the facility design and construction will not in and of itself make the new WRNMMC a *world class medical facility*, although it may prevent it from achieving such a level of excellence. Most of what will make the new WRNMMC a *world class medical facility* will be its “invisible architecture”—i.e., its values, culture, leadership, staff morale and processes of care.

As noted in our report and in my testimony, the three most urgent needs in this regard are to: (1) resolve the authority issue; (2) align funding sources; and (3) rapidly develop a master plan.

Mr. ORTIZ. If changes are implemented in the renovation effort, could they be implemented and still obtain the September 2011 BRAC deadline?

Dr. KIZER. It will be very difficult. If this deadline is to be met, then substantive work on the master plan and changes in the renovation effort must begin immediately. The likelihood of meeting the deadline diminishes every day that progress is not made in addressing the identified needs.

Mr. ORTIZ. In your estimate, what is the risk associated with moving the Walter Reed functions to Bethesda/Fort Belvoir by September 2011? What are the consequences (in terms of patient care)?

Dr. KIZER. If the NCR BRAC HSAS recommendations are addressed and implemented then there should be little risk. If they are not adequately addressed, then the consequences will depend on what problem(s) is/are not addressed, among other factors.

Depending on what specific problem(s) is/are not addressed, then care could be compromised in multiple ways, including patient safety, infection control, patient and family comfort, staff morale, confusion in way finding, physician and nurse productivity, and provision of critical services, to name some.

QUESTIONS SUBMITTED BY MS. BORDALLO

Ms. BORDALLO. Section 722 the National Defense Authorization Act for Fiscal Year 2008 called for the establishment of a Joint Pathology Center as a successor to the current Armed Forces Institute of Pathology. The legislation established a mandate to perform at least for core minimum functions:

1. Diagnostic pathology consultation services in medicine, dentistry, and veterinary sciences;
2. Pathology education, to include graduate medical education, including residency and fellowship programs, and continuing medical education;
3. Diagnostic pathology research; and
4. Maintenance and continued modernization of the Tissue Repository and, as appropriate, utilization of the Repository in conducting the activities described in paragraphs (1) through (3).

Notwithstanding this mandate, the Defense Health Board has on two separate occasions criticized the concept of operations for the Joint Pathology Center as insufficient to carry out the its mandate. Furthermore, in light of the National Defense Authorization Act for Fiscal Year 2010’s mandate to create a master plan that will “ensure the delivery of world class military medical facilities across the National Capital Region”, what concrete actions is the Department of Defense taking to ensure that the Joint Pathology Center will meet that world class standard?

Mr. MIDDLETON. Section 722 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 mandated a Joint Pathology Center (JPC) be established in to function as the reference center in pathology for the Federal Government. It stated that the JPC should provide at a minimum:

- Diagnostic pathology consultation in medicine, dentistry, and veterinary services;
- Pathology education, to include graduate medical education, including residency and fellowship programs;
- Diagnostic pathology research
- Maintenance and continued modernization of the Tissue Repository

Additionally, the JPC must be established consistent with BRAC law.

The Department of Defense (DoD) chartered a JPC work group in April 2008, that included senior leadership from the Armed Forces Institute of Pathology (AFIP), Uniformed Services University of the Health Sciences (USUHS), Military Services, Department of Veterans Affairs, and Department of Health and Human Services to develop options for a JPC within the Department. The JPC Working Group was instrumental in developing the initial Concept of Operations (CONOPS) to meet the mandate under Section 722 of the NDAA for FY 2008. Based on the initial CONOPS, the Department chose to establish the JPC under the Joint Task Force, National Capital Region Medical (JTF CAPMED).

Upon delegation of the JPC mission to JTF CAPMED in December 2009, an interim director was appointed. Prior to this, JTF CAPMED took the lead in establishing an inter-organizational Implementation Team consisting of members from the three Services, VA, USUHS, AFIP, OASD (Health Affairs), and Office of the Army Surgeon General to carefully review the concept of operations, identify gaps in proposed services, and develop an expanded concept of operations and implementation plan. As a result of this analysis, several critical services were identified and additional personnel requirements to appropriately staff the JPC were also identified. A detailed concept of operations and implementation that includes these critical services and personnel requirements is being finalized. Additionally, the JPC is working closely with AFIP to finalize a phased implementation plan for the JPC to enable the proper transfer of function to the JPC without loss of continuity of clinical care while appropriately balancing and addressing civilian personnel considerations.

The Defense Health Board (DHB), in its advisory role to the Department, reviewed the initial JPC CONOPS, which was not a detailed implementation plan. The implementation plan under development by the JPC Implementation Team addresses the concerns of the DHB and will meet the recommendations of the DHB review with the exception of JPC oversight being provided by a Board of Governors. Based on the JPC's mission set, the Department recommends a Federal Board of Advisors comprised of primary stakeholders.

The depth and scope of clinical services provided by the JPC include, but are not limited to the list below. In some areas, the services will be more robust than those provided by AFIP.

- The JPC will provide full-spectrum, comprehensive, expert secondary pathology consultation to the federal government utilizing state-of-the-art immunohistochemical and molecular diagnostic studies.
- The JPC will be one of the few centers in the country offering full-service muscle biopsy analysis and comprehensive Depleted Uranium testing and imbedded fragment analysis in support of our wounded warrior population and operations in-theater and will provide full-spectrum pathology support for the critical Armed Forces Medical Examiner mission.
- The JPC will continue and expand the AFIP mission of providing telemedicine expert consultation (telepathology) to remote hospitals and in support of pathology services in theater and overseas.
- The JPC will continue the AFIP mission of providing a one-of-a-kind comprehensive Veterinary Pathology service to the Department and several other federal government agencies that includes Veterinary Pathology Consultation, research, education to veterinarians worldwide, and a Veterinary Pathology Residency Training Program for the Department.
- The JPC will leverage state-of-the-art and evolving technology in providing its education mission through robust online educational opportunities to government physicians worldwide and will provide graduate medical education in support of government residency and fellowship programs nationwide.
- The JPC will support critical clinical research missions such as the Combat Wound Initiative and Traumatic Brain Injury initiatives.
- JTF CAPMED recognizes that the Tissue Repository is an invaluable asset that, if appropriately utilized, could be the leading Tissue Biorepository and greatly advance medical knowledge and technology. The JPC will partner with leaders in medical research and biorepository management to carefully develop a comprehensive plan to fully utilize the vast Tissue Repository in support of medical research throughout the federal government and in partnership with civilian academic institutions.

Ms. BORDALLO. Some members of the community surrounding the current Bethesda Naval Hospital have raised concerns about the level of interagency cooperation specifically between Navy, Army and NIH. In particular, there is significant

concern about the impact to traffic in the area. The stretch of Wisconsin Avenue that is impacted greatest by the realignment is already extremely congested during peak travel hours. A recent GAO report on the Guam military build-up reiterated the need for the convening of a meeting of the Economic Adjustment Committee to better coordinate all federal government resources. Would a meeting of the Economic Adjustment Committee better help facilitate an improved federal government interagency process to address the “outside the fence” impacts at Bethesda Naval Hospital?

Dr. ROBYN. [The information was not available at the time of printing.]

QUESTIONS SUBMITTED BY MR. LOEBSACK

Mr. LOEBSACK. How will you assure that patients receive the absolute best care in specialties such as pain care, mental health, TBI care, and prosthetic care at the new Walter Reed facility in Bethesda? Particularly on the pain care issue—Walter Reed is a leader in this specialty amongst the military medical facilities. How will this care be maintained and enhanced in the new facility? Are there specific issues that must be taken into account for specialties such as pain care and physical therapy that are being incorporated into the design plans for the new campus?

Mr. MIDDLETON. The Department will continue to provide absolute best care to patients at the new Walter Reed National Military Medical Center (WRNMMC). The Army’s capabilities at WRAMC with amputee care are leading transformations in prosthetics and rehabilitation and the Navy’s expertise in open Traumatic Brain Injury (TBI) at NNNMC is renowned world-wide. The integrated clinical chiefs of all the current departments within the National Naval Medical Center (NNMC) and the Walter Reed Army Medical Center (WRAMC) are dedicated to preserving the tradition of excellence that distinguishes both healthcare providers today.

Pain Management—WRAMC has become a center of clinical expertise for the art and science of advanced regional anesthesia techniques and acute pain management. This has become invaluable in the management of pain in both the austere environment of war and in the civilian clinical setting. Since this clinical advancement plays such a significant role in current and future operations, dedicated clinical space and personnel have been committed for both regional anesthesia and chronic pain management clinics planned for the Walter Reed National Military Medical Center. In Building 9, 8,500 sq. ft. of space is dedicated to the Pain Care Center of Excellence which will maintain the “world-class” expertise and training capabilities currently available at WRAMC.

Mental Health—Psychological health issues have become one of the most prominent injuries of the current conflicts. The Department has increased capacity to address these issues commensurate with the mission requirements. The new organizational structure will include both psychiatry and psychology as separate departments with personnel assigned that match these needs. In the new outpatient clinic, 45,000 sq. ft. of space primarily on the sixth level of Building A is dedicated to outpatient behavioral health. A robust partial hospitalization program to decrease the demand for inpatient beds has been designed in line with the current program at WRAMC and the Defense Veterans Brain Injury Center (DVBIC) clinical component. There will be two new inpatient psychiatry wards (27,000 sq. ft. in Building 10) with a total bed capacity of 28. An additional 12 inpatient beds and partial hospitalization capabilities are designed for the new Fort Belvoir Community Hospital (FBCH).

Traumatic Brain Injury (TBI)—Treatment for Traumatic Brain Injury will include a six bed specialty inpatient ward and a highly functional multi-disciplinary clinical group that includes clinical neurologists, psychiatrists, psychologists, orthopedists, physical and occupational therapists, neuropsychometrists, and other traumatic brain injury specialists. These programs will transition and integrate available expertise from both NNMC and WRAMC programs. All clinical expertise will be in close proximity to the new National Intrepid Center of Excellence at Bethesda that is dedicated to research, diagnosis and treatment of military personnel and veterans suffering from traumatic brain injury and psychological health issues.

Prosthetic Care—Military beneficiaries (active duty, retirees and dependants) with upper and lower extremity amputations currently receive the best medical care in the world. Nearly one whole floor in the new outpatient clinic addition (Building A) will be dedicated to physical medicine modalities with additional services and diagnostic support provided on two other floors. Over 115,000 sq. ft. is dedicated to Physical Therapy, Physical Medicine and Rehabilitation, Occupational Therapy, Amputee Center, Orthotics, Prosthetics, Chiropractic Services, Orthopedics, Podiatry, and a satellite Laboratory, Radiology, and Pharmacy on the first three floors of the

new outpatient clinic. This represents the largest physical medicine footprint in all of the Department of Defense and will continue to provide WRAMC's current capabilities in the care of amputees and the manufacture and adjustment of state-of-the-art upper and lower extremity prosthetics.

Physical Therapy—Physical therapy plays a major role in the rehabilitation of amputees, traumatic brain injured, and psychologically injured patients. Clinical space in the new clinical building outlined above and in the inpatient areas have been designed to offer the best medical care to these injured patients. Appropriate personnel have been designated on the current manpower document to complete the mission in these areas.

Mr. LOEBSSACK. How will you assure that patients receive the absolute best care in specialties such as pain care, mental health, TBI care, and prosthetic care at the new Walter Reed facility in Bethesda? Particularly on the pain care issue—Walter Reed is a leader in this specialty amongst the military medical facilities. How will this care be maintained and enhanced in the new facility? Are there specific issues that must be taken into account for specialties such as pain care and physical therapy that are being incorporated into the design plans for the new campus?

Dr. ROBYN. [The information was not available at the time of printing.]

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