HOUSE COMMITTEE ON ARMED SERVICES

U.S. House of Representatives
Washington, DC 20515–6035
ONE HUNDRED ELEVENTH CONGRESS

MEMORANDUM FOR READINESS AND MILITARY PERSONNEL SUBCOMMITTEE MEMBERS

RE: Joint Subcommittee Hearing on The New Walter Reed: Are We on the Right Track?

The subcommittee will meet in a joint open session on Wednesday, December 2, 2009 at 10:00 a.m. in room 210 of the House Visitor's Center to receive testimony on the realignment of the Walter Reed complex.

The prepared statements of the witnesses are attached. If you have any questions, please contact David Sienicki, Tom Hawley, or Megan Putnam at (x6-8979) of the committee staff.

WITNESSES

Mr. Al Middleton
Acting Principal Deputy Assistant Secretary of Defense
Health Affairs
Department of Defense

Dr. Dorothy Robyn
Deputy Under Secretary of Defense
Installations and Environment
Department of Defense

Vice Admiral John M. Mateczun, USN
Commander
Joint Task Force National Capital Region Medical

Dr. Ken Kizer
Chairman
Defense Health Board National Capital Region Base Realignment
and Closure Health Systems Advisory Subcommittee

Overview –The Base Realignment and Closure (BRAC) process of 2005 included a proposal to consolidate medical care in the National Capital Region. In this proposal, Walter Reed Army Medical Center was scheduled to close by September 2011 and the remaining functions would be moved to Bethesda Naval Medical Center and the Fort Belvoir DeWitt Community Hospital. However, the implementation of this recommendation has been plagued with controversy. In 2007, the Secretary of the Army and several general officers retired or were relieved in response to the plight of facilities at the Walter Reed Army Medical Center. In order to better manage the consolidation of medical care, the Department established a Joint Task Force- Capital Medicine. However, the organizational structure in the National Capital Region is fractured and the funding responsibility to support the realignment is dispersed among the Departments of Defense (DoD), the Army, and the Navy.

The inability to articulate a clear organizational structure and to provide unity of funding has manifested itself in disharmony in construction execution at the Bethesda National Military Medical Center. For example, different construction standards for similar requirements are being implemented at Bethesda and Fort Belvoir. Even at the same site at Bethesda, there are different standards of construction for operating rooms at the new construction and other renovation standards for similar requirements at the hospital complex. At the request of Congress, an Independent Design Review of the BRAC realignment was created to review the overall design and construction. In the review board's report to Congress, they indicated that the current design is not world class and the independent design review commission is close to recommending construction at the Bethesda campus halt until these flaws can be remedied.

BRAC 2005 – During the BRAC deliberations, the Department determined that excess medical capacity existed in the National Capital Region and further recommended closure of the Walter Reed Army Medical Center, elimination of inpatient care at Andrews AFB, and consolidation of care at the Bethesda and Fort Belvoir campuses. The BRAC Commission provided the following statement to support this determination:

> **"**This recommendation will transform legacy medical infrastructure into a premier, modernized joint operational medicine platform. This recommendation reduces excess capacity within the National Capital Region (NCR) Multi-Service Market (MSM: two or more facilities collocated geographically with "shared" beneficiary population) while maintaining the same level of care for the beneficiaries. Walter Reed Army Medical Center (AMC) has a military value of 54.46 in contrast to the higher military values of National Naval Medical Center (NNMC) Bethesda (63.19) and DeWitt Hospital (58). This action relocates medical care into facilities of higher military value and capacity. By making use of the design capacity inherent in NNMC Bethesda (18K RWPs) and an expansion of the inpatient care at DeWitt Hospital (13K RWPs), the entire inpatient care produced at Walter Reed AMC (17K RWPs) can be relocated into these facilities along with their current workload (11K RWPs and 1.9K RWPs, respectively). This strategically relocates healthcare in better proximity to the beneficiary base, which census data indicates is concentrating in the southern area of the region.
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> Development of a premier National Military Medical Center will provide enhanced visibility, as well as recruiting and retention advantages to the Military Health System.

> The remaining civilian authorizations and contractors at Walter Reed AMC that represent unnecessary overhead will be eliminated."[1]

Medical Organizational Structure – At the core of the BRAC recommendation was the requirement to combine an Army medical center and a Navy medical center. Recognizing the challenges this would present in terms of different service cultures and priorities, in September 2007 the Department of Defense created Joint Task Force-Capital Medicine (JTF-CAPMED). JTF-CAPMED was designed to overcome service rivalries by having a single general/flag officer oversee the integration of all DoD medical activities within the National Capital Region. JTF-CAPMED is commanded by a three-star, Vice Admiral John Mateczun, who in turn reports directly to the Deputy Secretary of Defense, Mr. Bill Lynn. The following is the JTF-CAPMED mission statement from its website:

> "The Joint Task Force National Capital Region Medical (JTF CapMed) was established in September 2007 by the Deputy Secretary of Defense to oversee the delivery of integrated healthcare in the NCA, ensure readiness, and execute the BRAC business plans to achieve the vision of establishing a world-class medical center at the hub of the nation's premier regional healthcare system serving our military and our nation."

In September 2007, the committee was briefed on the formation of JTF-CAPMED. Even at this point, the inherent weakness of its organizational structure was apparent. In fact, none of the questions posed during that first briefing have been answered. For more than two years the Department has assured the committee those decisions will be made soon, but to date fundamental questions about funding, lines of authority, and staffing have yet to be finalized.

Funding - JTF-CAPMED does not control any of the funding being used to build the new Water Reed National Military Medical Center at Bethesda. All funding for the Military Health System (MHS) is currently centrally managed for the entire Department of Defense by the office of the Assistant Secretary of Defense for Health Affairs/TRICARE Management Activity (HA/TMA). This arrangement of centralized programming and budgeting is used to set the services' hospital (military treatment facility, or MTF) operating, Information Technology (IT) systems, RDT&E (Research, Development, Testing, and Evaluation), procurement, and medical military construction (MILCON) budgets. Funding centrally programmed and budgeted by HA/TMA is allocated to the services for execution. This remains true for the MHS assets located in the NCR: the money is allocated to the services, and not JTF-CAPMED, for execution. This is a legal requirement of title 10, United States Code, but the DOD has neither proposed nor requested legislative relief.

However, most of the construction funding is associated with BRAC 2005 and the implementation of these funds was provided to the Navy to execute for Bethesda and to the Army to execute for Fort Belvoir. Finally, Operation and Maintenance funding for non-medical facilities (parking garages, barracks) are the responsibility of the supporting services. This lack of a unified budget

[1] BRAC Commission Medical Joint Cross Service Group Walter Reed National Military Medical Center, Bethesda, MD Recommendation # 169 (MED 4) dated September 2005

provides significant disharmony in overall direction in implementing the BRAC recommendation and ultimately providing effective patient care.

Lines of Authority - The commander of JTF-CAPMED is completely outside the normal lines of authority of the Military Health System (MHS). This was by design. The feeling was that an "honest broker," not beholden to any one service, was needed to implement the requirements of BRAC 2005, and that the person in charge would need to report directly to the Deputy Secretary of Defense to ensure that interservice rivalries would not hinder the process. While this made sense in theory, in practice what has happened is that there is no oversight of JTF-CAPMED; the office of the Deputy Secretary is not resourced to provide day-to-day oversight of a Joint Task Force or field operating activity. As a result, disagreements/disputes between MHS leaders (the office of the Assistant Secretary of Defense for Health Affairs and the service Surgeons General) and JTF-CAPMED have usually gone unaddressed. Congress has been concerned about the dysfunction of this arrangement since it was announced, but no substantive changes have been made.

A prime example of the difficulties this presents is the matter of who is in charge of construction and renovation at Bethesda. The short answer is that the Naval Facilities Command (NAVFAC) is responsible for issuing and evaluating Requests for Proposals (RFPs), awarding contracts, and overseeing actual construction/renovation. JTF-CAPMED's role is unclear. JTF-CAPMED maintains that they set the design requirements and standards, but NAVFAC believes they are provided insufficient guidance and must fill in the remaining blanks to properly execute a construction/renovation contract. NAVFAC believes that their client is the commanding officer of the National Naval Medical Center who reports to the Navy Surgeon General. As a result, the committee has been unable to determine who has ultimate responsibility for the design and construction/renovation of the new WRNMMC.

Staffing - Another concern that has been present since JTF-CAPMED's creation has to do with the staffing of the military treatment facilities within the NCR. JTF-CAPMED headquarters staffing is straightforward, as its personnel authorization document is a Joint Table of Distribution (JTD), the standard for joint task forces in DOD. The staffing of the actual military treatment facilities is a different matter. At the moment, there are no completely "joint" military hospitals; each MTF is under the control of an individual service. Personnel from all of the services are present in each MTF, but for command and control purposes a single service is in charge.

JTF-CAPMED has briefed the committee that they plan to use a joint manning document to staff not only the JTF headquarters, but also WRNMMC and the Fort Belvoir Community Hospital. This is an unprecedented and complex task and is central to the success or failure of implementing the BRAC 2005 recommendation and subsequent congressional requirements. Yet even the philosophical foundations of how MTFs will be staffed in the NCR remain unclear. Will all MTFs be staffed under JTDs, or just the two largest (WRNMMC and BCH)? Will services rotate general/flag officers through command billets, or will the positions be coded by service? Will JTF-CAPMED be responsible for the planning and programming of these personnel, or will that responsibility remain with the individual services? Will civilian personnel who currently fall under an individual service be forced into a centrally managed pool or will they remain with a service? Given the central importance of this issue, and the fact that less than

two years remain before the September 2011 BRAC completion deadline, it is of great concern that these questions have not been answered, let alone finalized.

BRAC Cost Variability - The single most variable BRAC recommendation was the realignment of the Walter Reed Army Medical Center. This has been influenced by a wide variety of cost impacts including costs influenced by additions to the proposed scope of work, acceleration costs to meet the September 2011 BRAC deadline, cost variability in construction, and a determination to seek a world-class military treatment facility. However, the most acute item that influenced the scope of effort was a *Washington Post* report in March 2007 that reported wounded warriors were being supported in substandard facilities. This determination eventually led to the resignation of former Secretary of the Army Francis Harvey and the early retirement of the Army Surgeon General Lieutenant General Kevin Kiley, as well as the relief for cause of the Commanding General of Walter Reed Army Medical Center, Major General George Weightman. The following is a timeline of the costs estimates as initiated by the BRAC Commission to date:

> September 2005 - At the request of the Department, the BRAC Commission reported that the overall realignment would cost $246.3 million and would require the addition/renovation of 509,000 square feet of medical space. This cost estimate has grown considerably every year.
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> July 2006 - The Department recognized that the construction prices were significantly underpriced for the proposed construction and the entire project scope was increased. Cost estimate was $493 million and the scope was to add/renovate 837,000 square feet.
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> July 2007 – An additional warrior care wing was added, price factors were updated and the Department recommended that the overall project be artificially accelerated to meet the September 2011 deadline. Cost estimate was $697.5 million and the scope was to add/renovate 1,057,000 square feet.
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> April 2008 – Additional facilities were added to the project to include an enlisted barracks, fitness center, dining facility and Warrior Transition Unit capabilities. Cost estimate was $939.6 million and the scope was to add/renovate 1,548,000 square feet.
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> October 2008 – Additional space and supporting facilities were identified. Cost estimate was $1.640 billion. [2]
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> October 2009 – The Department reported that the construction costs were not correctly inflated for the overall effort and higher cost estimates were determined to support the moving and purchasing of equipment. Current cost estimate is $2.418 billion.[3]

Construction Variability – As was discussed earlier, the indeterminate command structure coupled with a disjointed funding authority has led to significant impasse in the construction of a world-class medical

[2] GAO report MILITARY BASE REALIGNMENTS AND CLOSURES – Cost estimates have Increased and are Likely to Evolve" dated December 2007

[3] GAO report entitled "MILITARY BASE REALIGNMENT AND CLOSURES – Estimated Costs have increased while Savings have Decreased Since Fiscal Year 2009" dated November 13, 2009.

center. In November 2009, the independent design review panel determined that "the current plans were not those of a world-class medical facility"[4]. Furthermore, the independent design review panel indicated that "the recommendation that new construction continue was contingent on necessary corrective actions being contemplated in a timely manner. After reading the Department's plan of action[5], the Committee is less confident that new construction should not be halted." In making this determination, the independent design review team reviewed the various appropriations and the scope of the work and determined that there were several funding sources required to accomplish the realignment of Walter Reed.

- The principal funding source was associated with a centralized appropriation to implement the Base Realignment and Closure 2005 process that was responsible for the new construction of the Fort Belvoir Community Hospital and the new construction and some renovations at the Bethesda Naval Medical Center.
- The Defense Health Program, Operation and Maintenance (DHP, O&M) appropriation provides renovations at those medical facilities that were not covered by BRAC 2005.
- The Navy Operation and Maintenance (Navy O&M) appropriation is available to renovate non-medical facilities at the Bethesda campus.

While the BRAC 2005 account is fully funded, the Department has declared an end to the BRAC funding and has insisted that the Department rely on DHP, O&M and Navy O&M appropriations to perform the majority of the renovations. In execution, less than $30 million in BRAC 2005 is available for the renovations of the Bethesda campus. This level of funding will not bring the current campus into conformance with the current criteria used in the new construction and will definitely not bring the existing campus to the world class standard desired in the Department's vision statement.

To match the available O&M allocations, the scope of the renovations has been severely limited and will not provide a world-class medical center. Furthermore, the Department has yet to determine the scope of work associated with 33 of the 38 renovation projects. These renovations are on the critical path to completing a world class medical center concurrent with the new construction. Examples of specific deficiencies include the following:

- Single-patient rooms. A determination at the Bethesda campus to place two service members in the patient rooms leading to less-than-efficient infection control. The Fort Belvoir Community Hospital has implemented a single-patient room organization. The independent design review indicated "single patient rooms have been a well-established basic hospital design standard for some time."
- Operating rooms. At the Bethesda campus, there are three new operating rooms that meet current standards. However, the dearth of O&M appropriations has significantly suboptimized the capabilities of the 17 other operating rooms. The independent design review indicated "The Committee does not view the Department's plan of action in this regard to be adequate."

[4]Independent Design Review assessment entitled "DoD Response to NCR BRAC HAS Report" dated November 12, 2009

[5] DoD report to Congress, untitled dated October 15, 2009.

- Construction change orders. A determination by the Department not to accept further input from the clinicians to avoid expensive change orders in execution.
- Several other deficiencies were also highlighted by the independent design review panel.

Legislative History – The House Armed Services Committee has included legislation on concerns associated with this realignment in the National Defense Authorization Act (NDAA) for the past three years. These provisions have provided the impetus to better support service members and align medical care in the National Capital Region. The following is a legislative history of the provisions:

- Fiscal Year 2008 NDAA Section 1674 directed the Secretary of Defense to certify that a detailed transition plan ensures the Walter Reed National Military Medical Center provides the same care as at the Walter Reed Army Medical Center during fiscal year 2006.
- Fiscal Year 2009 NDAA Section 2721 directed the Secretary of Defense to:
  - Establish an independent design review panel to advise whether the design/plans for the Walter Reed National Military Medical Center are "world-class."
  - Requires a cost estimate for realigning the Walter Reed Army Medical Center and relocating it to Bethesda/Fort Belvoir.
  - Requires submission of a milestone schedule for transition/relocation of operations to Bethesda and Fort Belvoir.
- Fiscal Year 2010 NDAA Section 2714 directed the Secretary of Defense to submit a master plan for medical care in the National Capital Region, certify that the master plan meets medical standards and provides an updated cost/schedule estimate.

Implications for Future Construction – The Department of Defense maintains and operates a unique collection of medical facilities around the globe. By any standard, this facility inventory could be described as large, complex, diverse and aging. The current inventory includes 59 hospitals and 663 medical clinics. Calculations indicate that approximately 41% of the inpatient facilities are more than 40 years old and that 72% were constructed more than 20 years ago.[6] To support this infrastructure, the Department budgeted approximately $200-300 million annually during the 1990s and 2000s. Because of this level of investment, the overall capabilities of the medical infrastructure had deteriorated.

In response, Congress significantly increased the medical military construction appropriation above the President's request by $884 million in fiscal year 2008 and $1.8 billion in fiscal year 2009. As requested in the President's Budget, Congress provided $960 million in fiscal year 2010. This significant investment has been made when the standards to construct medical treatment facilities are in significant change. The Department of Defense will be challenged to properly apply the lessons learned from the numerous issues that have been addressed in the realignment of the Walter Reed Army Medical Center. Fundamentally, the Department will need to refine the goals and missions of a medical treatment facility and determine a standard of care commensurate with supporting the service members and their dependents.

[6] ASD(HA) Report to Congress, entitled "Medical Treatment Facilities Master Plan" dated August 24, 2009

Suggested Questions for DOD Health Affairs

Walter Reed Cost/Schedule. Walter Reed Army Medical Center was essentially closed by 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 pursing 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?

Future Medical Military Construction. 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 DoD Health Affairs in military construction?

Medical Care. Much progress has been made to improve the diagnosis and treatment of the so-called "silent wounds of war"—TBI and PTSD. However, medical practitioners at the National Naval Medical Center 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.

- 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 National Military Medical Center?
- To a large extent, the NNMC and WRAMC have become specialized in different medical disciplines—NNMC in brain injury and neurosurgical procedures and WRAMC in amputation and physical rehabilitation.
- In the future at a merged NMMC, 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 NMMC?

Suggested Questions for Joint Task Force –Capital Medicine

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?

Bethesda and Fort Belvoir differing construction standards. 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?

Clinician Input. 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?

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?
- 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?

Suggested Questions for Deputy Under Secretary of Defense (Installations & Environment)

Military Treatment Facility Construction Standards – 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?

BRAC Funding and Service Funding. 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?

BRAC Implementation. 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?

Support Infrastructure. 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 militaries 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 NNMC to the level now found at the Malogne House on the WRAMC campus?

Suggested Questions for Chairman, Independent Design Review

Bethesda National Military Medical Center - Vision. Using the current design, the Independent Design Review panel has indicated that the campus will not achieve a world-class standard.

- What recommendations can be offered to ensure that the construction designs obtain a world-class standard?
- If changes are implemented in the renovation effort, could they be implemented and still obtain the September 2011 BRAC deadline?
- 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)?