

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 NNMC 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 NNMC. 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
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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).

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- 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.

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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.

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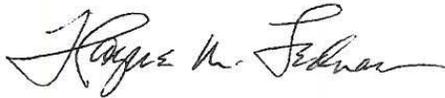
11. Background:

- 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.

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- 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
Surgeon General of the Navy
Surgeon General of the Air Force
Commander, JTF CAPMED
Joint Staff Surgeon
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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

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

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

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.

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.