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STATEMENT OF

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

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OF THE
HOUSE ARMED SERVICES COMMITTEE

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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.