

DCN 6318

DANIEL K. INOUE
HAWAII

APPROPRIATIONS
Subcommittee on Defense—Ranking Member

COMMERCE
Subcommittee on Surface Transportation and
Merchant Marine—Ranking Member

COMMITTEE ON INDIAN AFFAIRS

DEMOCRATIC STEERING AND COORDINATION
COMMITTEE

COMMITTEE ON RULES AND ADMINISTRATION

United States Senate

SUITE 722, HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1102
(202) 224-3934
FAX (202) 224-6747

July 29, 2005

PRINCE KUHIO FEDERAL BUILDING
ROOM 7-212, 300 ALA MOANA BOULEVARD
HONOLULU, HI 96850-4975
(808) 541-2542
FAX (808) 541-2549

101 AUPUNI STREET, NO. 205
HILO, HI 96720
(808) 935-0844
FAX (808) 961-5163

BRAC Commission

AUG 02 2005

Received

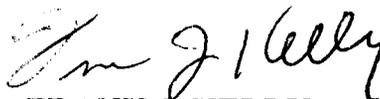
**The Honorable Anthony J. Principi
Chairman, Defense Base Closure and
Realignment Commission
2521 South Clark Street, Suite 600
Arlington, Virginia 22202**

Dear Mr. Chairman:

I wish to share with you a comprehensive study on why Walter Reed Army Medical Center should be removed from the BRAC List. The study was conducted and provided by knowledgeable individuals who have expressed interest in having this facility removed from the BRAC List.

Thank you for your consideration.

Aloha,



**FRANK J. KELLY
Legislative Assitant**

**FJK:mmy
Enclosure**

THE CASE
for
WALTER REED ARMY MEDICAL CENTER

WHY WALTER REED SHOULD BE REMOVED
FROM THE BRAC LIST

John R. Pierce, M.D.
4849 Sweetbirch Drive
Rockville, MD 20853

Introduction

The announcement on May 13, 2005 that the Department of Defense was recommending that Walter Reed Army Medical Center (WRAMC) be realigned to become the Walter Reed National Military Medical Center at Bethesda came as a surprise to many. This realignment would close the main campus at WRAMC and also close the Armed Forces Institute of Pathology. While many were alarmed by this recommendation, others saw it as a good opportunity to solve nagging facility problems at WRAMC. This document was put together by those who are very concerned that the inclusion of WRAMC on the base realignment and closure (BRAC) list would lead to the loss of irreplaceable health care facilities that have served the nation well and to this day are providing the majority of care to the most severely combat injured.

This document consists of 11 separate monographs that address different issues surrounding the recommended realignment (closure) of WRAMC. They included the selection process and metrics used to justify the selections made, the effects of closure on homeland security issues in the District of Columbia, effects on military graduate medical education, services to patients and their families, costs not assessed by the Department of Defense, and issues of health care culture.

Table of Contents

Introduction	ii
The Military Value Metric.....	1
Homeland Security	5
BRAC Impact on Graduate Medical Education Programs	7
Environmental Costs Disregarded.....	9
Bethesda and Ft. Belvoir are Inadequate Receiving Sites	11
Consolidation versus Dispersion of Military Facilities	13
GAO Study of BRAC Recommendations	15
Inability to Accurately Assess Military Health Care Costs.....	16
Compromised Service to Patients/Families	18
Why Walter Reed Army Medical Center?	20
The Culture of Army Medicine	22

The Military Value Metric

Military value is the primary consideration in the BRAC decision process. The process used by the Department of Defense seriously undervalued the military value of Walter Reed. Despite the lack of an articulated DOD policy to do so, the BRAC metric rewards primary care and penalizes larger tertiary care teaching facilities. It can only be assumed that this was done because the recommendations were predetermined and the metrics were developed to support the predetermined recommendations. It is critically important that the BRAC Commission understand the flaws in these biased metrics before they make irreversible decisions about irreplaceable health care facilities.

Military value was determined by assessing three functional areas.

- health care education and training
- health care services
- medical/dental research development and acquisition.

The scores obtained for the health care services metric were the justifications given for recommendations made to realign, basically close, Walter Reed Army Medical Center. Dewitt Army Community Hospital at Fort Belvoir received a score of 58 and Walter Reed Army Medical Center received a score of 54.46. How could Dewitt Army Community Hospital at Fort Belvoir with 43 inpatient beds and one graduate medical education training program have more military value than Walter Reed with 200 inpatient beds, high level tertiary care, and almost 50 graduate medical education training programs?

The only facility-specific data provided in Chapter X of the Joint Cross Service Working Group Report (http://www.defenselink.mil/brac/pdf/VolX_Medical-o.pdf) were those for throughput (workload) for inpatient care, outpatient care and dental care – which represent a significant portion of the metric for health care services. Inpatient admissions are not all the same in acuity, complexity and cost. Therefore, a commonly used standard for measuring patient admissions in the health care industry was used; inpatient care is reported in Relative Weighted Products (RWPs) and outpatient care is measured in Relative Value Units (RVUs).

The following table compares the relative workload and military value scores of Dewitt Army Community Hospital and Walter Reed:

	DeWitt	WRAMC
A.2 Health Care Services		
A.3.2.1 Ambulatory care		
Primary care (RVUs)	256,756	86,977
Specialty care (RVUs)	311,547	1,061,332
Total RVUs	568,303	1,148,309
A.3.2.2 Inpatient care (RWPs)	1,854	16,553
A.3.2.3 Dental services (Active duty population)	8,123	33,412
Health Care Services – MV score	58	54.46

How could Walter Reed with twice the outpatient workload, eight times the inpatient workload, four times the dental workload and almost 50 graduate medical education programs, compared to one medical education program at DeWitt, have less military value?

One reason is that caps were placed on the health care services metrics that dealt with throughput or workload. This approach greatly disadvantaged the larger medical center facilities in determining military value by limiting the military value for health care services delivered and is inconsistent with other language within the BRAC report that speaks to the value of military training platforms.

For example, Walter Reed had over 16,500 RVPs for inpatient care; DeWitt at Fort Belvoir has 1,854. By setting the cap at 10,000, Walter Reed did not receive credit for 38% of its inpatient workload and its military value for inpatient care was greatly minimized while DeWitt received military value credit for all its inpatient workload.

RVUs for outpatient care were capped at 450,000. Walter Reed's outpatient workload was 1,148,000 RVUs, therefore Walter Reed did not receive military value credit for 60% of its outpatient workload. DeWitt also lost some credit for its outpatient workload but not nearly as much as Walter Reed.

Caps were placed on pharmacy, radiology, and laboratory workload, but no data was provided for these measures in Chapter X. It is highly likely that Walter Reed's workload in these areas exceeded the cap as it did for inpatient and outpatient care; again, these arbitrary caps on the value of patient workload represent serious bias against larger facilities. The only reason to cap these metrics is to bias the outcome.

The civilian and lay communities generally consider their best hospitals to be the large teaching hospitals associated with graduate medical education and clinical research programs. Inexplicably there was no military value given in any of the BRAC metrics to medical research done within medical centers. Walter Reed Army Medical Center is known as one of the most productive research medical centers in the military; 11 papers have been published in the peer reviewed literature specifically reporting findings and outcomes from the current conflict. Yet large facilities received no military value credit for their own research. Only research done in medical research and development facilities like Walter Reed Army Institute of Research was credited with military value; however, this was not included in the military value for health care services but rather was accounted for separately in medical/dental research development and acquisition.

Graduate medical education performed in Department of Defense facilities received no recognition in contributing to health care services delivery and thus received no military value credit in the functional area of health care services delivery. Again in the civilian lay and professional communities consider the presence of graduate medical education training programs to be of great value in the provision of patient care.

No military value was given to Walter Reed Army Medical Center's unique facility features that have taken years to develop into productivity. These include:

- prostate cancer research center
- breast cancer research center
- women's cancer research center
- deployment health center
- vaccine health center

No military value was given to the expertise that has been developed in combat care related specialty care areas, i.e., polytrauma, amputation care, prosthetics, physical therapy, rehabilitation care, and occupational therapy. No military value was given to a facility with the depth and breadth of medical staff that can and has responded with the deployment of just about any specialist on a moments notice to anywhere in the world.

No military value was given for reputation and prestige built over a century as a facility capable of providing care in an appropriate, safe and secure location for the President of the United States, Members of the U.S. Senate, House of Representatives and the Cabinet; a location that has the capability of providing this care for more than one patient at a time. No military value was given for a facility that on a daily basis provides care in an appropriate, safe and secure location to active duty general officers at the highest levels of the Department of Defense. No military value was given for the capability of a facility to provide care in an appropriate, safe and secure location for foreign heads of state.

It is clear that the military value metrics were set up to disadvantage the larger facilities like Walter Reed. Another example of this in the extreme is that Hurlburt Field, a small outpatient facility in Florida, was judged to have more military value than Walter Reed.

The following table compares the health care provided at Hurlburt Field to that at WRAMC:

	Hurlburt Field	WRAMC
A.2 Health Care Services		
A.3.2.1 Ambulatory care		
Primary care (RVUs)	44,946	86,977
Specialty care (RVUs)	6,836	1,061,332
Total RVUs	51,782	1,148,309
A.3.2.2 Inpatient care (RWPs)	0	16,553
A.3.2.3 Dental services (Active duty population)	7,788	33,412
Health Care Services – MV score	56.42	54.46

The BRAC metric, without an articulated DOD policy justifying the approach, rewards primary care and penalizes larger tertiary care teaching facilities. Again, it can only be assumed that this was done because the recommendations were predetermined and the metrics were developed to support the predetermined recommendations.

It is disheartening to see that an institution such as Walter Reed with an impeccable reputation for excellence is being slated for closure. Walter Reed's contribution to the treatment of our service members, including those most seriously injured in the current conflicts in the Middle East, provides an invaluable service to our nation. The BRAC Commission should seriously question a process that ranks Walter Reed's world-class programs significantly below military facilities with much more limited capabilities and in some cases, no in-patient care at all.

Homeland Security

The Defense Department also failed to address the critical homeland security function of Walter Reed should our nation's capital be hit by a terrorist attack or other major disaster, creating mass casualties. This oversight is alarming, especially in light of the new legislatively-mandated emphasis in the current BRAC round on maximizing the ability of the Armed Forces to mobilize for homeland security missions (see BRAC Criterion No. 2, in Public Law 101-510, section 2913(b)).

In the case of a chemical, biological or radiological attack, or other calamity, the District has entered into a memorandum of understanding with the Defense Department whereby Walter Reed would serve as a critical resource in the District's efforts to treat mass casualties. Specifically, Walter Reed is positioned to provide to the District:

- a staging site for medical personnel and equipment, including the use of its helipad (one of the few available in the District);
- ambulances and personnel for the transport of civilian casualties;
- and use of critical decontamination facilities for the management of people exposed to chemical and biological agents;
- In addition, Walter Reed currently partners with the District to store and manage crucial stockpiles of pharmaceuticals that would be utilized in the case of a major attack.

The closure of Walter Reed would terminate this strategic capability, and cripple the emergency response capabilities of our nation's capital in the event of a major disaster.

Despite the stated emphasis on homeland security missions, and the high stakes for Washington, DC, the Medical Joint Cross Service group never bothers to address the removal of these critical homeland security capabilities from the nation's capital. In fact, July 1, 2005 GAO report points out the Medical Joint Cross Service-Group expressly excluded domestic homeland medical support from its analysis. The implications of taking these functions outside of the borders of Washington, DC are enormous.

- Walter Reed is located just 5 ½ miles from the White House, 6 ½ miles from the Capitol, 6 miles from the Washington Convention Center, and is strategically located just outside of the major commercial and government centers of the District.
- We cannot assume the Department Defense would continue to maintain this capability at Bethesda - they surely have not budgeted for it.
- Second, even if these critical resources were in Bethesda, it would require medical personnel and equipment to travel a 50 percent greater distance to reach those in need.
- That distance is significant - in light of the traffic gridlock that crippled the District following the September 11th attack on the Pentagon - when the District itself was not directly struck; It would be foolish to think that if the heart of our city comes under direct attack, the necessary resources could reach downtown Washington without access to a facility like Walter Reed.

It is inconceivable that the Pentagon can be so uninformed of the homeland security interests of the nation's capital that it would completely ignore the crucial role of Walter Reed in its BRAC recommendations. The removal of Walter Reed from the District's borders a critical issue that our Defense and Homeland Security officials need to pay attention to.

The Commission should fully explore the importance of Walter Reed to the emergency response capability of the nation's capital.

BRAC impact on Graduate Medical Education (GME) Programs

The BRAC recommendation to realign WRAMC to Bethesda will cause a loss of residency training in critical specialties (i.e., surgery, orthopedics, internal medicine and transitional internships) and will add to current shortages and deployment concerns.

Currently there are two graduate medical education programs (one each at WRAMC and NNMC) in each of these critical go-to-war specialties. Consolidating clinical care at Bethesda will cause the loss of one of these programs in each specialty. In the remaining programs, the number of residents in each year of training is determined by the civilian Residency Review Committees (RRC), not the DOD; and the number of residents in each year of training is not based on military needs. The total number of residents training in general surgery and orthopedic will be decreased. It is highly likely that the internal medicine and transitional year programs will also lose resident positions. The RRC will not tell you ahead of time how many positions might be lost. It is extremely unlikely that new graduate medical education programs could be started up at Dewitt; even if attempted, it could take years to get approval from the civilian RRCs.

Significant inculcation of the military medical culture occurs during graduate medical education. The additional years 3-5 years, or more, on active duty greatly increase the acculturation of young physicians. A well-known fact that should be of significant military value is the fact that retention rates are higher in physicians that train in military programs as compared to civilian programs. The acculturation of military ethics and virtues during graduate medical education accelerates the transition from civilian physician in the military to military physician.

BRAC Military value metric devalues Graduate Medical Education

Graduate medical education performed in DOD facilities received no recognition for contributing to health care services delivery and thus received no military value credit in the functional area of health care services delivery. Graduate medical education was considered in the education and training functional area but larger facilities were disadvantaged by how the metrics were set up. For example, instead of asking how many graduate medical education training programs were "interservice/integrated," the question was what percent of the graduate medical education training programs were "interservice/integrated." Thus a facility with one only program, if that program was integrated, received a score of 100 percent; in contrast, a larger facility with 15 graduate medical education training programs of which 5 were interservice/integrated, received a score of 33%. Therefore a larger facility with more graduate medical education training programs that were interservice/integrated, could receive a lower military value score. This approach was used throughout several of the education and training metrics, giving more military value to the percent of programs than the actual number of programs.

It is clear that the military value metrics were set up to disadvantage the larger facilities like Walter Reed. It can only be assumed that this was done because the answers were predetermined and the metrics were developed to support the predetermined answers. It is critically important

that the BRAC commission understand the flaws in these biased metrics before they make irreversible decisions about irreplaceable health care facilities.

Environmental Costs Disregarded

Should the Commission ultimately agree with the Department's plan to shutter Walter Reed, one huge issue is environmental clean-up. The criteria require DOD to consider the impact of costs related to environmental restoration. However, as the GAO noted in its report, "estimated costs for the environmental restoration of bases undergoing closure or realignment are not included on DOD's cost and savings analyses."

Excluding the costs of environmental restoration from DOD's cost and savings analyses significantly improves both the claimed savings and payback periods for DOD's proposed actions.

With respect to environmental issues, the Medical Joint Cross-Service Group recommendations note only that \$2.769 million is required for environmental cleanup costs associated with the realignment of Walter Reed. While it is not clear whether this figure would apply to the Walter Reed site or the receiving sites, it would be woefully inadequate to clean up the 113 acres that make up the Walter Reed campus.

GAO correctly points out that environmental costs can be significant, as evidenced by the nearly \$12 billion in total costs DOD is expected to incur when all restoration actions associated with the prior BRAC rounds are completed. GAO notes that, "as closures are implemented, more intensive environmental investigations occur and additional hazardous conditions may be uncovered that could result in additional, unanticipated restoration and higher costs." And those costs could be even higher, depending on the ultimate reuse of the property after closure.

These arguments apply with particular force at Walter Reed, which has served as the primary medical research and treatment facility for the Army and the Department of Defense for almost 100 years, and where it can reasonably be anticipated that any environmental remediation costs would be substantial.

The National Environmental Policy Act (NEPA) imposes specified procedural requirements on Federal agencies with respect to actions that have the potential for environmental effects. NEPA requires Federal agencies to prepare detailed analyses of proposed actions through an Environmental Impact Statement (EIS), which includes the following steps:

- open sessions to determine the scope of the issues that need to be addressed and the identification of significant issues related to the action;
- preparation of a draft Environmental Impact Statement;
- public comment period and public hearings;
- preparation of a final EIS;
- another public comment period; and
- preparation of a record of decision.

It is quite clear that at this time none of the required governmental environmental surveys have been performed and no one knows what the necessary environmental remediation would be.

Although we have no way of knowing what environmental liabilities are lying in wait at the Walter Reed site, it is important that these questions be raised. These environmental hazards will have to be addressed no matter what the ultimate disposition of the property. Although DOD refuses to take these environmental liabilities into account in its fiscal justification for the closure of Walter Reed, they are most certainly costs that will have to be borne by DOD before any efforts to put the property to alternative productive use may go forward. If properly accounted for, these costs will would radically change DOD's estimated cost savings and payback period.

What responsibility does DOD have to include environmental costs? Who is responsible for them? How can the federal government get away with ignoring these costs in a cost/benefit analysis? What level of abatement is appropriate? Who decides that? These issues should be addressed and solved before a decision is made.

Bethesda and Ft. Belvoir are Inadequate Receiving Sites With Incomplete Cost Data

The escalating costs of health care facilities and the recent GAO report should cause the Commission to seriously question the cost estimates of building equivalent facilities at Bethesda and Fort Belvoir to replace Walter Reed.

One of the BRAC criteria is the availability of land and facilities at the potential receiving locations, and related to that, the ability of the infrastructure of the potential receiving community to support the new forces, missions and personnel.

We must keep in mind that the recommendation is not just to close Walter Reed and move its mission to Bethesda. Only the tertiary in-patient care mission is going to Bethesda. The other part of the mission is being moved to a million-square-foot hospital yet to be built at Fort Belvoir along with 2,069 military and civilian health care providers. The Fort Belvoir hospital would provide all the non-tertiary inpatient care and all the outpatient care that is currently provided at Walter Reed.

Fort Belvoir, because of the cumulative actions by DOD in the National Capital Region, is proposed to receive an influx of over 20,000 military and civilian personnel – by far the facility with the greatest increase in personnel. The GAO in its report noted some serious issues that it said warranted further attention by this commission:

- inconsistencies in how DOD estimated cuts for BRAC actions involving military construction
- uncertainties in estimating the total costs for the government to complement the DOD's recommended action
- the potential impacts on communities surrounding bases expected to gain large numbers of personnel.

The GAO singled out Fort Belvoir for special consideration because it is the largest receiving site in the nation. And anyone who has driven the Route 1 corridor in Virginia during rush hour knows that it is gridlocked now. But the Department of Defense does not operate in the real world of zoning and land use planning, traffic studies and highway construction, or the operation and funding of mass transit. Nobody at DOD took into consideration how you would get 20,000 additional workers to and from those jobs on a military reservation where every single vehicle coming through the one or two open gates must be stopped, its occupant identified and the vehicle checked. The 20,000 figure does not even include the thousands of additional outpatients and hospital visitors coming every day to the new million square foot medical facility that must be built to carry out this recommendation.

DOD can make these moves by merely writing it on a piece of paper. But it is the state and local governments that actually have to bear the burden of making it happen. The GAO specifically noted that the proposed relocations at Fort Belvoir will almost certainly involve requests for millions of federal dollars for new roads and mass transit. In fact, the Fairfax County Executive stated at a meeting held to discuss the BRAC moves that Fairfax County would likely need \$2

billion in federal aid for transportation infrastructure at Fort Belvoir. None of these costs were included in the BRAC analysis.

This issue was brought up by General James Hill in the May 19 Commission hearing with the Medical Joint-Cross Service group. General Hill specifically asked how all of the additional people would be absorbed at Fort Belvoir and whether the Army had looked at the costs of the required community and traffic infrastructure there. The witness responded that, "the Army has put in about \$125 million to handle infrastructure improvements for that." Clearly the Army has not talked to Fairfax County about its more realistic \$2 billion estimate for infrastructure. These are major oversights on the part of the Defense Department.

If infrastructure costs were appropriately accounted for, they would dramatically change the cost/benefit calculation and the related payback periods for the Fort Belvoir site.

The same issues apply at Bethesda. Almost 2,000 new personnel would be moved to Bethesda. In addition to the transfer of Walter Reed, DOD proposes to move the Office of Naval Research, the Air Force Office of Scientific Research, the Army Research Office and the Defense Advanced Research Project Agency all to Bethesda. Those moves were proposed by the Technical Joint Cross-Service Group. There is no evidence that the Technical or Medical Joint Cross-Service Groups actually considered each other's actions or did any on-scene site inspection and planning to see where all this would go or how much it would really cost to build on a specific site. What corporation would move its research facilities to a location without doing the actual planning and cost-estimating required to make sound, practical business decisions?

As anyone who has ever visited Bethesda to see a patient or for a medical appointment knows, parking at the complex is a daunting challenge today, even without the new construction and 2,000 additional people. Let me share with you a little tidbit of advice that is posted on the Bethesda Fisher House website:

"Using your personal car to drive to the hospital is not advised since parking in the Visitor's garage is extremely limited"

Of course, parking only becomes a problem once you can get there. As Montgomery County Executive Douglas Duncan states in his Transportation Plan for the Future: "We're drowning in traffic congestion and it's costing the region billions each year...absolute gridlock is just around the corner."

Consolidation Versus Dispersion of Military Facilities

Protection of military forces – both active duty military and civilian – is a legitimate and important concern in the BRAC process. Making sure the men and women who serve our nation are as safe as possible is absolutely critical and it is a goal of the Defense Department BRAC process. The Department has been remarkably inconsistent in its approach to this issue as it relates to the location of government facilities, and the Walter Reed recommendation reflects that inconsistency.

In the Fall of 2002, in response to the terrible attacks on the Pentagon and in New York, Secretary of Defense Donald Rumsfeld publicly announced his intention to issue a directive that would prevent the construction or lease of any new military space within a 100-mile radius of the Pentagon.

In a published interview, the Secretary noted that decentralizing Department of Defense operations would help prevent disruption of government agencies in the event of another terrorist attack.

His reasoning? It is much more difficult to attack a mission that is located in multiple locations than it is to attack a mission that is consolidated at a single location.

But what has the Department proposed here? A major consolidation of the region's medical service facilities into a single location. Completely the opposite of what the Secretary said was necessary just a few years ago.

There is no more important function than adequately protecting our valiant service members who are being treated and are healing at military medical facilities. But the Walter Reed recommendation seems to ignore the Secretary's own advice and seeks to consolidate these treatment facilities in large, hard-to-protect single-location facilities.

It is a mistake from a security standpoint and it is also a mistake from the standpoint of provision of services. The population served by existing medical facilities in the region at Ft. Belvoir in Virginia and Bethesda in Maryland lives throughout the region. Some in Maryland. Others in Virginia. And others in the District of Columbia. But the only facility being closed is Walter Reed in the District of Columbia.

Why is that? The Defense recommendation seems to suggest that the population of those receiving services from these facilities is moving away from Walter Reed. But there is no data or evidence offered to support that position. The only thing that certain from implementation of this recommendation is that the large segment of those who need care and live in the District of Columbia will be inconvenienced. Truly supporting our nations troops would require making certain that care is easily accessible to them in a variety of locations.

Nowhere in the Department's analysis of this recommendation is it even suggested that a new facility could continue to provide the world class level of care provided by Walter Reed that will meet future needs and anything less directly harms operational readiness and morale. DOD's flawed analysis is evidenced by the fact that an outpatient clinic in Florida scored higher for military value than the nation's premier tertiary combat care facility gives pause to DOD's view that it can rebuild the same level of care, services and treatment that are now found at Walter Reed for our wounded service members.

There are already ominous signs that DOD will not be able to replicate the Walter Reed programs at other multiple locations. Indeed, not only will the proposed recommendation not improve operational readiness, but also it has already had a detrimental effect. On November 19, 2004, -- just over seven months ago -- the Army held a ground-breaking ceremony for a new multi-million dollar amputee-training center at Walter Reed. The new center was designed to support 300 amputees in a state-of-the art facility that was to contain a combined-function running track, rope and rock climbing wall, gait lab, military vehicle simulators and other training areas. Deputy Secretary of Defense Paul Wolfowitz presided over the ceremony. Major General Kenneth Farmer, the commander at Walter Reed praised the record time at which the project had gone from concept to reality. He said that the amputee center continued Army medicine's long history of taking care of the wounded-in-action that began with the American Revolution and that Walter Reed had been a central part of that history since 1909. The center was to bring together all the services involved in caring for military service members to one location.

And now eight months later, what has happened to this shining example of the military caring for its own? Nothing. The amputee center remains a hole in the ground. As General Farmer said, in the Walter Reed town hall meeting on May 20th held to discuss the BRAC closure with the hospital staff, the \$10 million dollar amputee center project remains on hold.

Resources that have already been funded to meet immediate needs of our wounded service members are being withheld. Even assuming that this facility will be placed on the Bethesda campus, such a decision will likely take a backseat to the time needed to properly plan the new medical complex and implement the same into its program requirements. As a result, this much-needed facility and the beneficial therapies and treatments that were intended by Congress to be available today are now being placed by the Army on an indefinite delay. This is not acceptable.

GAO Study of BRAC Recommendations

The Commission must consider this criticism of the process DOD used to arrive at its decision to close and realign medical facilities leveled by the GAO in their report of July 1, 2005. On page 204 of its report, the GAO noted:

“DOD’s ongoing assessment of its future wartime medical requirements . . . will not be completed until after BRAC decisions are finalized, following reviews by the BRAC Commission, the President, and Congress, therefore this assessment was not included in the medical group’s analysis.”

In time of war, when according to the Army Medical Department, over 20,000 soldiers have been evacuated to Army facilities, the medical group decided to close Walter Reed without having an assessment of the military’s wartime needs. And the 20,000 evacuees are only the Army personnel evacuated to Army facilities. The GAO, in an understatement of the wisdom posed by this decision-making process, stated:

“Without having such requirements available during the BRAC process, it is difficult for DOD to identify the appropriate medical infrastructure changes that are needed and to determine the appropriate size of the military health care system.”

The burden of this difficulty falls solely on those who have given their blood in the defense of our country, not on the bureaucrats who have gotten the analysis wrong because they did not have the correct data. In fact, according to the GAO, they didn’t have any data at all.

For this reason alone, the Department substantially deviated from its own criteria.

The fact that the GAO has found that the Defense Department lacks any data on its wartime medical requirements – and won’t even have them until after the BRAC process is completed raises the question of whether the recommendation takes into account the ability of both the existing and potential receiving locations to accommodate contingency, mobilization, surge, and future total force to support operations and training and establishes a prima facie case of deviation from the third BRAC military value criterion.

Inability to Accurately Assess Military Health Care Costs

One of the military value criteria requires an evaluation of the cost of operations and the manpower implications of the proposal.

Since the end of the Cold War and with the earlier base closing rounds in the late eighties and nineties, the military has closed many of its direct care military treatment facilities. This has caused military beneficiaries, both active and retired, and their eligible dependents to use TRICARE to get health care from civilian doctors and hospitals. Because of this ever-increasing reliance on the civilian marketplace for health care services, the Department of Defense has faced relentless and explosive growth in its healthcare budgets.

The Under Secretary of Defense for Personnel and Readiness testified to this trend before the Senate Armed Services Committee on April 21, 2005. Dr. David Chu told the Senate that DOD Health Care spending will reach \$36 Billion in 2005 and will reach \$50 Billion within 5 years. Dr. Chu noted that military health care spending has essentially doubled in just the past four years. At the hearing, Dr. Chu spoke of the actions the Department was taking to control costs and better manage resources. One of the ways the Department is doing that is by requiring its regional TRICARE contractors to refer more care to the Military Treatment Facilities. This approach is 180 degrees from the recommendations in the BRAC report as, systemwide, it recommends sending at least 10,000 RWP's into TRICARE.

Three weeks after Dr. Chu testified before Congress, the Pentagon announced that it is closing the military's flagship tertiary care facility – Walter Reed. How does this make sense? Where is the military value in shrinking the direct care system? How can it be that the Department wants to bring more care back into the military treatment facilities, yet here in the National Capital Area home to almost a half million beneficiaries, the Department is shrinking the capacity of its military treatment facilities. We have just seen first-hand, the Administration's inability to accurately predict the demand for military-related health care.

Last week, the Department of Veterans Affairs revealed that it would be at least \$2.6 Billion dollars short in its fiscal year 2006 health care budget unless Congress provided it additional supplemental funds. This came about because the Department of Veterans Affairs had projected that 23,553 veterans would return this year from Iraq and Afghanistan and seek medical treatment. However, Secretary of Veterans Affairs Jim Nicholson testified before the Senate Veteran's Affairs Committee that the number of veterans seeking health care was currently 103,000 – almost five times the original estimate.

That means that despite the fact the War on Terrorism is on the front page of every day's newspaper and the nightly news, our government could not even estimate the needs for health care from our returning service men and women within almost 500 percent. What is important to remember is that every single person seeking care through the Veterans Administration first went through the military's direct care system.

We must remember that it's the responsibility of the military health care system to heal an injured soldier, sailor, airman or marine to the inter units of modern medicine before that service member is transferred into the VA system. This is exactly the mission that Walter Reed Army Medical Center has been executing so well since its founding in 1909. The Commission should remember the critical role that Walter Reed has played in providing necessary medical care to our soldiers, but more importantly, it should consider the critical role that it plays today, for our nation currently engaged in conflict.

Compromised Service to Patients/Families

The support that exists for patients receiving treatment at Walter Reed and their families in the form of housing is a significant cost that the Department has failed to account for in its analysis. The low cost, and sometimes no-cost housing provided through the Fisher Houses and the Mologne House are assets that will be effectively thrown away when replacement hospitals are built in Bethesda and Fort Belvoir.

Walter Reed contains a lodging facility called the Mologne House, a 280-room facility that is used by convalescing patients who have gotten well enough to leave their hospital bed but still must be at Walter Reed for follow on treatment and physical therapy. It's where the amputees stay so that they can have ready access to care and the amputee support staff and facilities. It is also open to family members of wounded service members who can stay there, right on the same grounds as the hospital, to aid and comfort their loved ones who hospitalized.

The cost per night for a room at the Mologne House is about \$60 per night. That compares with a cost of about \$130 per night for a hotel room on Wisconsin Avenue near the Naval Medical Center. The cost is sometimes paid for by the Army in the case of active duty patients, or families on invitational travel orders. Otherwise, the lodging fees are paid for by the families.

Walter Reed also has three Fisher Houses. These are multi-unit houses that also serve as homes for the families of service members undergoing treatment at Walter Reed. Two of the houses are located on the main campus, the third at Forest Glen. The newest house just opened on the Walter Reed campus in 2004, with Chairman of the Joint Chiefs of Staff Richard Myers presiding over the ribbon-cutting ceremony.

The Zachary and Elizabeth Fisher Foundation built these houses as gifts to the military at a cost of several million dollars. Through the generosity of the Fisher Family Foundation, 29 other houses have been built at military installations and veterans' hospitals throughout the world. A family can stay at a Fisher House for a suggested donation of \$10 per night or, in appropriate cases, for free. In some cases, the availability of a room in the Fisher House has allowed parents or spouses to stay for as long as a year to assist in the recovery of severely wounded, multiple amputee soldiers.

Closing Walter Reed means that the Mologne House and the Fisher Houses on the main campus would be lost. In the minutes and briefing slides of the Medical Joint Cross Service Group, the issue of the loss of the Mologne House and the Fisher Houses was completely discounted. The reason? Because the Mologne House and the Fisher Houses costs were not funded by the Defense Health Program. Therefore, the increased costs to the Army and the families were completely dismissed because they were not so-called Defense Health Program programs.

What are the potential costs to the families? Let's look at this simple illustration. As I said, the difference between a night in the Mologne House and a night at a hotel in Bethesda is about \$70. With 280 rooms, that's an additional cost of over \$19,000 per day, or a burden of \$7 million per year. And that doesn't even take into account the difference between the Fisher Houses and off-post hotels. This burden is being shifted to our service members and their families. It is shifting

the cost to the very individuals who are already bearing the highest cost in service to their country. It is wrong and again illustrates the lack of forethought by DOD in its recommendation for Walter Reed.

Military service members, retirees and their families who have historically received their medical care at Walter Reed will experience a decrease in the level of care, if only by virtue of the fact that they will have to travel significant distances to receive alternative care. The traffic situation in this region is well documented, and I want to point out the significant challenge that exists for patients who will have to endure the traffic hang-ups in area surrounding Bethesda Naval Hospital, not to mention the gridlock associated with the Beltway and mixing bowl area around Fort Belvoir. Again, these infrastructure issues are costs the Defense Department refused to include in its analysis.

Why Walter Reed Army Medical Center?

Who is bearing the brunt of current casualties and will bear the brunt of future casualties? Clearly the Army. No one can challenge the United States on the seas or in the air, and as always the foot soldier will bear the brunt of injuries and death. Therefore the Army, even more than the other services, needs the capability to care for the complex wounded. The lethality and destruction of the improvised explosive device (IED) is obviously well known and will be copied by future enemies of the United States. Soldiers on the battlefield must have a military physician when needed. Closing Walter Reed could decrease the likelihood that that military physician will be there when needed.

Where do Army docs come from? Most come from Army graduate medical education programs. The majority of these programs and trainees are in the major medical centers. Why are the majority of trainees in the major medical centers and not the community hospitals? Because that is where the patients are that are needed to train these docs. The BRAC report itself talks about these "medical training platforms."

"Historically the military health system has often expanded its beneficiary population (at selected facilities) to include retirees to enhance clinical opportunities for uniformed providers. In fact, the largest military treatment facilities are located in areas with substantial non-active duty beneficiary populations as well as large numbers of active duty and their dependents. Since facilities with such populations serve as "medical training platforms" for operationally needed medical specialties, population characteristics represent a significant factor in facility capacity."

These are the exact facilities that were devalued by the BRAC military value metric. The reason major military medical centers exist is to provide the complex care needed in war and to provide a platform for training and skill competency during peace. Without major tertiary medical centers and the environment they provide, the Army would not be able to retain the cadre of senior experienced medical officers needed in war. Polytrauma casualties (amputation, fracture, head injury, burns, etc.) from the current conflict are surviving in numbers not previous seem and major tertiary medical centers such as Walter Reed are needed to care for them.

It is well known that currently the vast majority of these patients are brought to Walter Reed. Over the years Walter Reed has purposely developed this capability to care for very complex patients by seeking out that capability in patient care as well as graduate medical education and clinical research. This environment of cutting edge care, medical education and research has attracted a highly motivated, experienced and skilled group of senior officers who are daily fulfilling the promise to our soldiers, on the battlefield as well as in the medical center, of providing them every chance to recover to lead a full and rewarding life.

This capability exists during war because it was developed and maintained during peace. Tertiary medical centers committed to complex care, education and research during peace are the part of the cost of having a competent medical force during war. The reason the worst of the injured come to Walter Reed is because years ago, Walter Reed chose to be that place. Since the

Iraq invasion, Walter Reed has treated over 4,000 patients including a thousand battle casualties. Moreover, through May 31, 2005, Walter Reed has treated a total of 245 amputees evacuated from Iraq and Afghanistan.

Closing Walter Reed devalues the work that has been done there over the years, discourages others from attempting that same work elsewhere, and strikes at the sustainability of military medicine. It sends the wrong message to young physicians that may be considering a military scholarship for medical school because it decreases the graduate medical education training opportunities after medical school, as well as research and development opportunities after training. Actions that decrease the Army's ability to attract and train the best and brightest to become military physicians, decreases the likelihood that injured soldiers on the battlefield will receive the care they need.

If the purpose of the BRAC is to reduce excess capacity, why would you do that at the major tertiary medical centers? These centers are the very facilities needed in war to care for the worst of our casualties, and in peace to maintain a ready-supply of military health care expertise.

The Army cannot provide this health care without attracting and retaining the very best physicians. Walter Reed Hospital is one of the military's great teaching hospitals, we should not be so naïve as to think that we can readily reconstitute these world-class programs at two new, and separate, facilities. The Commission should keep in mind that Walter Reed's location has been a major factor in the Army's ability to attract and retain the best senior military doctors to provide specialized instruction to our military doctors of the future. Many of these senior people will likely choose not to move to other locations and will leave the Army at a time when we need their specialized skills the most.

The Culture of Army Medicine

The rhetoric will say that Walter Reed Army Medical Center (WRAMC) is being realigned to become the Walter Reed National Military Medical Center at Bethesda, but to those who truly understand the vital issue (the difference between the culture of Army medicine and the culture of Navy medicine) the significance is that the Army will no longer be in charge of the decisions that will determine the future of this great institution and the patients it serves.

Why does it matter? It matters because, despite the lip service, the track record of Navy medicine is that it is not interested in the robust provision of subspecialty care, and despite the lip service, the track record of Navy medicine is that it is not interested in diverse subspecialty graduate medical education. The term "medical center" is used loosely these days, but robust subspecialty care and diverse subspecialty graduate medical education are the heart and soul of any true medical center.

Since the integration of graduate medical education training programs between WRAMC and the National Naval Medical Center (NNMC) began in 1995, Navy medicine has repeatedly shown its lack of true interest and commitment. Even before the proposed integrated ophthalmology program got started, the Navy unilaterally withdrew its commitment to provide residents to the program. In the middle of an academic year, the Navy allowed two residents to leave the neurosurgery program, potentially crippling the program and placing its accreditation in jeopardy. The Army pulled two physicians out of general medical officer assignments, one from Korea, to save the program. This year the Navy pulled back from its commitment to jointly train pediatricians, proposing to not place any physicians in the program at the resident level.

The general public and non-medical military leaders assume that WRAMC and NNMC are similar, and that Army medicine and Navy medicine are similar. Nothing could be further from the truth. Let's try some facts. Although you may cry ancient history, a GAO report (GAO/HRD -89-47) in 1989 demonstrates an amazing cultural difference between Army medicine and Navy medicine, and shows the Navy's lack of commitment to providing care to its beneficiaries in its own facilities. Between fiscal years 1985 and 1987, the number of inpatient admissions to all Navy hospitals went down 32% and the numbers of outpatient visits went down 33%. Figures for the Army were 0% and 2% respectively. Navy medicine divested itself of a staggering one-third of its medical workload in just two years.

This reduction was not because the military services were downsizing and the workload was simply going away, the GAO report goes on to say that the increases in CHAMPUS workload mirrored the drawback in military workload. Military outpatient visits were down 2.6 million, CHAMPUS outpatient visits up 2.5 million; military inpatient admissions were down 65,000, CHAMPUS inpatient admissions were up 51,000. The Navy accounted for 85% of the outpatient workload decrease, and 69% of the inpatient workload decrease. Not surprisingly CHAMPUS costs increased by \$700 million during those two years.

More recent data supports these trends. A 1999 GAO report (GAO/HEHS-00-10) shows on page 37 a very interesting and little-discussed comparison between WRAMC and NNMC. In fiscal

year 1998, WRAMC operated 350 beds with a budget of \$148 million, NNMC operated 239 beds with a budget of \$147 million. WRAMC had a total of 3,144 personnel and NNMC 3,740. Outpatient visits at WRAMC were 646,000; outpatient visits at NNMC were 555,000. Let me do the math for you. With less than 1% difference in budget, WRAMC operated 111 or 46% more beds, and saw 101,000 or 18% more outpatients and accomplished both with 596 or 16% fewer personnel. This is a striking difference in operational efficiency.

Why does it matter? It matters because what is in jeopardy is the future of a true military medical center, serving a military currently at war. These two GAO reports demonstrate the huge cultural differences between Army medicine and Navy medicine. WRAMC is what it is because the Army has chosen the more difficult, and more expensive, path - providing high level tertiary care, subspecialty graduate medical education, and clinical research. We owe our severely combat wounded nothing less than the continuation of the very best and most sophisticated care available.