[H.A.S.C. No. 111–26]

MEDICAL INFRASTRUCTURE: ARE HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY PRIORITIES ALIGNED WITH SERVICE REQUIREMENTS?

JOINT HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

MEETING JOINTLY WITH

READINESS SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

HEARING HELD

MARCH 18, 2009

U.S. GOVERNMENT PRINTING OFFICE

50–823 WASHINGTON : 2010

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

MILITARY PERSONNEL SUBCOMMITTEE

SUSAN A. DAVIS, California, *Chairwoman*

VIC SNYDER, Arkansas
LORETTA SANCHEZ, California
MADELEINE Z. BORDALLO, Guam
PATRICK J. MURPHY, Pennsylvania
HANK JOHNSON, Georgia
CAROL SHEA-PORTER, New Hampshire
DAVID LOEBSACK, Iowa
NIKI TSONGAS, Massachusetts

JOE WILSON, South Carolina
WALTER B. JONES, North Carolina
JOHN KLINE, Minnesota
THOMAS J. ROONEY, Florida
MARY FALLIN, Oklahoma
JOHN C. FLEMING, Louisiana

DAVID KILDEE, *Professional Staff Member*
JEANETTE JAMES, *Professional Staff Member*
ROSELLEN KIM, *Staff Assistant*

READINESS SUBCOMMITTEE

SOLOMON P. ORTIZ, Texas, *Chairman*

GENE TAYLOR, Mississippi
NEIL ABERCROMBIE, Hawaii
SILVESTRE REYES, Texas
JIM MARSHALL, Georgia
MADELEINE Z. BORDALLO, Guam
HANK JOHNSON, Georgia
CAROL SHEA-PORTER, New Hampshire
JOE COURTNEY, Connecticut
DAVID LOEBSACK, Iowa
GABRIELLE GIFFORDS, Arizona
GLENN NYE, Virginia
LARRY KISSELL, North Carolina
MARTIN HEINRICH, New Mexico
FRANK M. KRATOVIL, Jr., Maryland
BOBBY BRIGHT, Alabama

J. RANDY FORBES, Virginia
ROB BISHOP, Utah
MIKE ROGERS, Alabama
TRENT FRANKS, Arizona
BILL SHUSTER, Pennsylvania
K. MICHAEL CONAWAY, Texas
DOUG LAMBORN, Colorado
ROB WITTMAN, Virginia
MARY FALLIN, Oklahoma
JOHN C. FLEMING, Louisiana
FRANK A. LOBIONDO, New Jersey
MICHAEL TURNER, Ohio

DAVID SIENICKI, *Professional Staff Member*
THOMAS HAWLEY, *Professional Staff Member*
MEGAN PUTNAM, *Staff Assistant*

CONTENTS

CHRONOLOGICAL LIST OF HEARINGS

2009

Page

HEARING:

Wednesday, March 18, 2009, Medical Infrastructure: Are Health Affairs/TRICARE Management Activity Priorities Aligned with Service Requirements? 1

APPENDIX:

Wednesday, March 18, 2009 23

WEDNESDAY, MARCH 18, 2009

MEDICAL INFRASTRUCTURE: ARE HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY PRIORITIES ALIGNED WITH SERVICE REQUIREMENTS?

STATEMENTS PRESENTED BY MEMBERS OF CONGRESS

Davis, Hon. Susan A., a Representative from California, Chairwoman, Military Personnel Subcommittee 2

Ortiz, Hon. Solomon P., a Representative from Texas, Chairman, Readiness Subcommittee 1

Wilson, Hon. Joe, a Representative from South Carolina, Ranking Member, Military Personnel Subcommittee 3

WITNESSES

Casscells, Hon. S. Ward, M.D., Assistant Secretary of Defense for Health Affairs 4

Potochney, Peter, Director, Basing, Office of the Deputy Under Secretary of Defense, Installations and Environment 7

Robinson, Vice Adm. Adam, USN, Surgeon General, U.S. Navy 10

Roudebush, Lt. Gen. James G., USAF, Surgeon General, U.S. Air Force 9

Schoomaker, Lt. Gen. Eric, USA, Commanding General, U.S. Army Medical Command, Surgeon General, U.S. Army 12

APPENDIX

PREPARED STATEMENTS:

Casscells, Hon. S. Ward 32

Davis, Hon. Susan A. 28

Forbes, Hon. J. Randy, a Representative from Virginia, Ranking Member, Readiness Subcommittee 30

Ortiz, Hon. Solomon P. 27

Potochney, Peter 47

Robinson, Vice Adm. Adam 63

Roudebush, Lt. Gen. James G. 58

Schoomaker, Lt. Gen. Eric 68

Wilson, Hon. Joe 31

Page

DOCUMENTS SUBMITTED FOR THE RECORD:

[There were no Documents submitted.]

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING:

Mr. Kline 77

QUESTIONS SUBMITTED BY MEMBERS POST HEARING:

Ms. Bordallo 88

Mr. Kissell 87

Mr. Wilson 81

MEDICAL INFRASTRUCTURE: ARE HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY PRIORITIES ALIGNED WITH SERVICE REQUIREMENTS?

HOUSE OF REPRESENTATIVES, COMMITTEE ON ARMED SERVICES, MILITARY PERSONNEL SUBCOMMITTEE, MEETING JOINTLY WITH READINESS SUBCOMMITTEE, *Washington, DC, Wednesday, March 18, 2009.*

The subcommittees met, pursuant to call, at 2:06 p.m., in room 2118, Rayburn House Office Building, Hon. Solomon P. Ortiz (chairman of the Readiness Subcommittee) presiding.

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

Mr. ORTIZ. The subcommittee will come to order.

Today, the Readiness Subcommittee and the Military Personnel Subcommittee will meet in a joint session to receive a briefing on how the Department is managing their medical military construction program.

As our Nation responds to different threats, we adapt and change our strategy and the force structure of our military, and one of the most recent decisions to change our force structure has been to expand the Army and Marine Corps and add 74,000 soldiers and 27,000 Marines.

The services have been steadily applying facility funds to accommodate this growth, but some areas are significantly lacking, including medical facilities to support the growing force.

It is imperative that the men and women that join our Armed Forces are provided the best medical care possible.

To this end, I am glad that we provided almost $1.3 billion to support medical facilities deficiencies in the stimulus bill.

I hope that the witnesses will take the opportunity to address the Department's investment priorities on how they are managing to address medical facilities needs for all of our growing installations.

On a related point, our subcommittees had the opportunity to visit Bethesda yesterday and we were amazed at the resilience of the wounded warriors, their high spirits, their bravery, their dedication to our country.

And to receive men and women at Bethesda within 48 hours of a casualty from anywhere in the world is an amazing feat, and I was very, very impressed to know that.

This capability that exists today will be particularly challenged when the Walter Reed complex is realigned to Bethesda and Fort Belvoir.

We were briefed that the majority of care will be moved from the Walter Reed campus in August of 2011. With the construction of almost $2 billion in the National Capital Region (NCR), in addition to commissioning the facilities and installing complex equipment, there is no question that this will be a very difficult task.

A seamless transition from Walter Reed to Bethesda and Fort Belvoir is essential to provide the quality of care for our wounded warriors.

[The prepared statement of Mr. Ortiz can be found in the Appendix on page 27.]

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

Mrs. Davis.

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

Mrs. DAVIS. Thank you. Thank you, Chairman Ortiz, Mr. Forbes and Mr. Wilson, for this joint hearing of the Readiness and Military Personnel Subcommittees.

The Military Personnel Subcommittee is tasked with oversight of the defense health program and the Readiness Subcommittee with the oversight of military construction.

While our staffs have already spent lots of quality time together on this topic, it is good that we are meeting jointly to receive testimony and explore the issue of medical military construction.

As Chairman Ortiz mentioned, it is vital that we program and build the infrastructure required to support the expansion of the Army and the Marine Corps. It is our responsibility to ensure that our service members and their families, specifically, their families, too, have the facilities they need from the outset and not be forced to wait years before these facilities are even programmed, let alone built.

We must also ensure that the recommendations of the Base Realignment and Closure Commission are implemented.

Yet another reason to have this hearing is the fact that medical military construction is handled differently by the Department of Defense and all other military construction (MILCONs). That is not to say that it is bad different or good different, just different.

Consequently, it is both appropriate and responsible oversight for our two subcommittees to examine this process so that we may understand exactly how the Department analyzes, prioritizes, budgets and then builds medical facilities.

We must also keep in mind the long-term enduring costs of maintaining these facilities once they are completed.

Today, we will hear from all of the relevant parties within the Department of Defense (DOD). Dr. Ward Casscells, the Assistant Secretary of Defense for Health Affairs, will describe how Health Affairs/TRICARE Management Activity (TMA) prioritizes projects.

Mr. Peter Potochney, director of basing for the office of the deputy under secretary of defense for installations and environment, will speak to Base Realignment and Closure (BRAC) issues.

Finally and importantly, we will hear from the service surgeons general, Lieutenant General Roudebush from the Air Force and Vice Admiral Robinson from the Navy, and Lieutenant General Schoomaker from the Army, of how well the current process supports their requirements.

Welcome to all of you and thank you very much for being with us.

Throughout our conversations today, it should go without saying that all of us, both members of the legislative and executive branches, are committed to providing the very best care possible to service members, their families and our retirees.

Chairman Ortiz rightly mentioned the impressive feats that our military health system has made routine.

On Monday, many of us had a chance to meet and speak with a wounded warrior at Bethesda. Given how recently he was wounded and the type and extent of his injuries, it was awe inspiring to see how far he has come so quickly.

All of his caregivers agreed that just a few years ago, any recovery, let alone one as dramatic as his, would have been all but impossible. That the standard of care has risen to such a high is a testament to the commitment displayed on a daily basis by everyone who is associated with the military health system.

We must all do our part to make sure this trend continues.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 28.]

Thank you, Mr. Ortiz. We look forward to the hearing.

Mr. ORTIZ. The chair now recognizes the distinguished gentleman from South Carolina, Mr. Wilson.

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

Mr. WILSON. Thank you, Chairman Ortiz.

And it is an honor for me to be here today with Chairwoman Davis. I appreciate joining our good friends on the Readiness Subcommittee, led by Chairman Solomon Ortiz and Ranking Member Randy Forbes, for our hearing on military medical construction.

I welcome the distinguished members of our witness panel.

At this time, Congressman Forbes is actually in a markup of the Judiciary Committee, and I would like to move for unanimous consent to submit his opening statement for the record.

Mr. ORTIZ. Without objection, so ordered.

[The prepared statement of Mr. Forbes can be found in the Appendix on page 30.]

Mr. WILSON. I believe that there is nothing more important than providing the outstanding members of our military, their families and our retirees with world-class health care delivered in world-class medical facilities.

There is no question, in my mind, that they deserve nothing less.

As the grateful father of four sons in the military today, our family has experienced the quality service, with two grandsons born at

Bethesda National Naval Medical Center, and a granddaughter born at Portsmouth Naval Hospital.

With that being said, I understand that there are a number of military treatment facilities that are 30 or more years old. In the district I represent in South Carolina, Moncrief Army Community Hospital at Fort Jackson was built in 1972 and the Navy hospital at Beaufort was built in 1947.

I know that the outstanding medical personnel in each of these facilities provide excellent care to our troops and their families.

On personal tours of each facility, I have been very impressed by the dedicated and competent professional personnel I have met.

I also know that as a medical facility gets older, it is more challenging to keep up with the advances in medicine.

As I prepared for the hearing today, I was reminded that the planning process for military medical construction is very different than that for other types of construction within the Department of Defense.

I am interested to hear from our panel why medical construction is unique within the Department. To that end, today, I hope to hear from our witnesses how the Department and the military services plan to spend medical construction dollars to either replace or modernize our military hospitals.

The members of our Armed Forces deserve the best.

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

[The prepared statement of Mr. Wilson can be found in the Appendix on page 31.]

Mr. ORTIZ. Today, we are very honored to have with us five distinguished witnesses representing the Department of Defense.

We have the honorable Ward Casscells, the Assistant Secretary of Defense for Health Affairs; Mr. Pete Potochney, Office of the Under Secretary of Defense for Installations and Environment; Lieutenant General Eric Schoomaker, the Surgeon General of the Army; Vice Admiral Adam Robinson, Surgeon General of the Navy; and, Lieutenant General James Roudebush, Surgeon General of the Air Force.

Without any objection, all of your testimony will be put in the record.

Mr. Casscells, whenever you are ready, you can begin your testimony, sir.

STATEMENT OF HON. S. WARD CASSCELLS, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Secretary CASSCELLS. Thank you, Chairman Ortiz, Chairwoman Davis, Ranking Member Wilson.

I am delighted to be here with my colleagues and I cannot tell you how much we appreciate your interest in our facilities and your recent visit to Walter Reed.

Joining me here today, from left to right, I think you have already mentioned, General Schoomaker, General Roudebush, Mr. Pete Potochney, who is representing Wayne Arny, the director of installations and environment, and Vice Admiral Robinson.

Secretary Gates has said over and over again that our service members and their families deserve the best medical facilities pos-

sible. We certainly agree with him and we appreciate very much the fact that the Congress has taken that to heart.

Let me be frank. We do not have big corporations and others for whom this is a top priority calling you. This is the group that advocates for military medical facilities and we are very grateful that you have taken it to heart.

We are in a bit of an awkward position today, because the President's budget won't come to you until April. In fact, we don't have the details ourselves.

We know what we have requested, and this is being arm-wrestled with the Office of Management and Budget (OMB) and the comptroller and so forth now.

So we don't know. We won't be able to answer some of your questions the way we would like to.

Likewise, the details of the stimulus proposal and our military medical construction proposals, as part of that bill, are not yet approved. I can tell you that we have requested a balanced construction program favoring the urgent, the strategic and the joint.

We also are a little bit handicapped today in the sense that we don't have the report from the independent review of the hospital design. This group is due to report now to the defense health board and we should have that report, also, in a matter of weeks.

Together, these have put us in a position of delay, as your staffs know well. The report that was due in January was only delivered to you, I understand, on your way out to Walter Reed, and I apologize for that. We had hoped you would have several days to digest that. And we will have a full report of all of this in early summer.

Mr. Chairman, you alluded to the fact that we have a different funding mechanism, as did Mr. Wilson. We do, indeed, and as opposed to regular military construction, which is done by a top line allocation to the services, the medical construction is done differently, as recommended by or as required by Congress, and as we, the surgeons and I and installations and environment leaders, as we have jointly designed.

The way this works has been different from other military construction since the defense health program was created by Congress several decades ago.

And what it means is that instead of having service surgeons general having to ask the line leaders for their budget, Congress set this up so that there would be a defense health program so that the budgets could be put together jointly and we wouldn't be trading hospitals versus weapons systems.

I think the wisdom of Congress' decision here is apparent, because we are now once again building hospitals, and I think that is good.

There was a time when we were letting the hospital maintenance be deferred year by year by year. I think the members of these committees are well aware that our accreditation has been—we have passed, our hospitals pass their inspections, but not with commendation, typically.

Usually, we are cited for deferred maintenance and we take the pledge to get to it. But you cannot defer these things indefinitely. Otherwise, you may compromise medical care eventually.

We are not doing that at this time, but we cannot defer the upgrades of these hospitals forever.

As you mentioned, sir, some of these hospitals were built before any of us were even in medical school. So that is 35 years ago. So they can't be neglected indefinitely.

The mechanism that we use now to determine these allocations, the priorities, are set by something called the capital investment decision model, or CIDM.

This is something that we and our predecessors actually developed. It has been a painstaking business model that has been developed, and we took our cues from the business community and, particularly, from the Veterans Administration (VA), which, as you know, has revitalized their facilities over the past couple of decades and they have some really first class hospitals now.

One of the things that has come out of that is commercially available software that facilitates this decision-making. So this is what we have used. We have worked on it together, and I hope that what we will be able to do today, if not answer every single question about a given facility, is at least persuade you that we are working on it in a transparent and in an earnest and joint fashion.

It remains to be seen whether this new process, CIDM, will actually be the right one or whether it is just another layer of DOD bureaucracy laid over top of service bureaucracies. None of us wants that.

What we want, of course, is to have an even playing field and to have people speak and meet together, share their best ideas, cross-fertilize, and reach a consensus on what the military hospital should look like, and I believe we have.

We want hospitals that will be welcoming, that will be empowering for the patients, that will be comforting. They will be a little bit different than the civilian hospitals. We compare ourselves constantly to what is happening at the Mayo Clinic or the Cleveland Clinic or Kaiser Permanente.

Our needs are a little bit different, because we have such a preponderance of psychological issues to deal with.

But many of the features are ones that we have been able to take from the VA and from the commercial competitors, and I say competitors in a respectful way, but we are the only Health Maintenance Organization (HMO) that deploys. I am sure you have heard that expression. And it is critical that the military treatment facilities (MTFs) be maintained strong and, in fact, be strengthened.

The future of the military health system requires this. We cannot outsource everything. There are things we can do in that vein and I want to commend what the Air Force has done, with great wisdom and great innovation, working with the private universities and private hospitals, where that is the best thing to do.

In other areas, we are working closely with the VA. So we have joint facilities.

Still, we have to have a core called the MTFs, the military hospitals or military treatment facilities, where people train together and so that they can deploy together. This is critical for the efforts we are engaged in overseas, whether it is the wars in Iraq and Afghanistan, caring for our wounded, whether it is the best preventive, getting them in the best shape to deploy, and whether it is

teaching the Iraqis and the Afghans to take care of their own people medically.

All these are things that we train to do together and the health of the MTFs is critical.

So thank you for supporting them. It is very heartening for us to have this opportunity to talk to you about the military treatment facilities.

I think next is General Schoomaker, and I think then we will have some questions at the end.

But thank you, again, on behalf of my colleagues and the Department of Defense for this opportunity.

[The prepared statement of Secretary Casscells can be found in the Appendix on page 32.]

Mr. ORTIZ. Mr. Potochney, go ahead, sir.

STATEMENT OF PETER POTOCHNEY, DIRECTOR, BASING, OFFICE OF THE DEPUTY UNDER SECRETARY OF DEFENSE, INSTALLATIONS AND ENVIRONMENT

Mr. POTOCHNEY. Good afternoon, Chairman Ortiz, Chairwoman Davis, Congressman Wilson and distinguished members of the subcommittees.

I am honored to appear today before you. I am taking the place of my boss. That is Wayne Arny, the deputy under secretary of defense for installations and environment, who is today attending his son's change of command at Naval Air Station (NAS) Lemoore. He is the outgoing Strike Fighter Weapons School Commanding Officer (CO).

Absent a significant personal commitment like that——

Mr. ORTIZ. Sir, if you could get a little closer to your mic, sir. Thank you.

Mr. POTOCHNEY. Absent a personal commitment like that, he would be here.

I will keep my remarks brief, and I would like to relate what we do in the installations community, in the construction world, compared to what we do with the other witnesses today, in the health affairs world, as well as BRAC.

So let me begin.

The installations and environment community, my world, has oversight responsibility for the Department's installation portfolio. We are the advocates for ensuring our facilities compete effectively for the investment necessary to sustain, restore and modernize them to ensure their continued operation in support of their mission occupants.

As such, we support our colleagues in the medical community in their application of the resources supporting the Defense Department's health program facilities.

The Department places great emphasis on sustaining all of our facilities. Sustainment is the term we use to describe what is necessary to keep facilities in good working order and the preventative maintenance necessary to avoid the increased costs and mission impacts that result from premature deterioration.

To this end, we use something called the facilities sustainment model, and it is a robust tool we have developed to parametrically estimate the funding required for this purpose, and it allows us to

gauge our investment against the requirement, and that was a substantial and significant development for us over the last couple of years, because now we had a tool to better compete for the limited resources we have in the Department, particularly because sustainment has been traditionally underfunded in the Department.

In the 2009 President's budget, we were at 90 percent of the overall requirement and health facilities were at 93 percent of the overall requirement. That is better than it used to be, but it is certainly not where it should be, and we are continuing to work to get it up, frankly, to 100 percent.

Sustainment is only one piece of the equation. Facilities must also be modernized through the investment we make in their recapitalization.

Modernization is driven by new standards, new technology and changing missions and, as such, it is not easily modeled.

However, the fact that the average age of our hospitals is less than other facilities indicates we recognize the relative importance of their modernization.

But here, too, there is certainly more to do and the witnesses at this table will provide details of the work we are doing in order to respond to medical care advances.

Restoration is the final part of the equation. While, in the past, the Department had focused on recapitalizing facilities on a yearly rate, essentially, a ratio of the funding we were placing in the budget compared to the replacement value of all of our facilities and then our 67-year goal was something I think you heard about in the past, we have recognized the limitations of this metric, particularly with regard to medical facilities and are working on more comprehensive measures.

To that end, we are using Q ratings now, much more so than in the past, and that is Q1 through Q4, Q1 being the best, Q4 the lowest, and they are essentially the percentage of work orders to repair a building compared to the building's replacement cost.

Medical facilities have a higher Q rating than the rest of the Department, but they are not a good indicator of our medical facilities' health, because—no pun intended—because medical facilities have a high priority, as I just said, and they are subject to accreditation requirements, and the accreditation requirements drive us to more robust engineering assessments of the individual condition of the facilities in coming up with our estimates.

So we are continuing to refine our approach and right now that is the best means we have available to gauge what it is we are doing as far as investing in recap, sustainment and restoration.

There is one special area that I need to note, and that is BRAC. Particularly, here in the National Capital Region (NCR) and in San Antonio, those are the two major BRAC areas.

BRAC is a significant recapitalization engine for the Department. BRAC is pouring a lot of money into our facilities across the board, but particularly in the medical community.

Through BRAC, the Department is realigning, rationalizing military health care, particularly in the NCR in San Antonio, as I said. In the NCR, we have avoided recapitalizing the aged Walter Reed facility so that we can instead focus our resources more effectively

by realigning functions into the new Walter Reed National Military Medical Center.

We are also building a new facility at Fort Belvoir that will address the significant demographic shift in patient population that has occurred in this area.

In San Antonio, we are consolidating inpatient services into a recapitalized Brooke Army Medical Center and converting the aging Wilford Hall to an ambulatory care center.

These two initiatives have produced investments in medical care in the NCR and San Antonio of $2 billion and $900 million, respectively. These two areas, coupled with lesser BRAC initiatives, represent a substantial recapitalization effort.

In closing, I want to thank the subcommittees for this opportunity. The Department's medical construction program has made great progress, but certainly more work remains, as you will hear from the other witnesses.

We also recognize and appreciate the great support you have demonstrated for all of our efforts.

Thank you.

[The prepared statement of Mr. Potochney can be found in the Appendix on page 47.]

Mr. ORTIZ. Thank you, sir.

General Roudebush, go ahead, sir.

STATEMENT OF LT. GEN. JAMES G. ROUDEBUSH, USAF, SURGEON GENERAL, U.S. AIR FORCE

General ROUDEBUSH. Thank you, sir. Chairman Ortiz, Chairwoman Davis, Ranking Member Wilson, it truly is a pleasure to be here today to review our MILCON activities with you, to hear your thoughts and to provide ours.

We believe this is a very, very useful and necessary opportunity. Thank you.

First, let me express our gratitude for the overwhelming support that Congress and you, in particular, have provided to address the critical needs of our medical facilities. Your efforts will greatly assist us in building and sustaining the state-of-the-art medical facilities that we require now and for the future.

This is especially important in the Air Force, as much of our medical infrastructure was built in the 15 years following the establishment of the Air Force in 1947.

The shortage of MILCON funds in the past several years has forced us to pursue ever increasing Operations and Maintenance (O&M) repairs on buildings well past their useful life.

While we have been successful in implementing stopgap measures in this manner, we cannot sustain an adequate baseline of maintenance and repair.

To properly characterize and prioritize our Air Force MILCON requirements, our Air Force health facilities division aggressively engages with each medical facility leadership to identify those modernization requirements that are most pressing.

Our prioritization of these requirements is then aligned to an Air Force-wide perspective.

For requirements that drive a MILCON solution, we now prepare a capital investment proposal and submit to the TRICARE man-

agement activity to be scored in the military health service capital investment decision model, the CIDM process, which you have heard a bit about this afternoon.

This CIDM process was successfully applied in 2008 to determine the Department of Defense fiscal year 2010–2011 military MILCON priorities, and I can report to you that the Air Force's most pressing medical projects were appropriately prioritized within this process.

As a result, we are beginning to turn the corner on our MILCON shortfalls. As we work to recapitalize our infrastructure in both the MILCON and O&M arenas, it is important to note that green design initiatives and energy conservation continue to be high priorities in the Air Force medical service.

We are already incorporating nationally recognized benchmark processes to design and construct buildings with sustainable design elements, such as increased natural day lighting, recycled or recyclable materials, and optimized energy performance.

We have established a rigorous system to capture and compare energy consumption data from all of our major facilities using the Energy Star measurement tool, and this system is already up and running at the majority of our medical facilities.

And finally, we recognize that caring for our airmen, soldiers, sailors, Marines, and their families in safe and well maintained medical facilities is both our duty and a national priority.

I assure you that the Air Force is meeting these expectations. All 74 Air Force medical facilities undergo regular and thorough inspections, both scheduled and unannounced, by two national accreditation organizations, the joint commission and the Accreditation Association for Ambulatory Health.

All Air Force medical facilities have passed inspection and are fully accredited.

Again, we thank you and look forward to your continued strong support in this critically important task, and I look forward to your questions.

Thank you.

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

Mr. ORTIZ. Thank you, sir.

Admiral Robinson.

STATEMENT OF VICE ADM. ADAM ROBINSON, USN, SURGEON GENERAL, U.S. NAVY

Admiral ROBINSON. Good afternoon, Chairman Ortiz, Chairwoman Davis, Ranking Member Wilson, distinguished members of the committee.

Thank you very much for the opportunity to testify before you today on the prioritization of military construction of medical facilities.

Your unwavering support of our service member, especially those who have been wounded, is deeply appreciated.

Navy medicine continues making significant strides in enhancing both living quarters and medical treatment facilities for our sailors and Marines. The military health systems capital investment decision model was implemented in May 2008 and was used in the pro-

gramming and budgeting of military construction projects slated for construction beginning with fiscal year 2010.

This new system serves all the services by carefully evaluating proposed medical MILCON projects through a rigorous capital investment prioritization method across the entire enterprise.

In addition, the new methodology allows more costly projects to receive the funding they need by harnessing the global, enterprise-wide perspective to effectively prioritize scarce resources.

Another positive aspect of the CIDM prioritization process is the inclusive representation of those who care for our war fighters as members of the military health systems capital investment review board (CIRB).

Clinicians, health system managers, resource managers and health care facility experts from the services and from TMA are all voting members of the capital investment review board. They represent their services or TMA and play pivotal roles in creating an enterprise-wide assessment of projects needed.

As Navy Surgeon General, I, as well as my Army and Air Force colleagues, can engage the capital investment decision model process to clearly articulate our views and priorities to all the members of the CIRB for consideration and deliberation.

The CIDM and the CIRB delivered the integrated military health system priority list of projects for the programming period from 2010 through 2015. The services surgeon generals and the TRICARE Management Activity came to a joint agreement on the top priority construction project, and it is the Naval Hospital Guam replacement.

This antiquated facility was built in 1954 and has survived 55 years in tropical climates.

The new prioritization system allows us to maximize our limited project planning money by focusing on projects that are considered by all to be a major priority and the best and most efficient use of limited resources.

Distinguished members of the Readiness and Military Personnel Subcommittees, thank you again for the opportunity to testify before you today on the positive results Navy medicine has experienced from the new medical MILCON prioritization process.

I believe that the military health systems' CIDM and associated CIRB, as implemented to date, offers the military health system enterprise the best overall means to properly prioritize military medical projects.

In addition, this new process ensures projects of the highest relative merit are consistently programmed, budgeted and executed first in a coherent fashion, while still ensuring the focus of the entire MILCON evaluation process remains where it should always be, namely, the health care needs of our sailors, our Marines, and their families, as our number one priority.

Thank you very much.

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

Mr. ORTIZ. General Schoomaker.

STATEMENT OF LT. GEN. ERIC SCHOOMAKER, USA, COMMANDING GENERAL, U.S. ARMY MEDICAL COMMAND, SURGEON GENERAL, U.S. ARMY

General SCHOOMAKER. Chairman Ortiz, Chairwoman Davis, Representative Forbes and Representative Wilson, distinguished members of the Readiness and Military Personnel Subcommittees, thank you for inviting me and my colleagues here to discuss this really important subject today of our medical infrastructure.

Before I go on, I would just like to take a moment to introduce my battle buddy, my Command Sergeant Major Althea Dixon. Although we are talking about buildings, brick and mortar today, I think we can all agree that the centerpiece of our formation are our people.

And the Army has declared this year the year of the noncommissioned officer, the NCO, and probably nobody better symbolizes the NCOs of our Army than my senior medic here to my left, who has kept me honest and on track for a number of years now.

The condition of our military medical facilities speaks volumes to our staff and our beneficiaries about how much the Nation values their service and their well-being. In fact, I used these exact words when I turned the soil with my colleagues at the new hospital at Fort Belvoir.

The most tangible evidence of the Nation's investment in the health and well-being of our people are the facilities that we build for them.

As I testified before the two Defense Appropriations Subcommittees last year, medical facility infrastructure was and remains today one of my top concerns.

On behalf of the 130,000 team members that comprise the Army medical department throughout the world and our 3.5 million beneficiaries whom we serve within Army medicine, I really want to thank you all here and the Congress as a whole for listening to our concerns about military medical infrastructure and taking some significant action to improve our facilities.

With your help, I think we have made some real progress in the last year.

Funding provided for military hospitals in the fiscal year 2008 supplemental bill and what we hope to have in the American Recovery and Reinvestment Act of 2009 will positively impact the quality of life of thousands of service members, family members, retirees, as we build new world-class facilities in places like Fort Benning, Georgia, Fort Riley, Kansas, and San Antonio, Texas.

And I think we can all sit here and talk to you about the abysmal state of some of our facilities, but I don't want to get in a contest with my colleagues here. We all are working very, very hard to raise the quality of our facilities and, while doing that, using our Sustainment, Restoration and Modernization (SRM) dollars to maintain the safety and the reliability of even these aging facilities.

Modern new facilities not only stimulate the local economy, they energize the hospital staff who work in these new spaces and they comfort the military beneficiaries who seek care in them. They become healing environments for our patients and they inspire confidence in their families.

As a child who was raised in and around Army hospitals and clinics myself, a husband and a parent of an Army family who has received care in these same and some newer medical treatment facilities, and as an Army physician who has served and commanded a variety of hospitals, I can tell you I have witnessed firsthand the impact that improvements of our infrastructure made.

I was one of the first chiefs of medicine at the new hospital that we opened in 1992 in Madigan Army Medical Center at Fort Lewis, Washington and I helped lead the transition from that.

The impact of that new facility was really nothing short of startling.

The old hospital, although it was beloved for this sprawling one-story cantonment facility, it covered many, many acres and miles and miles of corridors, it was really a challenge for all of those who attended to the sick and for our patients, as well.

And the new hospital, when we built it, was sited such that it either looked out over Mount Rainier or the Olympic Peninsula, and it had an instantaneous effect on patients.

It created a sense of patient and family-centered care and patient-friendly waiting areas and clinic spaces, the impact of all that light and fresh air, and even the selection of photographs, of artistic photographs that we had really was instantaneous on patients.

I saw it in my patients' faces, I heard it in the voices of their families, and I witnessed it in the renewed energy of our staff.

We really had little difficulty, following opening that building, attracting trainees into my department and we used it as a major recruiting tool for Army medicine, and continue to this day.

The three services and the TRICARE Management Agency have worked hard to develop an objective process for prioritizing medical MILCON requirements through this capital investment decision model. I won't go into it at length. You have heard about it from my colleagues.

But its criteria focus on supporting all of our needs simultaneously and, also, targets the heart of health care, looking at the need for functional modernization and customer and patient-centered care, our productivity and how we use our space.

In 2008, we in the Army participated in the development of the first version of this prioritization model and I believe it really is a step in the right direction. But it requires continuous development and refinement.

The Army is challenged, as all my colleagues have described, with aging facility infrastructure, with growing workload, and caring for a large portion of our DOD beneficiaries. We maintain about 40 percent of the total inventory of medical buildings, 1,800 in total, of which 386 are direct health care facilities with a replacement value of about $9 billion.

Our critical priorities right now for hospital replacement are at Fort Hood, Texas and Fort Bliss, Texas, Landstuhl, Germany, Fort Irwin, California, and Fort Knox, Kentucky.

We have identified requirements for another 12 hospital expansions, 25 health and dental clinic replacements or expansions, and 16 force projection projects. These are research facilities and blood centers and preventive medicine clinics and training facilities.

As Landstuhl Regional Medical Center, which many of you, if not all of you have gone through and probably been impressed by its critical role in evacuation of casualties back home, approaches its 56-year anniversary, we see this as a critical need for replacement.

Landstuhl is an enduring part of our evacuation and treatment plan for wounded, ill and injured soldiers throughout the world and I would ask you to consider it as a significant infrastructure need.

We also continue construction on a state-of-the-art replacement facility for the United States Army Medical Research Institute for Infectious Diseases, the hot zone up in Fort Detrick, Maryland. This is part of a national interagency bio defense campus that has partnered with the National Institute for Allergy and Infectious Diseases, the Centers for Disease Control and Preventive Medicine, the Department of Homeland Security, and the United States Department of Agriculture.

It is a realization of a post-9/11 vision that brings vastly different and new government agencies together for a common cause. Providing appropriate facilities for this and other areas of medical research are just as important as our hospitals and contribute greatly to the readiness of our soldiers and the defense of our country.

I respectfully request that we continue the support of the DOD medical construction requirements that deliver treatment and research facilities that are the pride of this Department.

In closing, I want to thank you on the Readiness Subcommittee for your interest in this issue and the Military Personnel Subcommittee for your vigorous and enduring support of the defense health program and of Army medicine.

I greatly value the insights of the Armed Services Committee and look forward to working with you and your staffs over the next year.

Thank you for holding this hearing and thank you for your continued support of the Army medical department for our warriors and our families.

[The prepared statement of General Schoomaker can be found in the Appendix on page 68.]

Mr. ORTIZ. General, thank you so much. And we want to thank all the witnesses and all the staff for the fine work that you have done and will continue to do for delivering the best that you can medically for our soldiers.

Mr. Potochney, let me ask you a question. On Monday, we had the opportunity to visit Bethesda and see the magnificent care that is being provided to the wounded warriors, and, frankly, I was very, very impressed. So were the members who were with us on this tour.

We were also briefed on the magnitude of the BRAC effort associated with the realignment of Walter Reed. We were told that the moves associated with this realignment would occur in August 2011, one month before the statutory deadline.

Maintaining the quality of care that exists today is extremely important. Now, how important, in your estimation, is meeting the September 2011 deadline and what steps will be put in?

I have been here several years in the Congress. I am just wondering, how did we get to the 2011 date? Was it you in the medical

field? Was it DOD? How did we get to that date, 2011? Was it the BRAC commission?

Maybe that is the first question that we would like to know.

Mr. POTOCHNEY. I will take the first shot at it, if I could, sir. The Department is implementing the BRAC commission recommendation on the schedule that it established.

A year and a half ago or so, the Department also decided to enhance and accelerate, but mostly enhance, some of the construction and the facilities at Bethesda, which has stretched out some of the construction.

So the Department itself, and we can't blame it on the commission, has decided upon a construction schedule, a facilitization schedule that brings us bumping up against the end of the statutory six-year period, which is September 2011.

That is the answer to your first question, sir, I believe. Yes, we did it.

Mr. ORTIZ. The thing is this, I know you are going to receive the hospital when the construction is finished, but then you are going to have to buy a lot of equipment and a lot of equipment would be there, there would be testing on the equipment.

Is it realistic to say that by September 2011, not only will the hospital be finished, but that you will also have all the equipment to start functioning as a first class hospital?

Mr. POTOCHNEY. Yes, sir. I wouldn't argue that it is an aggressive schedule and it is a challenge. Admiral Madison, who you all met on Monday, is confident, and we have spoken at length about this, that while it is aggressive and it is a challenge, he can do it and he wants to do it that way.

He will have equipment delivered before then and the hospital will be run through its paces. But the actual transition of patients over into the new facility will happen in a compressed period of time within the statutory deadline.

Why is it a compressed period of time? Admiral Madison feels strongly, based on his own opinion and the research that he has done, that doing it in a compressed period of time is the best for the patients.

In other words, if you will permit me, it is do it in a concentrated effort, get it over with quick, so you are back up and running as fast as you can, and that is his position.

Mr. ORTIZ. So you feel comfortable that by the date of September 2011, you will be running smoothly and ready to go.

Mr. POTOCHNEY. Yes, sir. But I can't say that we are not wary and exercising a fair amount of vigilance to make sure that it remains on track.

Mr. ORTIZ. We want to be sure that this does not degrade the quality of care. This is why earlier I said what we would like to do—and I don't want you to feel pressure from me or from some of the members here—we want you to do it right.

Mr. POTOCHNEY. Yes, sir. So do we.

Mr. ORTIZ. And this is more important than anything of meeting a deadline. But it will not degrade the quality of care that you are going to——

Mr. POTOCHNEY. Yes, sir. We have signed up to that and right now we are on a schedule that we can meet.

If something changes, I am sure you will be seeing that as quickly as we are.

Mr. ORTIZ. And just like I stated earlier, we walked into the hospital and we were so impressed. For once, I saw something that I said, "My God, they have it right," the way you are giving treatment to the warriors.

I don't want to take too much time, because we have got a lot of members here who have a lot of questions.

But I would like to turn it over now for questions to my good friend, the chairperson of the Military Personnel Subcommittee, Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman.

Again, thank you, all of you, for being here and for your service to our country.

General Schoomaker, I wanted to ask you about any limitations that the Army may have providing care as a consequence of an undersized or antiquated military treatment facility.

The issue really is that if we have an MTF commander who feels a need to send a beneficiary downtown, for example, because they can be treated in the facility for whatever reason that might be, perhaps it is because they would get treatment sooner if they did that, if they went to another facility.

Does the MTF then not get credit for that workload and can that come back at some future time to suggest that the workload isn't as great as they might be representing? How might it affect future budgets down the line?

How does the decision-making around that impact future budgets or even the workload generally?

General SCHOOMAKER. Well, ma'am, I think that is an excellent question. I would say in the past, we would have been much more focused on what I call how many widgets of health care we build and deliver in sort of a simple productivity model.

But I think that led to some bad clinical and business practices, not the least of which was an impetus to hospitalize people when perhaps management in an ambulatory setting was much more important.

What we in Army medicine are doing, and I am pleased to say that we, across the Military Health System (MHS) are doing increasingly, is shifting to a model that really looks at the total outcome of care and asks the question, "What is best for a patient and what does the patient need for that particular condition and/or what can we do to prevent the beneficiary from being a patient at all by doing preventive measures."

And so we are shifting a lot of our resources and our revenue generation, if you will, toward prevention and toward outcomes.

I, frankly, spend more time with my commanders, regional commanders and, through them, my medical treatment facility commanders, focusing on, "Are you practicing good evidence-based medicine? Are you practicing good preventive medicine," and not whether they are shifting work downtown or keeping it within the hospital.

Mrs. DAVIS. Is there a lot of care that is being shifted? How would you characterize the kind of care that needs to be diverted from a major facility?

General SCHOOMAKER. Well, we still perform the vast majority of the care, both inpatient and ambulatory care, within the direct care system. We are sending more cases of patients that are enrolled in our facilities downtown, as we are taking care of more wounded, ill and injured soldiers, as we are more intensively placed in there, as we deploy our own caregivers to theater of operation and don't prompt replacement because of hiring lags and the like.

But those are the dynamics that generally—and then there are highly specialized care that may be given, say, in South Carolina at Columbia. We won't necessarily have highly specialized cancer care or something and so we lean upon or we depend upon our colleagues in the VA and Columbia or in the private sector to deliver that care.

That is really kind of the rubber band between the direct care system, as we call it in our uniformed services, and our TRICARE managed care support contractors.

Mrs. DAVIS. I know in certain areas it is going to be more than others, but is there a way of saying that a third of the care, a quarter of the care?

General SCHOOMAKER. No, ma'am. I would say my ballpark would be across Army medicine, I would estimate that probably no more than about 20 percent of the care that we enrolled in our hospitals is going downtown and that shift to downtown for specialty care or when families are displaced by soldiers that are growing in the community, that is occurring in a minority of the cases.

Does that answer your question, ma'am?

Mrs. DAVIS. I think so. I think part of the concern is I think initially is that there is—is there a reluctance to even send a beneficiary for care someplace else?

General SCHOOMAKER. Yes, ma'am. I think there is very much a reluctance, in part, because when we use the network of care, if I have enrolled—we use very, very strict enrollment models to ensure that our hospitals do not over-enroll to their capacity to deliver primary care, which is the principal driver for getting sub-specialty care.

There is a reluctance to send our enrollees into the network, for a number of reasons. Number one, it disrupts continuity of care. Number two, we don't have the information systems that give us ready access to what is done downtown and it may take us a month or longer sometimes to get information back about the patient that has gone downtown.

So is there a reluctance? There is, but I have given direct and specific orders to all of my subordinate commanders that they will not compromise access standards under the TRICARE published access standards in order to hang onto a patient that should go downtown.

Mrs. DAVIS. All right. Thank you. I appreciate that.

Kind of quickly, I think it has been mentioned, Dr. Casscells mentioned the fact that there are about 59 hospitals in the military health system.

And how many of those, Dr. Schoomaker, are Army of those 59?

General SCHOOMAKER. I have a total of how many 36—35, 35 hospitals in the Army.

Mrs. DAVIS. When you look at the system that is being used now in terms of the prioritization, and we, obviously, have representation here in Congress, no matter how many issues we have, we have one vote on a particular issue.

Does that in any way compromise the outcome whether or not you could move and each have a single vote as opposed to a collective vote on those issues or even a proportional vote?

General SCHOOMAKER. Well, I have suggested that I get the entire vote, but that didn't go over very well with my colleagues.

Ma'am, I think this is one of the really tough things about running the CIDM process is trying to decide the strategic value of various installations and various facilities and ensuring that, as a Department, that we don't leave someone behind simply because they don't have a constituency.

You heard my comments about Landstuhl. I think you heard Admiral Robinson's comments about Guam. It is very hard to get a constituency for some of our Outside the Continental United States (OCONUS) facilities, even though they may have strategic value to the force.

So I look at the CIDM process, I characterize it the way we look at personnel sometimes, we are not happy until everybody is equally unhappy.

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

Mr. ORTIZ. Mr. Wilson.

Mr. WILSON. Thank you, Chairman Ortiz.

I want to join you and my colleagues for the opportunity that we had to meet with Admiral Madison and his staff. It was really exciting to me, just as it was for you, to see the dedicated staff.

They were so interested in the wounded warriors, each one. They were so proud of the progress that they were making. It just made you feel so good to see the extraordinary planning and thoughtfulness put into the individual care given to each one of these young people who make such a difference for our country.

Additionally, for each of the surgeon generals, I think you should be—I want to thank you for making military medicine some of the most advanced in the world.

It is looked to around the world as leading the efforts in terms of prosthetics, in terms of trauma care, in terms of preventive virtual medicine, on and on. I wish the American people knew of how extraordinary military medicine is and the challenge that you have.

And for each of the surgeon generals, and you have touched on this, but all of you have hospitals and military facilities that would be considered old by any standard.

How do you each of you prioritize the facilities that you submit to the military health system MILCON prioritization process and what are your top priorities for medical MILCON for the next five years?

Admiral, I had the opportunity to fly over, I didn't actually visit, the Naval hospital last month at Guam, but I am very happy, as the Marines are being relocated there, to hear that that is proceeding.

Admiral ROBINSON. Yes, sir. Thank you very much for the opportunity.

Guam is proceeding. I think that Guam represents the overseas OCONUS facility that doesn't necessarily have the constituency, does not necessarily have the TRICARE network downtown that can take care.

Not suggesting a network doesn't exist, but it doesn't have the robust network that a CONUS facility may have.

So the point is that the educational, development, instructional programs, the exceptional family member programs, the programs that are related to specialty care with the network, all of those programs may be at either lesser condition or may not exist OCONUS, which then makes those facilities a top priority, from a Navy medicine perspective, because then I would have to make sure that the men and women and families there are cared for appropriately in that particular geographic location.

I also think, related to the question of network care and going downtown, network care and access standards are always going to drive how we do business, and they should.

At the same time, the reasons that patients often don't want to go downtown or we send them downtown is that they don't want to go down, they would rather stay with us.

With that said, we will never degrade care or get into a quality issue with the patient related to an access standard.

I would suggest that if we could relook at network and how we run military networks within a geographic area and give more responsibility to local commanders with the network, that there could be a more seamless and effective method of how we would actually run our patients and the network, both from the direct and the purchase care side, so that we could have a better and a much easier system of care, and I think the continuity and the quality would follow.

General ROUDEBUSH. Mr. Wilson, I appreciate your question, because it helps me put things in context for the committee.

As I mentioned, a significant amount of our medical facilities were built within 15 years after the Air Force was established.

The Air Force is positioned across the United States, generally in small communities, and many of our medical facilities were, in fact, small hospitals.

But we very appropriately followed the U.S. medical model and we closed those small hospitals in favor of ambulatory clinics, because they didn't have the critical mass, they were costly, and, frankly, they were not safe.

They didn't have the caseload and complexity to maintain the currency that the staff would require.

So we followed that model and we have a significant number of ambulatory facilities, which really are in old inpatient chasses which have been modified over the years.

So those do, in fact, create a concern.

Now, I will tell you that we have 15 hospitals and we have leveraged our O&M dollars, as well as our MILCON, to maintain those platforms, although several of those come up on the priority list that you asked about, and two primary ones would be the Wilford Hall Medical Center, which, under BRAC, becomes a large ambulatory surgical center, as does the Andrews Hospital become an ambulatory surgical center.

So from an aging infrastructure standpoint, they need to be replaced, and from an alignment with BRAC, to assure that they are viable parts of that BRAC outcome, they need to be replaced.

So that is, in fact, driving our prioritization as we work through this process, along with other facilities in the 2010–2011 window, but that is where we find ourselves with aging facilities, but also the need to align appropriately with other activities, with our sister services and BRAC.

General SCHOOMAKER. Sir, we use a model of prioritization that is based upon three principal factors, what the current condition of the hospital or the facility is and how much it is going to cost to repair that.

Obviously, the more that is going wrong within a facility that we can't get back to a safe and high standard, then the more impetus to replace it.

We look at the population that is supported by that facility and what its capacity is to take care of that population, to include the population that is moving.

I think you all are aware that the Army right now is going through four simultaneous kind of word salads—Global Defense Posture Realignment, Grow the Force or Grow the Army, Army modularity, and Base Realignment and Closure—GDPR, GTA, AMF and BRAC are moving about 250,000 people right now, the largest movement of soldiers and their families across communities in a generation.

And so we are also looking at projected populations served by those facilities.

The last thing I will make a comment about, as General Roudebush says, although we tend to be sort of hospital-centric in our thinking, we are comprehensive in building facilities that attend to the health requirements and dental requirements and preventive medicine requirements and veterinary public health requirements of that community, and I don't think we want to lose track of that.

Mr. WILSON. Thank you very much.

In the interest of time, I will submit further questions, because we have votes.

Mr. ORTIZ. We will now allow Mr. Reyes to ask a question, because it will take 45 minutes before we come back and you are very important individuals. We don't want to keep you here.

So we will proceed with Mr. Reyes. Do you have a question?

Mr. REYES. Yes, Mr. Chairman, thank you.

Secretary Casscells, the Navy surgeon general stated in his opening statement that the replacement of the Naval hospital at Guam is the top military construction priority identified by the capital investment model.

Can you share that report with our committee and, also, can you tell us how new missions, like expansion or Grow the Army and return of overseas troops are accounted for in that model?

Secretary CASSCELLS. Mr. Reyes, I will be able to share the detailed analyses that Admiral Robinson mentioned in just a few weeks' time.

I can say, as a general matter, that Grow the Force and Grow the Army initiatives are generally paid for by the Army, not by the defense health program.

The defense health program pays for the bulk of the replacement and maintenance of these facilities, but those two initiatives are really line initiatives.

We work closely with the services, for example, Fort Bliss, as you know, and Fort Sam Houston, which are both impacted by multiple Army initiatives, transformation, Grow the Force and so forth.

So all the cards are on the table when we make the—when the military health system makes its decision.

As you know, it is a process that the surgeons and I jointly devised and we jointly participate in with our staffs, equal votes. And I must say these are some tough calls, but we have ended up in unison on these so far.

What we hope to be able to tell you in a few weeks is the detailed results of that as part of the President's budget and, hopefully, a year from now, those who will still be with you, like General Schoomaker, will be able to tell you whether the capital investment decision model is, in fact, the plus that we think it is right now.

Right now, it is promoting communication and transparency and unity. So far, it looks good.

Mr. REYES. Well, it doesn't look too good from where I am sitting, because Fort Bliss is about to quadruple in size, in troop size. We are going to have 100,000 to 125,000 people that are going to depend on the facility there, which was designed to accommodate about 12,000 troops.

So my concern, and this is why I asked the question, my concern is being up there as the next priority, because if we are not, then we are not going to have a medical facility ready and prepared for all the troops that get assigned to Fort Bliss.

I had a discussion with General Schoomaker earlier on that and he has promised to get back to me on several questions that I had. But there has got to be a way to factor into your formula, into your decision, facilities like mine that don't have adequate medical facilities and are going to grow the way they are.

So I hope you take that into account and I am going to follow up with both you and General Schoomaker in the next week or so.

Secretary CASSCELLS. Yes, sir. May I just follow on and say that my medical privileges as an Army Reserve doctor are at William Beaumont and I know it well. I know its shortfalls. That was where my pre- and post-deployment experiences were. I have been a patient there, and I absolutely agree with you.

I can only say that our understanding with the Army now is that they have got that covered, but it is our obligation collectively to make sure that that comes true.

Mr. REYES. Very good. Thank you.

Thank you, Mr. Chairman.

Mr. ORTIZ. Thank you so much.

I would like now to allow members—I am sorry.

Mr. Kline, do you have a question?

Mr. KLINE. I do, Mr. Chairman, thank you very much. I will just get the answer for the record once I ask for a nod.

General Schoomaker, you mentioned there are three services, and, of course, there are, that provide medical services. But there is a fourth service that uses those medical services, generally, in the responsibility of the admiral.

But I know, from my past experience, there are a lot of Marines who live down at Quantico who go to Fort Belvoir because there is no Naval hospital at Quantico, and we are building a new facility there, as we are BRACing Walter Reed and so forth.

And I just want to be reassured that CIDM and the system is accounting for that fourth service.

And there will not be time for an answer, because we have got a vote. But if the system accounts for that, then we are on track. But it is an Army hospital. It has got a lot of Marines and other service, but particularly because there is a very large Marine contingent at Quantico, if somebody will just tell me that the system has accounted for that.

[The information referred to can be found in the Appendix on page 77.]

Secretary CASSCELLS. Absolutely, absolutely.

Admiral ROBINSON. It not only does, because Guam is a number one priority partly because of the Marine growth at——

Mr. KLINE. I understand that, but that is because of Marines living there at Guam. This is a little bit different situation.

We have got a vote. I am going to yield back, but I would like to follow up with your staffs on how that works.

Thank you.

Mr. ORTIZ. Thank you so much.

What I would like to do is to allow other members who couldn't be here to submit questions for the record, and I know that there are many questions.

I wonder if my good friend, the chairwoman of the personnel—do you have any statement?

Thank you so much. You were outstanding witnesses today.

The hearing stands adjourned.

[Whereupon, at 3:14 p.m., the subcommittees were adjourned.]

A P P E N D I X

March 18, 2009

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 18, 2009

Readiness Subcommittee
Opening Statement of Chairman Solomon Ortiz
Joint Hearing with Military Personnel Subcommittee on Medical Military Construction
March 18, 2009

"The subcommittees will come to order. Today, the Readiness Subcommittee and the Personnel Subcommittee meet in a joint session to receive a briefing on how the Department is managing their medical military construction program.

"As our nation responds to differing threats, we adapt and change our strategy and the force structure of our military. One of the most recent decisions to change our force structure has been to expand the Army and Marine Corps and add 74,000 soldiers and 27,000 marines.

"The Services have been steadily applying facility funds to accommodate this growth but some areas are significantly lacking, including medical facilities to support the growing forces.

"It is imperative that the men and women that join our armed forces are provided the best medical care possible. To this end, I am glad that we provided almost $1.3 billion to support medical facility deficiencies in the stimulus bill.

"I hope that the witnesses will take the opportunity to address the Department's investment priorities and how they are managing to address medical facility needs for all of our growing installations.

"On a related point, our subcommittees had the opportunity to visit Bethesda yesterday and we were amazed at the resilience of our wounded warriors. To receive men and women at Bethesda within 48 hours of a casualty, from anywhere in the world, is an amazing feat – very impressive.

"This capability that exists today will be particularly challenged when the Walter Reed complex is realigned to Bethesda and Fort Belvoir. We were briefed that the majority of care will be moved from the Walter Reed campus in August 2011.

"With the construction of almost $2 billion in the National Capital Region, in addition to commissioning the facilities and installing complex equipment, this will be a difficult task.

"A smooth, seamless transition from Walter Reed to Bethesda and Fort Belvoir is essential to ensure the quality of care to our wounded warriors.

"The Chair now recognizes the distinguished chairwoman from California, Ms. Davis, for any remarks she would like to make."

Military Personnel Subcommittee
Opening Statement of Chairwoman Susan Davis
Joint Hearing with Readiness Subcommittee on Medical Military Construction
March 18, 2009

"Thank you, Chairman Ortiz, Mr. Forbes, and Mr. Wilson for this joint hearing of the Readiness and Military Personnel Subcommittees. The Military Personnel Subcommittee is tasked with oversight of the Defense Health Program, and the Readiness Subcommittee with the oversight of military construction. While our staffs may already spend lots of quality time together on this topic, it is good that we are meeting jointly to receive testimony and explore the issue of medical military construction.

"As Chairman Ortiz mentioned, it is vital that we program and build the infrastructure required to support the expansion of the Army and the Marine Corps. It is our responsibility to ensure that our service members and their families have the facilities they need from the outset, and not be forced to wait years before these facilities are even programmed, let alone built. We must also ensure that the recommendations of the Base Realignment and Closure Commission are implemented.

"Yet another reason to have this hearing is the fact that medical military construction is handled differently by the Department of Defense than all other MILCON. That is not to say that it is bad-different or good-different, just different.

"Consequently, it is both appropriate and responsible oversight for our two subcommittees to examine this process so that we may understand exactly how the Department analyzes, prioritizes, budgets, and then builds medical facilities. We must also keep in mind the long-term, enduring costs of maintaining these facilities once they are completed.

"Today we will hear from all of the relevant parties within the Department of Defense. Dr. Ward Casscells, the Assistant Secretary of Defense for Health Affairs, will describe how Health Affairs/TRICARE Management Activity prioritizes projects. Mr. Peter Potochney, Director of Basing for the office of the Deputy Under Secretary of Defense for Installations and Environment, will speak to BRAC issues. Finally, and importantly, we will hear from the service surgeons-general, Lieutenant General Roudebush from the Air Force, Vice Admiral Robinson from the Navy, and Lieutenant General Schoomaker from the Army, how well the current process supports their requirements. Gentlemen, welcome.

"Throughout our conversations today, it should go without saying that all of us, both members of the legislative and executive branches, are committed to providing the best care possible to service members, their families, and our retirees. Chairman Ortiz rightly mentioned the impressive feats that our Military Health System has made routine.

"On Monday we met and spoke with a wounded warrior at Bethesda. Given how recently he was wounded, and the type and extent of his injuries, it was awe inspiring to see how far he has come so quickly. All of his caregivers agreed that just a few years ago any recovery, let alone one this dramatic, would have been all but impossible.

"That the standard of care has risen to such a high is a testament to the commitment displayed on a daily basis by everyone who is associated with the Military Health System. We must all do our part to make sure this trend continues."

Readiness Subcommittee
Opening Statement of Ranking Member J. Randy Forbes
Joint Hearing with Military Personnel Subcommittee on Medical Military Construction
March 18, 2009

"I thank the chairman. I also thank the witnesses and appreciate their being here to discuss a vitally important topic—building the best facilities possible to provide medical care for our troops, their families, and retirees.

"As you know, Chairman Ortiz, Chairwoman Davis, Ranking Member Wilson, other members and I visited Bethesda Naval Medical Center on Monday to get an update on the construction at Bethesda and Ft. Belvoir and to visit with wounded warriors and their families. As always, I was inspired and uplifted by these troops.

"After the difficulties the Army experienced a few years ago at Walter Reed, the military services are correctly placing strong emphasis on all aspects of wounded warrior care. That emphasis was evident during our visit and in our conversations with several wounded warriors and their families. I applaud these efforts.

"It was also apparent from those discussions how the military services take different approaches to wounded warrior care that fits with the culture and ethos of the individual service. I commend the Commandant of the Marine Corps for enforcing certain standards for his Marines, as do the other service chiefs for members of their services.

"Although we've integrated many aspects of military medicine, not every aspect of military medicine requires a joint approach. I'm not sure putting the Office of the Secretary of Defense in charge of all medical military construction is the best way to meet individual service needs. I understand that each of the surgeons general has input, but I will need to be persuaded that the current system leads to the best results.

"Sometimes corporate decisions are not in the best interest of the service; in most cases, it's better to have the customer responsible for resource allocation for important functions. Military medical facilities may well fit into that category, but I am willing to keep an open mind on the subject.

"I would like to note I was very impressed with the work at Bethesda and commend the Army and the Navy for continuing to provide outstanding care for our nation's heroes and their families.

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

Military Personnel Subcommittee
Opening Statement of Ranking Member Joe Wilson
Joint Hearing with Readiness Subcommittee on Medical Military Construction
March 18, 2009

"Thank you Chairwoman Davis. I appreciate joining our good friends on the Readiness subcommittee today, led by Chairman Solomon Ortiz and Ranking Member Randy Forbes, for our hearing on military medical construction. I welcome the distinguished members of our witness panel.

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

"With that being said, I understand that there are a number of military treatment facilities that are thirty or more years old. In the district I represent in South Carolina, Moncrief Army Community Hospital at Fort Jackson was built in 1972 and the Navy Hospital at Beaufort was built in 1947.

"I know that the outstanding medical personnel in each of these facilities provide excellent care to our troops and their families. On personal tours of each facility, I have been very impressed by the dedicated and competent professional personnel I have met. I also know that as a medical facility gets older it is more challenging to keep up with advances in medicine.

"As I prepared for the hearing today, I was reminded that the planning process for military medical construction is very different than for other types of construction within the Department of Defense. I am interested to hear from our panel why medical construction is unique within the Department.

"To that end, today I hope to hear from our witnesses how the Department and the military services plan to spend medical construction dollars to either replace or modernize our military hospitals. The members of our armed forces deserve the best.

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

PREPARED STATEMENT

OF

S. WARD CASSCELLS, MD
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEES ON MILITARY PERSONNEL AND READINESS

MARCH 18, 2009

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

Madam Chairwoman, Mr. Chairman, good afternoon and thank you for the opportunity to share with you the some of the progress we have made to improve our medical facilities within the Department of Defense (DoD).

I am pleased to be joined today by the Surgeons General and Peter Potochney representing Mr. Wayne Arny, each of whom has shared their commitment to improving the quality of our built environments – whether they be hospitals, clinics, training centers, research laboratories, or mission support facilities.

Lieutenant General Schoomaker, Lieutenant General Roudebush, and Vice Admiral Robinson and I are all physicians. Together we have many years of experience in caring for patients, sometimes in the finest facilities in the world, and at other times in a tent in a war zone or ship at sea. Some of us have been patients, too, and we know what it feels like to lie in a hospital bed with an uncertain future. And we all experienced the satisfaction of sharing good news with a patient's family, and the sadness we feel when the news is not so good. Having spent so much time in health care facilities, we all recognize their contribution to the delivery of care.

Our buildings can enable or impede the work that occurs within their walls. They can be institutional in appearance, inefficient in size or configuration, and not able to readily adapt to constantly evolving technology, clinical practices, and patient expectations. Or they can be safe, efficient, and welcoming – providing the environment that conveys the message to our patients, their families, and our staff, that we understand their needs and will do everything possible to meet them.

My goal today is to apprise the members of this committee of our approach to creating the facility infrastructure of which we can all be proud. I hope to achieve this goal by providing you with a clear understanding of how the DoD and the Services collaborate to overcome the many challenges we face in our efforts to acquire and operate our medical facilities. You will learn of the transformational changes we have made to improve our capital investment decision-making and gain some insight as to its positive impact on our future. And I sincerely hope you will leave today knowing that there are many motivated, capable people -- in the DoD, the Army, the Navy, and the Air Force -- striving together to

acquire and apply the knowledge and best practices necessary to make our buildings the very best we know how.

The Current State of Medical Facilities in the DoD

The DoD acquires, maintains, and operates a unique collection of medical facilities around the globe. By any standard, this facility inventory could be described as large, complex, diverse, and aging. The current inventory consists of over 1,000 major facilities and includes:

- 59 hospitals
- 663 medical and dental clinics
- 258 veterinary clinics
- 26 medical research and development facilities
- 19 training facilities
- 10 medical installations

The majority of military medical facilities are well-maintained from a facilities standpoint, Recapitalization of this large and diverse set of complex buildings poses substantial challenges. About 41% of our inpatient facilities are over forty years old and 72% were constructed more than twenty years ago. Most of our hospitals were constructed prior to the introduction of modern and ever-changing clinical processes and technology that today are considered the standard of care.

The Importance of DoD Medical Facilities

I believe our medical facilities are a strategic national asset. Our buildings support the vital, diverse, and worldwide mission of the Military Health System (MHS). We need outstanding facilities to deliver patient care, train medical professionals, conduct cutting edge research, and provide the support functions necessary to succeed on the battlefield and protect our nation.

Health Affairs as Facility Advocate

Let me be clear that, in my role as the Assistant Secretary of Defense for Health Affairs, I am a strong advocate not only for military medicine and the people who make it succeed, I am also a committed to dramatically improving our facilities. I take this responsibility seriously and have worked with the Surgeons General and others in the DoD to raise our own bar and ensure my conviction that high quality facilities are essential to the success of our Armed Forces and the security of our nation.

There are many others in the Department that share my perspective. You may recall that, in May of 2007, Secretary Gates stated, *"Our nation is truly blessed that so many talented and patriotic young people have stepped forward to serve. They deserve the very best facilities and care to recuperate from their injuries and ample assistance to navigate the next step in their lives, and that is what we intend to give them. Apart from the war itself, this Department and I have no higher priority."*

We provide life-saving services to both the toughest war fighter and the most vulnerable newborn. The work we perform in our facilities affects the readiness of our forces, the well-being of their families, and their willingness to continue serving our nation. Our facilities represent the tangible commitment we make to our active duty service members and their families. Investing in our buildings tells people that we care about them. Where our facilities fall short, we send a signal that taking care of our people is not a high priority.

Health care is one of the few functions performed within the DoD that can be compared directly to our civilian counterparts. We must compete with the private sector for the loyalty of our patients. The perceived quality of our facilities can often influence the perception of the quality of care we deliver. In those instances where these perceptions have not been favorable, patients and families have demonstrated a willingness to seek other options for their care. In order for the MHS to succeed, we need a diverse and robust

mix of patients coming through our doors to train and maintain the readiness of our medical staff and our deployable medical capability.

Modern hospitals are expensive and complex environments where information systems, cutting-edge equipment, and trained staff converge with the basic human needs, fears, and hopes of our patients and their families. We operate hospitals 24 hours a day, every day, and in so doing continuously consume millions of dollars in supplies and pharmaceuticals, feed thousands, park hundreds, run utility plants and laundries, process the deceased, comfort and provide a place for spiritual healing for families, while treating hundreds of thousands of patients, including our war wounded. We are subject to inspection and accreditation by outside entities and must meet their standards in order to continue operations. Our facilities are among few others in the DoD subject to outside civilian review to confirm their accreditation in striving for world-class health care. Allow me to take a moment to express my appreciation for the Congress and your efforts to provide focus on our facilities. As one recent example, the engagement of Defense Health Board and their independent design review of the National Capital Region Base Realignment and Closure (BRAC) projects. I welcome their soon to be published assessment and recommendations, which we expect to receive this month. We are certain they will confirm our investment strategy, and provide guidance for further improvements we intend to make to improve service and care.

As we learn more about the impact of the built environment on human performance, we find ways to balance the provision of care that combines "high tech" with "high touch". I can assure you that my experience on both sides of the patient bed has confirmed for me the absolute necessity to design and operate our facilities in ways that fully support the human needs of our patients, their families, and our medical professionals.

The potential also exists for adversaries to unleash chemical or biological weapons on distant battlefields as well as on our own soil. As part of our mission, the MHS must also address the national security imperative to replace unique but costly, biological, and chemical research facilities. DoD is committed to conducting the advanced research necessary to counter such threats. The Department has recognized the need to construct the

facilities necessary to better understand these dangerous agents and develop preventive and therapeutic interventions. Currently underway are replacements for the U.S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, MD, and the U.S. Army Medical Institute of Chemical Defense, located at the Aberdeen Proving Grounds, MD. These two facilities represent an investment in excess of $1 billion. Neither facility may ever treat a patient, but the work performed there may save countless lives of combatants and civilians.

Finally, our buildings typically cost more to design, construct, and operate than other facilities within the DoD inventory and must be resourced to keep pace with the increasingly dynamic world in which military medicine operates today and in the future. Just as we have a responsibility to care for our people, we also must serve as stewards of the resources provided by the American taxpayer. We must provide and operate truly excellent facilities but do so in a fiscally responsible manner. Striking this balance represents a significant challenge, but one I am confident we can meet especially if we all take an advocate and stewardship role.

Given the importance, cost, and complexity of our medical facilities, it is essential to strive for the knowledge and best practices and apply them to our buildings. We must also obtain the resources necessary to ensure we acquire and maintain the right mix of modern hospitals, clinics, research laboratories, training centers, and support facilities as platforms for the multiple missions of the MHS. Before addressing the actions we have taken in recent years to improve our infrastructure, I would like to provide some context that hopefully will help you understand the extent of our efforts to improve this vital national asset.

Historical Perspective for Facility Management in the MHS

Consolidation within the DoD of the three Service medical military construction programs followed the 1986 report of the *DoD Blue Ribbon Panel on Sizing of Military Medical Facilities.*

I think it is safe to say that prior to 1986, each of the Service medical departments did the best job possible in competing for resources from the line for their respective medical facilities. They faced stiff competition from their line counterparts, who also required buildings, weapons systems and other support directly tied to war fighting. This lack of support for medical facilities over the years was coupled with the lack of a coordinated approach to planning, design, construction, and maintenance and prohibited the MHS to deliver a uniform and consistent health benefit.

The Blue Ribbon Panel assessed the processes by which the Army, Navy, and Air Force each planned, programmed, and acquired their medical facilities. Among their findings, the panel noted an absence of:

- consistent cost models
- cost estimating standards
- common planning assumptions
- consistent functional and design criteria
- a coherent method to define priorities and select projects for funding
- central process and inventory management
- centralized advocacy

The findings and recommendations of the Blue Ribbon Panel led directly to the creation in 1987 of a central function to manage and coordinate the planning, programming, and acquisition of military medical facilities. Established under the Assistant Secretary of Defense (Health Affairs), this office has undergone organizational evolution over the years and is now organized as the Portfolio Planning and Management Division (PPMD) in TRICARE Management Activity (TMA). The staff of PPMD works closely with the respective facility offices in the Army, Navy, and the Air Force and coordinates with the other key stakeholders from within and outside the Department on all matters pertaining to health facility life-cycle management including planning, programming, funding, and acquisition. PPMD supports me in my capacity as the advocate and resourcer for the entire medical military facilities portfolio.

Since the consolidation occurred in 1987, most of the deficiencies reported by the Blue Ribbon Panel have been addressed and the medical military construction program has become more robust. But as the active duty forces were reduced following the end of the Cold War, the resources made available to acquire and renew our medical infrastructure were not sufficient to keep pace with demand, changes in codes and practice, new technologies, and modern health care environments.

Eventually the process by which resources were allocated to the needs of each Service became one based on the size of their respective existing inventory. Available funding was allocated to each of the Service medical departments based upon the percentage of the total inventory attributed to their respective Service. While this approach essentially guaranteed the Army, Navy, and Air Force medical departments with a predictable funding stream, it came with some significant drawbacks. For one, the relative small increases in medical military construction funding could not keep pace with rapid cost growth for building supplies, labor, and equipment. Each year, the Services were forced to put forward the proposed projects they could afford and not necessarily those that were their most compelling. A form of "horse-trading" sometimes took place, where one Service might donate a portion of its allocated share to another with the expectation that it would be repaid in the future. The net effect was that our hospitals began to grow older, become less efficient, and lose their appeal to our patients and their families. The previous allocation method also prevented us from linking our capital investments to a more systematic, MHS-wide business model.

A study conducted for the Department in 2003 compared private sector health systems with DoD. The results showed that private and public hospitals recapitalize their inventory approximately every 21 years – a benchmark rate that we, at over 50 years, were not close to meeting. This study helped confirm our assumptions – that each year we were falling further behind in efficiency, appeal, and core capability of our medical facilities.

Bright spots have emerged since that study in 2003 was completed. The commitment of the Department and Congress to successful implementation of the 2005 BRAC recommendations has helped us take a major step forward. Recapitalization of the

major facilities in two of our largest markets would not have been possible without this Department level commitment and investment. Other resources made available through the Fiscal Year (FY) 2008 Defense Supplemental Appropriations Act and generated by actions to grow the Army and Marine Corps to re-station forces from overseas have also contributed to our bottom line.

As part of the Defense Health Program, the Department programs and budgets Medical Military Construction projects as part of the Defense-wide Military Construction account. The requirements for medical projects are identified by the Military Service operational and medical communities and submitted to Health Affairs (via TMA), which reviews the projects and facilitates determining priorities in coordination with the Military Departments. The prioritized projects are then vetted through the Department's program and budgeting system where civilian and line leader/stakeholders advise the final decisions that inform the Department's presidential budget submitted to congress. Other strategic initiatives such as grow the force and BRAC influence this decision process by helping inform the prioritization scheme. The entire OSD leadership team (Comptroller, Health Affairs, Program Analysis and Evaluation, Installations and Environment) provide oversight throughout the process. For the FY 2010 President's budget and the FY 2010 to FY 2015 Future Years Defense Program, the Department instituted a new medical enterprise-wide approach and decision support tool to help prioritize the projects. The collective effort of the new prioritization method and Military Department efforts associated with grow the force have all been factored into the development of the FY 2010 budget as DoD prepares to execute our medical capital improvement program.

Concurrent with the growing awareness that our medical facilities were not receiving the resources necessary, we engaged experts in each Service to identify a methodology that would resolve a lingering problem first identified by the Blue Ribbon Panel in 1986 – the absence of a rational and fair process to prioritize the competing requirements of the Army, Navy, and Air Force for medical military construction funding. As a leadership team, we needed an approach that could:

- balance the needs of an integrated health system while respecting the unique operational requirements of each Service
- rationally determine why one proposed investment might be more important than another
- help ensure that our capital investments align with the strategic imperatives of the Department and the MHS
- help articulate our requirements for the resources necessary to provide a modern, capable medical facilities infrastructure

To address this requirement, we embarked on a process which led to development of our Capital Investment Decision Model (CIDM). I would now like to share with you some of the details about the process and model and how its implementation has improved transparency, management and oversight.

The MHS Capital Investment Decision Model

In 2005, we first looked to assess the state of the art in decision-making, with the expectation of adapting best practices we found for use in the MHS. Our research took us to our colleagues at VA who have employed a structured decision-making process since 1997. The VA shared their insights and lessons learned which we applied to the design of our process.

Together with representatives from each of the Services, our collective staffs developed evaluation criteria and establish the business rules that would govern implementation of the CIDM. We proceeded in a deliberately sought consensus among the Service medical departments. We recognized from the outset that developing and implementing the CIDM represented a change from status quo. Moving to this new approach also had an impact on our planning, design and construction partners, the Naval Facilities Engineering Command, the U.S. Army Corps of Engineers, and support teams responsible for performing project planning. Transitioning to CIDM was essential to our

efforts to systematically improve our facility inventory and by extension life cycle management by improving the process that guides investment.

The CIDM work group agreed on the following investment evaluation criteria and their associated weights:

- **Strategic and Tactical Alignment 33%**
  How well does the proposed investment support near and long-term direction articulated by DoD and MHS senior leadership?
- **Risk Mitigation 33%**
  What are the risks of not supporting the proposed investment?
- **Physical Environment 22%**
  Does the proposed investment support provision of safe, compliant, contemporary environments that focus on the needs of our customers?
- **Operational Performance 12%**
  Will the proposed investment support improved utilization of resources?

Once consensus was reached concerning the criteria, each of the Services developed their capital proposals, using a mutually agreed-upon format and schedule. Each Capital Investment Proposal (CIP) was submitted online and consists of:

- a standard template describing the project and its relevance to the evaluation criteria
- a Form DD1391 that reflects scope and cost
- a summary program for design describing the type and quantity of space required
- a standardized net present value analysis of alternatives
- photographs of existing facility conditions and/or potential construction sites

The Services submitted a total of 43 CIPs (to a secure web site) in late May of 2008, reflecting their own highest priorities. A diverse panel of medical professionals from the Services, Health Affairs, and TMA, including physicians and administrators at the O-6 or GS-15 level, reviewed the CIPs. Each reviewer recorded his or her score (via the web) using a common decision support tool. The tool recorded all the scores and provided a strawman "order of merit" list for the 43 proposals. Together, the Surgeons General and I

reviewed this list of priorities as part of our Senior Medical Military Advisory Council responsibilities. This list of priority investments is the heart of our medical military investment plan for FY 2010 through 2015.

I look forward to sharing with you the details of the plan after the President submits his budget next month and more recently, the recent addition of military hospital projects as part of the American Recovery and Reinvestment Act of 2009. We remain grateful for your support in all of our investment programs.

It is worth noting some of the important features of our new decision-making process. First, each Service was asked to submit sufficient proposals that would drive them to a 21-year recapitalization rate consistent with the study conducted in 2003. We did not impose an artificial programming limit but instead asked for submissions to address their actual requirements. We believed it essential to develop not only which investments were the most compelling, but also identify the full array of resources necessary to address them, including initial outfitting and future operations and staffing costs.

Unlike the previous method for allocating resources, we attempted to link our capital investment strategy to the strategic imperatives of the MHS. Each potential investment would be viewed not just from the perspective of the acquisition cost, but also include consideration of facility life cycle costs. We fully appreciate that the total cost of facility ownership occurs in operating and maintaining buildings over several decades including the initial and important investment for design and construction.

While the software produced an order of merit listing but also provided the capability to adjust inputs, such as criteria weights or funding levels, and create alternative investment scenarios. The Surgeons General and I reviewed, debated, and ultimately approved our final priority list. We considered various options and in the end made adjustments where we deemed appropriate. This final version was shared appropriately with leadership and other key stakeholders in the Department. The program that the Surgeons General and I approved was subsequently validated through the Department's program review process without further adjustment.

Anticipating the Future

While pleased with our new decision-making process, we know it is far from perfect and needs to continually adapt to changing requirements. The outputs from our Capital Investment Decision process have helped build a rational foundation for building an investment program for our most urgent needs. The results also helped demonstrate the size of the fiscal challenge we face and how resources would be used if provided. The Surgeons, my staff, and I have used this information to internally adjust our proposed funding priorities for the future.

I must stress to you that we do not intend to build bigger, newer versions of our existing hospitals and clinics. The clinical process and technology changes we see emerging every day -- coupled with our growing understanding of the impact of health care facilities on safety, outcomes, and operational efficiencies – compel us to create environments capable of "leaning forward." We strive to be both "high tech" by incorporating the latest technical innovations in health care, and "high touch" by providing the environment and support needed by our most important asset – our active duty members, their families, and the dedicated professionals of the MHS.

We are also engaged with leaders in both the public and private sectors, along with academia, to share knowledge and pursue best practices. We continue to work with VA leaders, both to ensure the best care for our patients and the best facilities. Health Affairs has also engaged experts at Georgia Tech and Rice University to help us acquire knowledge, conduct collaborative facilities research, and improve our acquisition and business processes. The Army Medical Command works with Clemson University to investigate hospital room design and test new approaches in actual clinical settings. We have assumed a prominent position in the national community dedicated to creating safe and efficient healing environments. Our work has been highlighted in a variety of national publications, including national newspapers and professional journals. We have forged collaborative relationships with other health systems, including Kaiser-Permanente, the Mayo, and Cleveland Clinics. These research associations allow us to learn from the best

and to share with them some of our innovative system-wide approaches to the planning, acquisition, and operation of our facilities.

It is with great pleasure that I can report to you the genuine willingness of our colleagues outside the Department to work with us. We have also found that the MHS has a good story to tell and that we have a real capability to contribute to the delivery of better care in better health and research buildings across the nation.

My colleagues, the Surgeons General, are charged with operating the facilities, delivering care, conducting research and training activities, and directly supporting our soldiers, sailors, airmen, marines, their families, and others entrusted to our care. My job is to help my colleagues successfully conduct of their missions. I do that by advocating for and obtaining resources and working collaboratively to create the fiscal and business roadmap that will lead us to a future to which we all aspire.

I would like to conclude my time with you today by stating that we have made great progress in recent years and have a clear idea of where we must be in the future. Congress has played a supportive role in the concerted effort to improve the quality, capabilities, and effectiveness of our medical facilities. Most recently, inclusion of $1.33 billion for funding of military hospital construction in the American Recovery and Reinvestment Act of 2009 will help to provide the medical facility infrastructure so vital to our patients and their families. Our new MHS prioritization process was used to help determine which projects to fund.

Looking ahead, we are encouraged by the opportunity to continue to work with our partners in the VA as we pursue joint market and clinical solutions. We look forward to making our buildings greener as we take lessons from our facility research and apply them as new criteria for creating healthier healing environments. We also look forward to working with the Congress in the future to explore better, faster and cheaper ways to acquire and maintain our facilities as we leverage the talent in the private sector and use our investments as a way to stimulate the economy in both short- and long-term.

I appreciate the excellent support provided by the members of this committee, its professional staff, and others in Congress who share our passion to care for our nation's heroes and their families. It remains my humble honor to have served with you and to continue to work with you to improve the healing places for our heroes, current, past and future.

Thank you for your continued strong support of our military health care system and our infrastructure to support it.

END

HOLD UNTIL RELEASED
BY THE COMMITTEE

STATEMENT OF

MR. PETER POTOCHNEY
DIRECTOR, BASING
OFFICE OF THE DEPUTY UNDER SECRETARY OF DEFENSE
(INSTALLATIONS AND ENVIRONMENT)

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

MARCH 18, 2009

Chairman Ortiz, Congressman Forbes, and distinguished members of the Subcommittee, I appreciate the opportunity today to appear before to discuss the Department's Military Construction (MILCON) and BRAC programs as each relates to the Department's medical facilities.

Overview

As we have testified in the past, our installations are the foundation of America's security – these assets must be available when and where needed, with the capabilities to support current and future mission requirements. As the enterprise managers of the defense installations portfolio, the Office of the Deputy Under Secretary of Defense (Installations and Environment) is a focal point in ensuring their capabilities are delivered effectively and efficiently in support of our operations. Our role in supporting medical facilities is the same as that for all other facilities – we focus on fostering the best management practices to ensure the facilities are available when and where needed. As such, we are the advocates for ensuring the facilities receive the investment necessary for their continued operation. In carrying out our responsibilities as they relate to medical facilities, we work closely with the Assistant Secretary of Defense (Health Affairs) and the Tricare Management Activity (TMA). Since the establishment of TMA in 1998, our office has worked with the Military Departments, their Surgeons General, and TMA to prioritize operational and facility requirements, and develop programming plans necessary to implement their priorities.

Currently, our extensive inventory of medical facilities has an estimated plant replacement value (PRV) of approximately $20 billion. While most of the medical facilities are hospitals, there are also medical and dental clinics and supporting facilities like medical research, training facilities, warehouses and ambulance shelters. All of these facilities are essential to the provision of quality medical care throughout the Department. In our role as advocates for all facilities, we focus on the same areas of investment for medical facilities as for all other facility types in DoD's inventory. The investment that we make in our facilities is essential to the optimal performance of those facilities throughout their lifecycle.

Managing Infrastructure

The Deputy Under Secretary of Defense (Installations and Environment) oversees the acquisition, maintenance and recapitalization of all facilities, is responsible for related policy and advocacy within the Department's programming and budgeting process. The overarching goal is to continually improve the quality of military installations. Managing DoD real property assets is integral to achieving the appropriate level of quality.

First and most important, we are focused on our investment in facilities sustainment which supports the regularly scheduled maintenance and repair that is required to keep the facilities in good working order. Providing sufficient funding for maintenance and repair is critical to preventing premature deterioration of the facilities. Recognizing the need for renewed emphasis on facilities sustainment, the Department has

issued guidance that directs funding for facilities sustainment at no less than 90% of the requirement generated by the Facilities Sustainment Model (FSM). FSM estimates the resources needed to perform the regularly scheduled maintenance required to keep facilities in good working order. It includes periodic repair or replacement of facility components such as roofing, HVAC systems, plumbing and electrical systems, and fire protection throughout the life cycle of facilities. As is true of all facilities, funding at a minimum of 90% of the sustainment requirement will also reduce the risk of premature deterioration of our medical facilities. Medical facilities are funded at 93% in the FY 2009 President's Budget.

In addition to facilities sustainment, we're also very concerned about the recapitalization of medical facilities so that they remain mission ready and are modernized on a schedule that prevents obsolescence. Mission readiness and modernization require investments in facilities beyond the regularly scheduled maintenance and repair. We're in the process of refining our methodology for determining the appropriate level of investment, and in part, that will be determined by the Condition Index of a given facility.

The Condition Index is a general measure of the constructed asset's condition at a specific point in time, and one measure of the impact that facility funding has on the quality of facilities. It is calculated as a function of the resources needed to restore a facility to a condition equivalent to its originally designed capacity or capability,

compared to its PRV. Within DoD, the Condition Index is referred to as the "Quality Rating" (Q-Rating), and is expressed on a scale of one to four with one being in good condition, and four being in failing condition. Our long-term goal is to focus our recapitalization investment to eliminate all facilities that are rated as Q-3 or Q-4 either by addressing the shortcomings of each facility or demolishing and replacing them if restoring and modernizing them is not economically feasible. For medical facilities, given the requirement for accreditation, the Service medical departments base their facility condition ratings on more detailed engineering assessments that provide a comprehensive picture of the condition of the medical facility portfolio.

Our focus on the effectiveness of our recapitalization effort is of particular importance for medical facilities. In the past, methodologies used to determine the right level of investment proved to be problematic for accurately evaluating or forecasting the resources needed to keep our medical facilities current with the latest advancements in medicine and approaches to overall patient care. We have recognized for some time that our medical facilities need to be modernized on a much shorter timeline, and that the guidelines that applied to other types of facilities are not sufficient for medical facilities. We're continuing to refine and evolve the manner in which we determine the appropriate level of funding to recapitalize our inventory, and will continue to be mindful of the distinct requirements for medical facilities.

Ongoing Initiatives

Within the Department, it has been and continues to be our goal to provide the right quality facilities in the right locations in the most cost-effective manner. One example of how we're accomplishing that in our medical facilities is through the collaborative effort that we've undertaken with the Veteran's Administration. By combining medical facilities where practicable, we can best serve the entire eligible population with consistent care for all. That approach is well underway at the Navy's Great Lakes Training Center, and we believe that the consolidation of the Great Lakes North Chicago Hospital project at the Chicago Veteran's Administration Medical Center will pay great dividends in the long term. The federal health care facility that consolidates all North Chicago and Great Lakes health care resources is an 8-year, 3-phased approach which began in 2002 and will see the activation of phase III in the fall of 2010.

In addition to specific undertakings with the Veteran's Administration, we continue to pursue a robust military construction program for medical facilities. The FY07, 08, and 09 budgets included over $620 million for hospitals, medical research facilities, medical training facilities, primary care clinics, dental clinics, women's health services facilities, and supporting facilities such as a utility plant and a parking structure. The majority of these improvements and additions are being made at our installations within the continental US.

Rationalizing and Recapitalizing Medical Infrastructure through Base Realignment and Closure (BRAC) 2005

BRAC 2005 is the largest round of base closures and realignments undertaken by the Department and the first one to review comprehensively the Department's medical infrastructure. After an exhaustive examination of over 1,200 alternatives, the Secretary of Defense forwarded 222 recommendations to the BRAC Commission for its review. The Commission accepted about 65 percent without change and its resulting recommendations were approved by the President and forwarded to the Congress. The Congress expressed its support of these recommendations by not enacting a joint resolution of disapproval by November 9, 2005; therefore, the Department became legally obligated to close and realign all installations so recommended by the Commission in its report. A key component of this BRAC round was rationalizing Medical infrastructure. This rationalization is needed to address the transformation in healthcare that has occurred since these facilities were constructed and to adapt our facilities to address the continuing changes in warrior care. At one end of the scale, BRAC enabled the Department to close seven small and inefficient inpatient operations, converting them to ambulatory surgery centers. BRAC also enabled DoD to realign medical operations from McChord Air Force Base to Ft Lewis and transform the Medical Center at Keesler, Air Force Base into a community hospital. On the larger end of the scale, BRAC enabled DoD to realign two of its major military medical markets: San Antonio and the National Capital Region. The strategic realignments in San Antonio and the National Capital Region address a critical need to realign and consolidate key clinical

and clinical research capabilities while addressing serious facility modernization requirements. These transformations, requiring facility closures as well as restructuring, could not have bee accomplished holistically or efficiently without the authority provided by the BRAC process.

In San Antonio, DoD is consolidating in-patient services into a recapitalized Brooke Army Medical Center while facilitating DoD's goal of replacing the aging Wilford Hall medical center with state-of-the art ambulatory outpatient center. The BRAC analysis correctly determined that the San Antonio healthcare requirements would be best served with a single medical center and a large ambulatory care center (at Wilford Hall) that allows for focused facilities that will provide the best possible care for the foreseeable future.

We are working similarly in the National Capital Region. BRAC allowed DoD to close Walter Reed and transfer its services to both an expanded Bethesda and the new community hospital at Ft. Belvoir. In addition, the medical center at Andrews Air Force Base will be transformed into a clinic by the closure of the inpatient wards. This allows DoD to forgo the cost of renovating the aging Walter Reed facility and instead focus its resources to re-align the active duty beneficiaries to the remaining hospitals in line with their demographics. The BRAC recommendation correctly recognized that renovation of the Walter Reed Army Medical Center was not the optimum application of our resources due to its age (and doing so would significantly degrade the availability of the healthcare

needs across the NCR). As such, through BRAC we were able to address long-standing health needs regarding the need to better match facility locations and capabilities, medical advances, and changing wounded warrior needs.

After BRAC, the National Capital Region will host two premier facilities that will provide the best possible care while being a center of research and training of health care professionals. For the National Capital Region, the FY 09 costs (including those born in the FY 2009 supplemental) are $2.0B. As is the case with San Antonio, costs rose due to construction inflation, wounded warrior lessons learned, and unforeseen costs as the construction process has unfolded.

Unique to the National Capital Region is the effort to enhance and accelerate construction at Bethesda and Ft. Belvoir as result of lessons learned and the Department's commitment to implement 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 Secretary Togo West and former Secretary of the Army and Congressman Jack Marsh). The IRG's April 2007 report recommended a variety of measures to improve medical care and recommended that DoD accelerate BRAC projects in the National Capital Region (NCR). In order to implement the report's recommendations and incorporate other war-related lessons learned, the Department committed to create Warrior Transition Unit facilities at the Bethesda Campus to enhance wounded warrior care, especially the

outpatient convalescent phase. The Department also committed to enhance the inpatient facilities at both Belvoir and Bethesda. These enhancements together with a commitment to accelerate construction to ensure that the new facilities will be operational as soon as possible, required the investment of an additional $679M. The FY 2008 supplemental appropriated $416M. As noted in the justification material submitted with the FY09 President's Budget, "DoD intends to seek additional funding of $263.3 million" for the balance of funding. These enhancements and other cost increases (construction inflation and scope increases) would bring the total of the investment to $2.0B as of the FY 09 President Budget (including the $263M).

Also unique to the National Capital Region is the Department's decision to place the control of the facilities and the management of BRAC into the hands of a Joint Task Force Capital Medicine headed by VADM John Mateczun. This decision enables unity of command and fosters the development of joint management of the hospitals. This not only ensures that each Military Department will benefit from modernized facilities being constructed, but this also mirrors the joint nature that infuses military medical support to military operations around the world.

One other medical-related BRAC issue is significant. The Department is proceeding to implement the Commission's recommendation to co-locate a Combined Medical Headquarters within the National Capital Region. Besides realigning these HQs into a proximate location, this recommendation requires consolidation of support

functions which will further jointness and efficiency. Co-location will enable Health Affairs, the TRICARE Management Activity, and the Service Surgeons General to function even more as a unified team. More detail on how this will occur will unfold as the Department and the General Services Agency work together to solicit competitive bids for a leased location.

Conclusion

In closing, Mr. Chairman, I sincerely thank you for this opportunity to highlight the Department's efforts regarding Military Medical facilities, the medical MILCON program, and BRAC. Just as our military must be flexible and responsive, our installations must also adapt, reconfigure, and be managed to maximize that flexibility and responsiveness. We appreciate your continued support and we look forward to working with you as we continue to transform our medical infrastructure.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE SUBCOMMITTEE ON MILITARY PERSONNEL
AND
SUBCOMMITTEE ON READINESS

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: MEDICAL INFRASTRUCTURE: ARE HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY PRIORITIES ALIGNED WITH SERVICE REQUIREMENTS?

STATEMENT OF: LT GENERAL (DR.) JAMES G. ROUDEBUSH
SURGEON GENERAL OF THE AIR FORCE

MARCH 18, 2009

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

Chairwoman Davis, Chairman Ortiz and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service and our military construction requirements and plans. First, let me express our gratitude for the overwhelming support Congress has provided to address the critical needs of our medical facilities. Your efforts will greatly assist us in building and sustaining the state-of-the-art medical facilities we require for the future. Modern facilities are crucial to our ability to provide high quality health care to our patients and to retain the best and brightest medical personnel.

Our medical treatment facilities (MTFs) are physical platforms for personnel from the Air Force Medical Service (AFMS), our sister Services, and in many cases, Department of Veterans Affairs (DVA), to perform patient care, readiness training, research, and a multitude of support missions. Appropriately funded Military Construction (MILCON) and Operations and Maintenance (O&M) - Sustainment, Restoration & Modernization (SRM) programs are essential to recapitalizing our infrastructure, repairing and maintaining our facilities, and improving energy efficiency.

The Air Force Health Facilities Division, a specialized team of architects, engineers and operational healthcare experts, continuously engages with Medical Treatment Facility leadership at each base to identify, validate and execute necessary sustainment, repair and modernization projects. Requirement prioritization, approved through our corporate structure, is aligned to an AFMS-wide perspective. For requirements that drive a MILCON solution, we prepare a Capital Investment Proposal and submit it to the TRICARE Management Activity (TMA) to be scored biennially in the Military Health Service (MHS) Capital Investment Decision Model (CIDM) process.

The CIDM process, modeled after the DVA's, was instituted to establish a consistent, rigorous approach to prioritizing MILCON requirements across all three medical Services. Along with our sister Services and TMA, we were active participants in developing scoring criteria. The criteria allow structured decision-making using comparative assessments of quantitative and qualitative factors in four key areas: 1) alignment with MHS strategic and tactical goals; 2) adequacy of physical environment; 3) impact on operational performance; and 4) mitigation of risk. The CIDM process was successfully applied in 2008 to determine DoD's Fiscal Year 2010/2011 Medical MILCON priorities. The Air Force's most pressing medical projects were appropriately prioritized.

With the FY10 President's Budget proposal, we are hopefully turning the corner on allocating necessary funding to the medical MILCON program. This is urgent, as the overall medical facility portfolio average age is higher than it has ever been. Most of our medical infrastructure was built in the 15 years following the establishment of the Air Force in 1947. Twenty-six of our 75 medical facilities (35 percent) are from that pre-1965 timeframe, and are approaching, or are already more than, 50-years old. As our infrastructure ages and deteriorates, significant facility problems become more common, more severe, and more directly disruptive to patient care. While we've been successful in implementing stop-gap measures, we must sustain an adequate baseline of maintenance and repair.

In addition to the criticality of facility recapitalization, recent history has demonstrated that healing wounded, ill, and injured warriors in world-class, well-maintained medical facilities is both a sacred duty and national priority. I assure you the Air Force is meeting these expectations. All 75 Air Force MTFs undergo regular and thorough inspections, both scheduled and unannounced, by two national accreditation organizations - the Joint Commission and the

Accreditation Association for Ambulatory Health. All Air Force medical facilities have passed inspection and are fully accredited. We greatly appreciate the additional $60 million in O&M funding provided in this year's budget, and the $130 million provided in the stimulus package, to further reduce our unfunded backlog of facility projects. These additional funds will make our facilities more accessible, repair critical infrastructure systems, and modernize and improve energy efficiency.

In both the MILCON and O&M arenas, green design initiatives and energy conservation continue to be high priorities for the AFMS. We are already incorporating nationally recognized benchmark processes, such as Leadership in Energy and Environmental Design (LEED), to design and construct buildings--like our new medical clinics at Tinker AFB, Oklahoma and Spangdahlem AB, Germany--with sustainable design elements using grey water systems, solar shading, increased natural day-lighting, recycled/recyclable materials, and optimized energy performance. We have established a rigorous method to capture energy consumption data from all of our major facilities and continuously compare performance across peer groups using the Energy Star measurement tool. This data gathering system is already up and running at 62 of our MTFs, and allows us to identify top performers to better proliferate best practices throughout the AFMS. We engage with weaker performers to create a path for improvement that incorporates operational changes and re-designed or repaired systems.

The Nation expects world-class healing environments for all Service members and their families. We greatly appreciate the interest and support you've provided to help us meet this expectation through the modernization of the Air Force's medical infrastructure. We look forward to your continued strong support for our recapitalization and sustainment, repair and

modernization initiatives so that we may continue to serve and provide the highest quality healthcare to our military members, their families, and the Nation. Thank you.

**Not for Publication until released by
the House Armed Services Committee**

Statement of

Vice Admiral Adam M. Robinson, USN, MC

Surgeon General of the Navy

Before the

**Subcommittee on Military Personnel
and
Subcommittee on Readiness**

of the

House Armed Services Committee

Subject:

**Medical Infrastructure: Are Health Affairs/TRICARE Management Activity
Priorities Aligned with Service Requirements?**

March 18, 2009

**Not for Publication until released by
the House Armed Services Committee**

Chairman Ortiz, Chairwoman Davis, Representatives Forbes and Wilson, distinguished members of the committee – thank you for the opportunity to testify before you today on this very important issue of prioritization of military construction of medical facilities.

Your unwavering support of our service members -- especially those who have been wounded -- is deeply appreciated.

Nearly two years have passed since the facilities where wounded service members were housed; where they received medical care, and where they went for non-medical support came under public scrutiny by the media, and Congress, the warriors themselves and their families. Since then, Navy Medicine has become even more vigilant and we continue to make significant strides in enhancing both living quarters and medical treatment facilities for our Sailors and Marines.

The Military Health System (MHS) Capital Investment Decision Model (CIDM) and MILCON prioritization system was implemented in May 2008 and was used in the programming and budgeting for MILCON projects slated for construction beginning with FY2010. This new system serves all the Services by carefully evaluating proposed Medical MILCON projects through a rigorous capital investment prioritization method across the entire enterprise.

One important outcome from that experience two years ago, is that the TRICARE Management Activity (TMA), in conjunction with the Services, reviewed how capital planning decisions were made, resulting in significant changes in prioritizing MILCON capital investments in medical facilities. These changes have yielded positive outcomes for Navy Medicine.

Prior to implementation of the CIDM, each Service independently determined capital improvements. The Services received an allocation from the MHS Medical MILCON program managed by TMA. The allocation was based on the percentage of the total physical plant inventory (real property) owned and managed by each Service medical branch. Under this method, Navy Medicine was allocated approximately $72 million in MILCON program resources each year, or roughly 30 percent of the total available MHS MILCON.

While each Surgeon General prioritized his allocation, the total dollars available per project per year did not meet the steadily rising construction costs for a large project -- such as a hospital replacement. As a result, the Services negotiated amongst themselves, with TMA oversight, to acquire sufficient budget authority to complete large projects where total project costs exceeded a Service's annual budget. This method was never fully capable of assessing the overall needs of the MHS from a provider-enterprise perspective. In addition, it did not meet MILCON resource needs tied to the larger and more costly projects of which all the Services had urgent need. The new methodology has resolved this dilemma by harnessing the global, enterprise-wide perspective to effectively prioritize scarce resources.

Another positive aspect of the CIDM prioritization process is the inclusive representation of those who care for our warfighters as members of the MHS Capital Investment Review Board (CIRB). These clinicians, health system managers, resource managers, and healthcare facility experts, from the Services and TMA, are voting members of CIRB. They represent their Service or TMA and each plays a pivotal role in creating an enterprise-wide assessment of projects needed. Each proposed project is

assessed and the end result is a prioritized project list that meets the defined criteria and enterprise-wide goals. Using the CIDM process, the CIRB develops the enterprise-wide investment perspective for review and concurrence of the MHS leadership. This represents a major improvement over the previous MILCON allocation system.

As the Navy Surgeon General, I, as well as my Army and Air Force colleagues, can engage the CIDM process to clearly articulate my views and priorities to all the members of the CIRB for consideration and deliberation. The new system enables the Services and MHS leadership to share an understanding of required physical plant recapitalization needs, while also delivering the compelling message needed to fully communicate the urgent needs to leadership of the Department of Defense (DoD) and beyond.

The CIDM and CIRB delivered the integrated MHS priority list of projects for the programming period from 2010 through 2015. This master priority list was submitted to the MHS leadership via the Senior Military Medical Advisory Committee (SMMAC), which has agreed to the MILCON listing and submitted it for final review and approval by the DoD. The Services' Surgeons General and the TRICARE Management Activity came to a joint agreement on the top priority construction project across the MHS. This project is the Naval Hospital Guam replacement of a strategic but antique hospital built in 1954 that has survived 55 years in the tropics.

This is an example of how the new prioritization system allows us to maximize our limited project planning dollars by focusing on projects that are considered by all to be a major priority and the best and most efficient use of limited resources. Once a project is programmed in the out-years of the programming and budgeting cycle, the next

step is to develop and finalize the facility studies needed to fully document the project for purposes of final MHS evaluation. This provides Navy Medicine the right mix of project studies at the right time to meet the specific timelines and criteria-driven approach required by the CIDM.

Navy Medicine will budget for selected facility studies needed to support the CIDM documentation standards. This avoids unnecessary expense and ensures that our information relies upon the latest data sources to support projects already approved for programming on the Military Health System MILCON priority list.

Distinguished Members of the Readiness and Military Personnel Subcommittees, thank you again for the opportunity to testify before you today on the positive results Navy Medicine has experienced from the new Medical MILCON prioritization process. I believe the Military Health System CIDM and associated CIRB, as implemented to date, offers the Military Health System enterprise the best overall means to properly prioritize Medical MILCON projects. In addition, this new process ensures projects of the highest relative merit are consistently programmed, budgeted, and executed first. It is particularly encouraging to me that the new process provides the Military Health System with clear-cut means to fully address large project recapitalization requirements in a coherent fashion, while still ensuring the focus of the entire MILCON evaluation process remains where it should always be, namely the healthcare needs of our Sailors and Marines and their family members.

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

LIEUTENANT GENERAL ERIC B. SCHOOMAKER, MD, PhD
THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND COMMANDER, US ARMY MEDICAL COMMAND

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
SUBCOMMITTEE ON READINESS

UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 111TH CONGRESS

MEDICAL INFRASTRUCTURE: ARE HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY PRIORITIES ALIGNED WITH SERVICE REQUIREMENTS?

18 MARCH 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Chairman Ortiz, Representative Wilson, and Representative Forbes, distinguished Members of the Military Personnel and Readiness Subcommittees, thank you for inviting me to discuss this important subject. The condition of our military medical facilities speaks volumes to our staff and our beneficiaries about how much the Nation values their service and their quality of life. Eleven months ago I testified before the Senate Appropriations Subcommittee on Defense and identified medical facility infrastructure as one of my top three concerns. Two months before that, I testified before the House Appropriations Subcommittee on Defense that I had significant concern about the increasing age of the Army's medical infrastructure around the world and the increasing demand being placed on these facilities. Although the age and condition of medical treatment and medical research facilities is still one of my top concerns, I am pleased to report that with the assistance of the Congress over the last year, we have made significant steps to address facility infrastructure needs and are moving firmly in the right direction.

On behalf of the 130,000 team members that comprise the Army Medical Department and our 3.5 million beneficiaries, I want to thank the Congress for listening to our concerns about military medical infrastructure and taking significant action to reverse the decline of our facilities. Funding provided for military hospitals in the FY08 supplemental bill and in the American Recovery and Reinvestment Act of 2009 will positively impact the quality of life of thousands of Service Members, Family Members, and Retirees as we build new World Class facilities in places like Fort Benning, Georgia, Fort Riley, Kansas, and San Antonio, Texas.

Modern new facilities not only stimulate the local economy, they energize the hospital staff who work in these new spaces and comfort the military beneficiaries who seek care in them. I can remember a field artillery battalion commander from Germany who was assigned to Fort Sam Houston, San Antonio

in the early 1990s. Immediately upon arrival at Fort Sam, he eagerly visited Brooke Army Medical Center (BAMC) and the world-renowned burn unit to which several of his Soldiers had been evacuated. He knew Fort Sam was the "Home of Army Medicine" and contained the best the Army Medical Department had to offer—he had comforted his Soldiers with this very message before they were medically evacuated. But after seeing the 50-year old facilities with Soldiers and Family members recovering in open bays and the cinder block shower stalls used for debriding the wounds of burn patients, he was shocked and dismayed. His Soldiers had no complaint about the incredible, life-saving care they received at Brooke, but the care environment clearly left much to be desired. In 1996, the new Brooke Army Medical Center opened its doors and completely changed the perception of military health care in the Fort Sam Houston community and throughout the Army. Since that time, the Army Medical Department opened doors to only two new hospitals (Womack at Fort Bragg, North Carolina, and Bassett at Fort Wainwright, Alaska), but with your assistance, we will double that within the next six years. I expect our new facilities will have the same kind of positive impact on their communities as Brooke, Womack, and Bassett have had on theirs. Our new facilities will incorporate principles of Evidence Based Design which have been demonstrated to improve clinical outcomes, enhance patient safety, foster trust with beneficiaries, and provide a satisfactory work environment for staff.

This infusion of funds has been very helpful in meeting our medical infrastructure needs, and I am currently working closely with the Assistant Secretary of Defense for Health Affairs, Dr. S. Ward Casscels, and the leadership of the Department of Defense to determine the level of investment our medical facilities will need in the future.

The three services and the TRICARE Management Activity (TMA) have worked hard to develop (and continue to develop) an objective process for prioritizing medical MILCON requirements through the Capital Investment Decision Model (CIDM). The CIDM evaluation criteria focus on supporting the Army, Navy, and Air Force, but also target the heart of healthcare looking at

functional modernization, customer centered care, healthcare, productivity, and space utilization. In 2008 we participated in development of the first version of a prioritization model, and I've directed my staff to evolve this process as it must accurately target both the Army and DoD's highest priorities. I am confident that TMA understands the importance of a transparent prioritization process that is both fair and rational and appreciates the complex infrastructure needs across the entire Department of Defense.

The Army is challenged with an aging facility infrastructure, expanding missions, increasing workload, and care for a large portion of DoD beneficiaries. The Army Medical Department (AMEDD) maintains over 1,800 buildings (including 386 health care facilities), covering 33.4 million square feet, with a plant replacement value in excess of $9 billion. A third of Army hospitals are over 50-years old and another third are 25-50 years old. We're meeting this challenge of aging infrastructure by leveraging the increase in MILCON with additional efforts toward proper sustainment through effective maintenance programs ensuring reliable infrastructure.

We rely on execution of a Facility Life Cycle Management Program that ensures reliable facilities through strong maintenance and repair. Congress has been very helpful over the last several years by providing supplemental funding for our facility Sustainment, Restoration, and Modernization (SRM) accounts. These Operation and Maintenance dollars help us maintain our old facilities in reliable, operational conditions. For example, the FY08 and current FY09 SRM funding will reduce our critical system deficiencies by 19 percent.

As an example, due to years of a strong maintenance program, Ireland Army Community Hospital at Fort Knox recently endured a severe ice storm. The storm limited water and electricity on Fort Knox and throughout the surrounding community. However, the hospital continued to operate under emergency power and maintain proper water pressure. Without a strong maintenance program, an event like this could have crippled health care delivery at Fort Knox. Ireland was built in 1957 with an outpatient addition in 1976. Although the infrastructure is

still considered reliable, it was not designed with the flexibility and adaptability of our new hospital structures.

As Landstuhl Regional Medical Center (LRMC) approaches its 56-year anniversary of its opening, I would like to highlight it as another older facility that has used a strong facility maintenance program to remain a comfortable and reliable first stop for our wounded warriors as they make their way home. Most Congressional delegations visit LRMC on their way into or out of theater, so you have likely been able to see first-hand the value that LRMC brings to our national defense. LRMC is an enduring part of our evacuation and treatment plan for wounded, ill, and injured service members far from home

In the rapidly changing environment of healthcare, facilities must be built and managed with an eye toward flexibility and an ability to adapt to future innovations. Over the last few years of the current conflict, we have identified new clinical missions requiring appropriate facilities, including mild Traumatic Brain Injury, Psychological Health, and clinical support for Warriors in Transition. For instance, our focused work with Warriors in Transition has allowed us to recognize the need to develop healing campuses that provide lodging, care, and family services in close proximity to one another. Thank you for your support of these Warrior Transition Complexes.

The rapidly changing health care environment also has a significant impact on medical research. We continue construction on a state-of-the-art replacement facility for the US Army Medical Research Institute of Infectious Disease as part of the National Interagency Bio-Defense Campus (NIBC) at Fort Detrick, Maryland. NIBC is the realization of a post 9-11 vision to bring vastly different and new government agencies together for a common cause. Providing appropriate facilities for this and other areas of medical research have been of paramount importance to the Department because they contribute greatly to the readiness of our Soldiers and defense of our Nation.

We cannot discuss medical military construction without acknowledging the steep rise in construction costs for military medical facilities. The Assistant Secretary of Defense (Health Affairs) sanctioned a study from the Rice Institute

and published the results in October 2008. The study identified issues leading to higher costs in DoD healthcare construction. This study provides a roadmap for DoD and the three services to pursue changes in the process of delivering healthcare facilities. I believe these changes will result in quicker and less costly construction of medical facilities.

It is not enough to continue to run and operate our facilities the way we have in the past. Working in conjunction with civilian health care facilities, AMEDD and the Center for Health Promotion and Preventive Medicine are introducing ways to manage facilities in a more sustainable and environmentally friendly manner. Initiatives include incorporating Leadership in Energy and Environmental Design (LEED) principals in all our designs, reducing the use of hazardous materials, reducing water and energy consumption, procuring green products, and tracking/minimizing our greenhouse gas emissions. We have turned to industry to develop a healthcare sustainability strategy and joined forces with organizations such as Practice Green Health. One of the key facets to building Green Healthcare Facilities is the focus on improving patient outcomes and reducing staff risk. Simple aspects such as adequate natural lighting and ventilation have positive outcomes in healthcare and staff. The new Fort Belvoir hospital will incorporate the lessons learned from our Patient Chair Lift pilot at Madigan Army Medical Center where we minimize the staff's exposure to health risks during movement of patients.

The Army requires a medical facility infrastructure that provides consistent, world-class healing environments that improve clinical outcomes, patient and staff safety, staff recruitment and retention, and operational efficiencies. The quality of our facilities – whether medical treatment, research and development, or support functions – is a tangible demonstration of our commitment to our most valuable assets – our military family and our Military Health System staff staff. Not only are these facilities the bedrock of our direct care mission, they are also the source of our Generating Force that we deploy to perform our operational mission. To support mission success, our current operating environment needs

appropriate platforms that support continued delivery of the best health care, both preventive and acute care, to our Warfighters, their Families and to all other authorized beneficiaries. I respectfully request the continued support of DoD medical construction requirements that will deliver treatment and research facilities that are the pride of the Department.

In closing, I want to thank the Readiness Subcommittee for your interest in this issue and the Military Personnel Subcommittee for your terrific support of the Defense Health Program and Army Medicine. I greatly value the insight of the Armed Services Committee and look forward to working with you closely over the next year. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors and Families that we are most honored to serve.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MARCH 18, 2009

RESPONSE TO QUESTION SUBMITTED BY MR. KLINE

Secretary CASSCELLS. The respective priorities of each component of the Military Health System (MHS) have been reflected in the efforts to develop and employ the Capital Investment Decision Model (CIDM). Representatives from the Surgeons General of the Army, Navy, and Air Force actively participated in the development of the CIDM. They collectively helped establish the evaluation criteria and business rules associated with the CIDM. The Capital Investment Proposals that were submitted for evaluation and prioritization were all generated by the staffs of the Surgeons General and reflected their highest priorities at the time of submission in May of 2008. One of the key evaluation factors for each proposal was alignment with elements of the MHS Strategic Plan, developed in concert with the Assistant Secretary of Defense (Health Affairs) and Surgeons General. Every effort has been made, and will continue to be made, to ensure the priorities of each of the Military Services find voice in the process to identify, evaluate, and prioritize medical capital investments in the MHS.

With respect to Quantico, the Navy provides medical support to the Marines and operates the existing medical facilities on the installation, including the Branch Health Clinic and smaller clinics at the Officer Candidate School and the Basic School. The ongoing initiative to "grow the Marine Corps" will result in modest increases of approximately 300 per year to the levels of officers and officer candidates that receive training at Quantico. This increase is not sufficient to significantly augment the existing medical facility infrastructure or provide inpatient services at Quantico.

The National Capital Region (NCR) is one of the largest and most complex markets in the MHS. The NCR is also experiencing profound change resulting from Base Realignment and Closure (BRAC): Walter Reed Army Medical Center will close; the current National Naval Medical Center will expand and become the Walter Reed National Military Medical Center; and the obsolete hospital at Fort Belvoir will be replaced with the most robust community hospital in the Department of Defense's (DOD's) inventory. Construction of the new facilities is well underway at Bethesda and Fort Belvoir. To support coordinated execution of the changes wrought by BRAC and manage the market-wide delivery of health care services, DOD established a Joint Task Force. The Joint Task Force will continue to assess demand within the market and will allocate resources to facilities in the NCR to best meet that demand. Should the Joint Task Force eventually determine the need to further expand medical capability in or around Quantico, it will pursue the appropriate facility or operational solution. But, for the foreseeable future, specialty care, hospital services, and inpatient care will continue to be provided at the hospital on Fort Belvoir. [See page 22.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MARCH 18, 2009

QUESTIONS SUBMITTED BY MR. WILSON

Mr. WILSON. I have heard that a major problem with military medical construction projects is that by the time the facility opens its door for the first time it is already either too small or not properly designed to accommodate the current and future population it is meant to serve. How does the new prioritization process produce a facility better aligned to the population it is intended to serve?

Secretary CASSCELLS. Reducing the "time to market" required to bring new medical facilities online is a challenge faced in both the public and private sectors. The increasingly rapid evolution of health care technology, information systems, and clinical practices makes accurate forecasting of facility size and configuration extremely difficult.

One of the stated goals of implementing the new Capital Investment Decision Model (CIDM) is expediting the planning and acquisition of military medical facilities. The template used by the Army, Navy, and Air Force for submission of proposed capital investments has been standardized and simplified. CIDM has emphasized increasing the use of parametric cost estimating in lieu of devoting the time and resources necessary to attain a 35% design. Less specificity on the exact size and content of a proposed facility is required prior to submission for approval. CIDM encourages the execution of more parallel activities and acquisition strategies such as design/build, in which the designer and builder work together. This contrasts with the more traditional design/bid/build approach, which relies on a sequential processing of tasks that in turn extended the time to market.

There are other initiatives underway by the Military Health System. The United States Army Corps of Engineers and the Naval Facilities Engineering Command intend to expedite the delivery of Department of Defense medical facilities. Successful implementation of CIDM is one of many efforts that, hopefully, will reduce the potential for a misalignment of facility capability with the needs of the population.

Mr. WILSON. How does the new Capital Investment Decision Model (CIDM) differ from the process used by the Department of Defense (DOD) and the Military Services to develop priorities for nonmedical military construction? What is the benefit of having a unique process for medical construction?

Secretary CASSCELLS. The Military Health System (MHS) needed a rational, transparent, and structured method to evaluate competing priorities for a finite pool of military construction (MILCON) resources. Prior to implementation of the CIDM, a satisfactory process did not exist to prioritize candidates for MILCON funding. There was not a reliable procedure to rank order potential MILCON investments that reflected both the needs of each Military Service as well as the strategic imperatives of the MHS overall. The CIDM is similar to the manner the Department of Veterans Affairs (VA) has ranked their proposed facility projects for several years. As is the case with the MHS, the VA must also use a rational and structured process to identify its highest priorities across a large, complex organization with multiple stakeholders.

The processes employed by the Military Services and other entities within DOD to prioritize their respective MILCON programs vary and may be influenced by such factors as size, scope, complexity, and culture. Each component establishes their own business rules and evaluation criteria consistent with particular needs as they strive to meet individual challenges in setting priorities and allocating resources. However, several components have adopted the same approach and employed the same commercial software product, Decision Lens, as the MHS. For example, Decision Lens is used by the following entities to support their respective decision-making in the areas noted:

- Joint Staff
  - Budget Allocation, Capabilities Planning, IT Selection, and Source Selection
- National Geospatial Intelligence Agency
  - Budget Allocation, IT, Human Resources, and Intelligence Analysis
- United States Navy—Commander, Navy Installations Command

- Budget Allocation
- United States Army Special Operations Command
  - Budget Planning
- United States Air Force Research Lab
  - Strategic Planning, Budget Allocation for Research and Development
- United States Navy N6—SPAWAR—NETWARCOM—PEO C4I
  - IT Capital Planning and Portfolio Management

The logic and approach to the CIDM is not unique to DOD or the Federal Government. The basic concept of using transparent evaluation criteria within a structured process to determine priorities is logical and has been employed in varying forms throughout the public and private sectors. It has proven to be particularly useful for the MHS for several reasons. Typically, medical facilities are some of the most expensive and complex buildings within the DOD. Health care is one of the most dynamic fields of endeavor, subject to constant change in medical technology, information systems, clinical practice, diagnostic techniques, and patient and family expectations. Few other facility types within the DOD inventory must address the challenges of cost, complexity, and dynamism. In today's challenging environment, the MHS needs an approach to the capital investment decision making process that is transparent, logical, structured, and addresses the needs of each of the Military Services and MHS. Implementing the CIDM last year, and continuously striving to improve future versions, will help ensure precious medical MILCON resources are used to their best advantage.

Mr. WILSON. I have heard that a major problem with military medical construction projects is that by the time the facility opens its door for the first time it is already either too small or not properly designed to accommodate the current and future population it is meant to serve. How does the new prioritization process produce a facility better aligned to the population it is intended to serve?

Mr. POTOCHNEY. Reducing the "time to market" required to bring new medical facilities on-line is a challenge faced in both the public and private sectors. The increasingly rapid evolution of health care technology, information systems, and clinical practices makes accurate forecasting of facility size and configuration extremely difficult.

One of the stated goals of implementing the new Capital Investment Decision Model (CIDM) is expediting the planning and acquisition of military medical facilities. The template used by the Army, Navy, and Air Force for submission of proposed capital investments has been standardized and simplified. CIDM has emphasized increasing the use of parametric cost estimating in lieu of devoting the time and resources necessary to attain a 35% design. Less specificity on the exact size and content of a proposed facility is required prior to submission for approval. CIDM encourages the execution of more parallel activities and acquisition strategies such as design/build, in which the designer and builder work together. This contrasts with the more traditional design/bid/build approach, which relies on a sequential processing of tasks that in turn extended the time to market.

There are other initiatives underway by the Military Health System, the U.S. Army Corps of Engineers, and the Naval Facilities Engineering Command intended expedite the delivery of DOD medical facilities. Successful implementation of CIDM is simply one of many efforts that hopefully will reduce the potential for a misalignment of facility capability with the needs of the population.

Mr. WILSON. How does the new Capital Investment Decision Model differ from the process used by DOD and the military services to develop priorities for non-medical military construction? What is the benefit of having a unique process for medical construction?

Mr. POTOCHNEY. The Military Health System needed a rational, transparent, and structured method to evaluate competing priorities for a finite pool of military construction (MILCON) resources. Prior to implementation of the Capital Investment Decision Model (CIDM), a satisfactory process did not exist to prioritize candidates for MILCON funding. There was not a reliable procedure to rank order potential MILCON investments that reflected both the needs of each of the military services as well as the strategic imperatives of the overall MHS. The CIDM is similar to the manner in which the Department of Veterans Affairs (VA) has ranked their proposed facility projects for several years. As is the case with the MHS, the VA must also use a rational and structured process to identify its highest priorities across a large, complex organization with multiple stakeholders.

The processes employed by the military services and other entities within DOD to prioritize their respective military construction programs vary and may be influenced by such factors as size, scope, complexity, and culture. Each establishes their

own business rules and evaluation criteria consistent with their needs as they strive to meet their own challenges in setting priorities and allocating resources. However, it is worth noting that several have adopted the same approach and employed the same commercial software product, Decision Lens, as the MHS. For example, Decision Lens is used by the following entities to support their respective decision-making in the areas noted:

- The Joint Staff
  - Budget Allocation, Capabilities Planning, IT Selection, and Source Selection
- National Geospatial Intelligence Agency
  - Budget Allocation, IT, Human Resources, and Intelligence Analysis
- US Navy—Commander, Navy Installations Command
  - Budget Allocation
- US Army Special Operations Command
  - Budget Planning
- US Air Force Research Lab
  - Strategic Planning, Budget Allocation for Research and Development
- US Navy N6—SPAWAR—NETWARCOM—PEO C4I
  - IT Capital Planning and Portfolio Management

Decision Lens also has several other clients within the Federal Government and private industry, including the Department of Agriculture, National Archives and Records Administration, the Nuclear Regulatory Commission, Amtrak, and eBay.

The logic and approach to the CIDM is not unique to the DOD or even the Federal Government. The basic concept of using transparent evaluation criteria within a structured process to determine priorities is logical and has already been employed in varying forms within the public and private sectors. It is has proven to be particularly useful for the MHS for several reasons. Typically, medical facilities are some of the most expensive and complex buildings within the DOD. Health care is one of the most dynamic fields of endeavor, subject to constant change in medical technology, information systems, clinical practice, diagnostic techniques, and even expectations of patients and families. Few other facility types within the DOD inventory can match these challenges of cost, complexity, and dynamism. In today's challenging environment, the MHS clearly needs an approach to capital investment decision making that is transparent, logical, structured and addresses the needs of each of the military services as well as the MHS. Implementing the CIDM last year, and continuously striving to improve future versions, will help ensure that precious medical MILCON resources are used to their best advantage.

Mr. WILSON. I understand that the new MILCON prioritization process has only been in place for a short time but from your perspective how can it be improved to better meet service priorities?

General SCHOOMAKER. The three Services, in conjunction with the TRICARE Management Activity, are currently working on the next version of the medical MILCON prioritization process with the intent of using this new process during the next program build. Areas for improvement include refining evaluation criteria, structuring submissions to ensure a consistent approach in addressing criteria, and accounting for the various service equities (for example, the Army comprises 46% of the overall medical building square footage in the Military Health System). The evaluation criteria should separately address the different types of medical facilities (i.e. hospitals versus medical clinics versus dental clinics versus veterinary clinics versus medical warehouses) rather than attempting to compare them against each other. The criteria should validate the beneficiary populations versus the enrolled populations when describing the required capacity, and should normalize the infrastructure assessments across the three Services to achieve an equivalent comparison.

Mr. WILSON. The military medical facilities at Ft. Jackson, Naval Hospital Beaufort and Naval Hospital Charleston in South Carolina are all at least thirty-five years old. What are your plans to either modernize or replace these facilities?

General SCHOOMAKER. Fort Jackson is an important installation that supports the Army's training mission. In FY08, the Army funded a facilities planning effort at Fort Jackson to determine whether any gaps exist between healthcare requirements and facility capabilities. This effort will also scope requirements to address any identified gaps. The analysis is still underway and will culminate with the most critical military construction requirements being prioritized in the spring of FY10 for inclusion in future budget requests.

Mr. WILSON. What are some of the challenges of providing world-class medicine in aging facilities?

General SCHOOMAKER. The greatest challenge is keeping our facilities functionally relevant to the changes in the provision of care. Adaptability and flexibility are the keys to meeting the facility needs of a dynamic healthcare system. A properly maintained facility "ages" due to the lack of proper recapitalization to meet the changing needs. The Military Health System (MHS) recently established a 31-year capitalization rate, with the expectation of several renovations before the 30-year mark. The decision to reduce this rate from the original 50-year target led to a requirement to increase the overall funding in the medical military construction program. DOD responded by providing a significant increase in funding, which will help us improve our facilities after years of flat funding.

Healthcare advances through improvements in technology and use of evidence-based medicine. In many cases, improved practices and procedures rely on equipment and infrastructure to ensure proper clinical outcomes. A great example is the diversity of imaging, which focused on the traditional X-ray for many years. This area has now grown into multiple forms of imaging, to include interventional radiology where procedures are conducted using real-time imaging. These changes require the facility to transform to accommodate the technology and the procedures.

Keeping pace with these changes in aging facilities requires more frequent renovations to meet the demand. The MHS is faced with facility functional failure, as opposed to infrastructure failure. The Army Medical Department's aggressive approach to Facility Life Cycle Management ensures reliable facility infrastructure, but is limited in addressing a facility's functionality. The majority of the Army's healthcare facilities were designed between 1950 and 1980, when our focus was on inpatient care. Healthcare delivery has changed significantly from inpatient to outpatient settings and now includes new methods such as same-day surgery and mother-baby care. The inability of some of our facilities to adjust to these changes has rendered them functionally failing.

Maintaining relevancy in a dynamic healthcare environment requires either more flexibility in using operations and maintenance funding and/or a military construction program that is more adaptable to the environment. Current budget planning cycles do not allow for rapid adjustments. The current "new work" limitations for DOD facilities severely limits the use of operations and maintenance funds to meet rapid changes in healthcare. This leads to operating outpatient clinics and administrative functions within inpatient spaces, resulting in high maintenance costs, poor space utilization, and frustrated staff.

Mr. WILSON. Over the past twenty years BRAC requirements and decisions by the military services have significantly changed the size and type of medical facilities in the Military Health System. How well do the remaining hospitals and clinics meet our beneficiaries' needs and where would you make additional changes to provide the best care possible? With so many clinics and small hospitals, how do you provide medical personnel with the necessary experience to maintain their clinical skills?

General SCHOOMAKER. With the reduction in medical services available because of BRAC and Overseas Contingency Operations, the Army Medical Department (AMEDD) has taken steps to ensure that our beneficiaries continue to receive the highest level of care. For example, the AMEDD routinely cross-levels resources from areas of less need to areas of greater need. In addition, we hire contract providers and use TRICARE network providers in the local community.

BRAC and Grow the Army decisions drove construction and staffing requirements to meet the expanded population's health and dental care needs. In some cases, with the help of the DOD and Congress, we were able to consolidate these growth requirements with additional funding to completely recapitalize a facility instead of adopting a piecemeal approach. The DOD also recognized the positive impact that facilities have on the quality of care and increased the levels of funding in our medical MILCON program. Additional actions to provide the best care possible include continued full funding in our Sustainment account (to ensure proper maintenance) and continued funding of a robust medical MILCON program to address all our medical facilities beyond the current focus on hospitals. This would include medical, dental, and veterinary clinics.

Medical personnel within the Military Health System maintain their clinical skills in a fashion similar to their civilian colleagues. Licensure and credentialing criteria apply for each individual, as well as a competency-based assessment system. This system sets certain thresholds that medical personnel must meet to maintain credentials in their specific specialty. If a facility is unable to supply the resources a provider requires to perform in his/her specialty, the provider will be moved to a location where resources remain available. Our staffing is frequently adjusted to op-

timize use of our providers and to ensure all providers have the necessary experience to maintain their clinical skills.

Mr. WILSON. I understand that the new MILCON prioritization process has only been in place for a short time but from your perspective how can it be improved to better meet service priorities?

Admiral ROBINSON. As the Navy Surgeon General, I was able to use the new Capital Investment Decision Model (CIDM) process to clearly articulate my views on Navy Medicine MILCON priorities for the current budget cycle. The new evaluative process also accounts for the MILCON priorities of my colleagues in the Army and Air Force through decisional criteria weighting which helps ensure overall Service priorities are considered on a level playing field. This process fully reflects common agreement achieved to support the new Medicine MILCON prioritization system across the Services. Current efforts underway by the CIDM Tri-Service Working Group to refine the CIDM evaluative process will retain this key decisional factor to ensure the Services and Military Health System (MHS) leadership share a common understanding of high priority Medicine MILCON needs. The CIDM process also allows the MHS enterprise the ability to communicate those urgent needs to leadership of the Department of Defense and beyond. The Medicine MILCON project priority list delivered through CIDM represents the core success of the new system over the previous allocation system which did not capture the critical enterprise perspective required to effectively program vital capital investments.

Mr. WILSON. The military medical facilities at Ft. Jackson, Naval Hospital Beaufort and Naval Hospital Charleston in South Carolina are all at least thirty-five years old. What are your plans to either modernize or replace these facilities?

Admiral ROBINSON. The Medical Facilities on Fort Jackson are owned by the Army and are under the purview of the Army Surgeon General.

The replacement facility for existing Naval Health Clinic Charleston is in the final stages of construction, and is scheduled to be operational by 30 Nov 2009. The replacement facility in Charleston will be classified as a Naval Ambulatory Care Center with state of the art ancillary services required to support our beneficiary population. All inpatient services will be handled by the TRICARE network and supported by local community hospitals in the area and other Military Treatment Facilities as required.

Naval Hospital Beaufort is approaching 60 years of age and is in need of replacement. The aging infrastructure at Beaufort is not conducive to modern, outpatient-centric, healthcare delivery. We have developed planning and programming documents for a 17 bed, 233,847 square foot replacement hospital and have submitted them to Office Assistant Secretary of Defense, Health Affairs/Tricare Management Activity for project consideration within the Defense Health Program Military Construction Program. We have also secured site approval on Marine Corps Air Station Beaufort for the replacement facility.

Mr. WILSON. What are some of the challenges of providing world-class medicine in aging facilities?

Admiral ROBINSON. Aging infrastructure is not conducive to modern, outpatient-centric healthcare. Aged facility designs are not energy efficient and create dysfunctional flow for both healthcare providers and patients alike. Further, modern healthcare legislation and accreditation practices such as the Americans with Disabilities Act, Health Insurance Portability and Accountability Act, and Joint Commission on Accreditation of Healthcare Organizations are major drivers for current Military Health System (MHS) space requirements. Worth mentioning is the vast change in healthcare architecture and engineering. Modern healthcare design and construction has led to better patient outcomes and satisfaction. Modernizing our facilities will greatly complement our efforts to provide world-class medicine moving forward. Finally, aged infrastructure prevents us from taking full advantage of new medical technologies and equipment that enhance health outcomes in similar populations across the United States.

Mr. WILSON. Over the past twenty years BRAC requirements and decisions by the military services have significantly changed the size and type of medical facilities in the Military Health System. How well do the remaining hospitals and clinics meet our beneficiaries' needs and where would you make additional changes to provide the best care possible? With so many clinics and small hospitals, how do you provide medical personnel with the necessary experience to maintain their clinical skills?

Admiral ROBINSON. Navy Medicine is committed to meeting the health care requirements of our beneficiaries by maintaining a well-qualified and robust complement of health care providers. Although Base Realignment and Closure (BRAC) may ultimately alter the size and scope of the health care services provided at medical treatment facilities (MTFs), those changes are addressed and mitigated by Navy

Medicine during the BRAC planning process. In those instances where MTFs are reduced in capability and capacity, the delivery of health care is complemented by civilian-based provider networks established through the TRICARE Program.

As active participants in the Joint Commission accreditation process, we embrace the Joint Commission standards that focus on maintaining the clinical skills of our providers. Joint Commission standards include the Focused Provider Performance Evaluation (FPPE) and Ongoing Provider Performance Evaluation (OPPE) programs. To maintain an infrequently used skill, a provider can go to another facility for temporary additional duty (TAD) where the patient volume and MTF capacity and capability exist.

In the event that medical procedures cannot be safely supported with the required staff and resources at a facility, those privileges will not be granted to the provider and the medical procedure will not be performed. Upon the providers transfer to another MTF, the provider participates in FPPE to assure clinical competency.

Navy Medicine incorporates a Quality Assurance system and robust Graduate Medical Education programs to maintain provider skills and meet the health care needs of our beneficiaries. The Navy Medicine Quality Assurance system provides continuous monitoring of the medical practice of every privileged provider. Trends and deficiencies are identified for corrective training. In addition to the informal TAD training noted above, Navy Medicine has initiated a formal Professional Update Training program that coordinates periodic clinical training to ensure that specialists maintain their clinical skills when the circumstances of their current assignment do not provide cases in sufficient numbers or diversity to maintain all the clinical skills required by their clinical privilege sheets. Navy Medicine also engages centers of excellence, fostering internal and external partnerships, and leverages our Navy Fellowship Training Program to provide our physicians with training in the latest treatment and surgical modalities.

Currently, Navy Medicine is focused on improving the integration of health care delivery between the MTFs and the civilian networks. Our main objective is to improve the continuity of patient and family-centered care as patient care is provided in multiple venues. This area represents an opportunity of improvement for the entire Military Health System, including our civilian partners.

Mr. WILSON. I understand that the new MILCON prioritization process has only been in place for a short time but from your perspective how can it be improved to better meet service priorities?

General ROUDEBUSH. The Capital Investment Decision Model (CIDM) was developed by TMA and the Services to assist in prioritizing future capital investments across a diverse Defense Health Program (DHP) facility inventory. Lessons learned from CIDM 1.0, the model used to prioritize the FY10–15 DHP MILCON POM, are being incorporated into CIDM 2.0—building on our successes with selection criteria and overall process. It is important to recognize that CIDM provides a baseline priority list to be further shaped by variables that may include alternative budget constraints, incremental versus phased or full funding guidance, or supra-departmental "must-pay" project inserts. Various scenarios may be presented to the Service Deputy Surgeons General and the DASD (Health Affairs) for consideration. Their recommendation going forward to the Service Surgeons and ASD (HA) provides for a full vetting/advocacy of Service-specific priorities. While CIDM 2.0 is not intended to exclusively address AFMS priorities, it provides a reasonable and appropriate balance of our needs against those of our sister Services and TMA.

Mr. WILSON. The military medical facilities at Ft. Jackson, Naval Hospital Beaufort and Naval Hospital Charleston in South Carolina are all at least thirty-five years old. What are your plans to either modernize or replace these facilities?

General ROUDEBUSH. Since these are Navy facilities, the Air Force defers the response to the Navy.

Mr. WILSON. What are some of the challenges of providing world-class medicine in aging facilities?

General ROUDEBUSH. The challenges in delivering world-class medicine within our aging facilities occur in four major categories; patient safety, technology integration, cost, and functional efficiency. In aging facilities, ensuring patient safety becomes increasingly challenging. Infection control is a major facet of patient safety. Numerous studies have shown that modern air handling systems decrease the risk of hospital acquired infections, and the installation of anti-microbial surfaces can also decrease hospital acquired infections. Another aspect of patient safety is minimizing falls, which can be accomplished through proper facility design.

Integrating new technologies is difficult, with many of our legacy facilities having limited floor-to-floor heights that preclude larger duct sizes, fiber optic backbones, and enhanced air handling for rooms with the latest equipment.

The financial burden of higher sustainment costs necessary to provide world-class medicine in older, often re-purposed, former inpatient facilities has been significant. In one study of 3 bases with former hospitals operating or proposed to operate as clinics, the estimated additional cost for maintaining the outmoded and oversized infrastructure was $29.5M per year.

Clinics operating in former hospital chassis often maintain excess emergency generators, medical gas systems, inefficient air handling systems, steam boilers, and nurse call systems. Functional efficiency is compromised due to operating in "as-is" inpatient footprints. Clinicians cannot optimize their practice when operating around existing load bearing walls, tight column grids, and inefficient circulation patterns. While this issue is challenging, we appreciate that Congress has provided funding to make targeted renovation investments where appropriate and replacement when necessary.

Mr. WILSON. Over the past twenty years BRAC requirements and decisions by the military services have significantly changed the size and type of medical facilities in the Military Health System. How well do the remaining hospitals and clinics meet our beneficiaries' needs and where would you make additional changes to provide the best care possible? With so many clinics and small hospitals, how do you provide medical personnel with the necessary experience to maintain their clinical skills?

General ROUDEBUSH. Our beneficiaries tell us we are doing extremely well. Their satisfaction rate for the past 6 consecutive years has been the highest among 50 leading healthcare plans according to independent Wilson Health Information surveys. We've accomplished this through the care we provide in our Military Treatment Facilities and our Managed Care Support Partnerships. These complementary means of healthcare delivery have allowed us to optimize our services as directed by BRAC while still delivering a world-class benefit to our military families through our civilian partners when needed.

The Air Force Medical Service is undertaking two additional strategies to further optimize services, the Family Health Initiative (FHI) and Surgical Optimization. The two primary goals for these programs are to enhance access and continuity of services to our population, and increase the complexity of the patients seen. FHI utilizes a patient centered medical home model to provide appropriate staffing. This model makes the coordination of all a patient's care the primary focus of the team and is led by a Family Practice Physician. Surgical Optimization combines AFSO 21 advanced management and production techniques to decrease operating room changeover time resulting in a greater throughput of surgical cases. This increase in cases bolsters the currency of surgeons and their staff. It also improves outcomes through increased proficiency of surgical techniques.

The Air Force Medical Service has developed a variety of training programs to ensure our health care providers remain the best trained and equipped in the world. The Air Force Expeditionary Medical Skills Institute's Center for Sustainment of Trauma and Readiness Skills (C–STARS) is a medical training program embedded in three civilian academic trauma centers. C–STARS is a skills sustainment platform with multiple affiliations to refresh or hone trauma and reconstructive surgical skills. A newer training platform, Sustainment of Trauma and Resuscitation Skills–Program (STARS–P) has begun at five other locations. STARS–P is a readiness skills verification training platform providing personnel the opportunity to perform clinical rotations several weeks annually at host facilities for the purpose of skills sustainment. Training is also accomplished using no cost Training Affiliation Agreements (TAAs) with civilian or other sister-service facilities to include VA Sharing Agreements. Since 2006, the AF has entered into over 262 TAAs for clinical proficiency and sustainment training. Another trend is using Simulation Laboratories (SIMLABs) utilizing high quality human-like training models. The Air Force has a network of simulation laboratories to enhance skills sustainment. Each year AFMS personnel retain professional licensure and certification status by attending civilian conventions/symposia or military formal training courses to obtain continuing education. Humanitarian missions also expose our practitioners to pathology and challenging cases that improve diagnostic and clinical skills when treating a large number of patients in a short time period.

QUESTIONS SUBMITTED BY MR. KISSELL

Mr. KISSELL. I represent the Fort Bragg area. Fort Bragg is projected to grow from just 57,000 military personnel assigned in 2006 to just under 70,000 by the end of fiscal year 2011. These numbers, of course, do not include all of additional family members that will come with these 12,000+ soldiers. Now, Womack Army

Medical Center is a relatively new and unquestionably beautiful facility, but it doesn't seem large enough for our current population on Fort Bragg, let alone the growth we're expecting over the next few years. For example, the emergency room waiting area is tiny, with something like twenty chairs. What analyses have the Army done to assess the capacity of the current facility, and what plans have been made to ensure that the military personnel assigned to Fort Bragg, and their families, will have access to the care they need?

General SCHOOMAKER. Based on the projected population growth at Fort Bragg, the Army has planned and programmed medical military construction projects totaling $141M to support the projected increase of Soldiers and Family members. These projects include: an addition/alteration to the Robinson Health Clinic ($18M, FY 08), a new Primary Care Clinic ($27M, FY 10), a new Blood Donor Center ($4.8M, FY 10), a new Behavioral Health clinic ($32M, FY10), and an addition/alteration to Womack Army Medical Center (WAMC) that will expand the Emergency Department, Women's Health, Pediatrics, Pharmacy Services, and various other departments ($59M). This addition/alteration is desired in the FY 12 program following completion of the new Behavioral Health Clinic, which is programmed in FY 10. That stand-alone facility will remove Behavioral Health Services from WAMC to accommodate staffing increases and allow for the expansion of hospital-based functions, such as the Emergency Department.

Once completed, the MILCON projects will significantly expand the medical infrastructure at Fort Bragg. Approximately 65% of the Fort Bragg growth in population has already been realized. A dedicated recruitment effort has led to filling 82% of the new positions identified to support this population. In the interim period while MILCON construction is ongoing, WAMC is coordinating with Pope Air Force Base to assume control of the Pope Clinic in July 2010. This will provide a partial expansion of primary care until the new clinic is built. In 2008, WAMC completed a construction project that converted 12,700 square feet of storage area into administrative and educational space which freed approximately 16,000 square feet of clinical space. Currently, WAMC has initiated a renovation project that converts seven former administrative offices into treatment rooms for the Emergency Department. Additionally, we relocated the TRICARE offices to provide the Emergency Department a secondary waiting room and an additional 10 offices or exam rooms.

The most profound change has been the development of the Warrior Transition Battalion (WTB), which at Fort Bragg has grown to four companies. Until the Warrior Transition Complex is completed, the hospital has dedicated over 20,000 square feet of clinical space to the WTB. Clinical services for all beneficiaries, not just the Warriors in Transition, continue to improve and expand. At Fort Bragg, prominent examples are Traumatic Brain Injury (TBI) treatment and research, and the Pain Clinic's advanced technology and multidisciplinary alternative therapies. Behavioral health services are another area of growth that is defined by the population's increase as well as the population's increasing needs.

In summary, the Army has assessed the projected population growth at Fort Bragg and is implementing actions to provide all the necessary health care services to support these beneficiaries.

Mr. KISSELL. And since we are talking about how medical military construction is centrally managed by Health Affairs/TRICARE Management, is it the Army's responsibility or Health Affairs' responsibility to do these analyses?

General SCHOOMAKER. The US Army Medical Command (MEDCOM) conducts the detailed analyses required to develop medical military construction requirements. These analyses include facility requirements, staffing requirements, and the right mix of personnel skills to ensure we properly support our beneficiary population. MEDCOM provides our completed analyses and facility requirements to Health Affairs/TRICARE Management Activity for prioritization and programming.

QUESTIONS SUBMITTED BY MS. BORDALLO

Ms. BORDALLO. My question is about how the Navy, in conjunction with the TRICARE Management Activity and the Department of Defense's Office of Health Affairs, developed the requirements for number of beds and services that will be added as a result of the renovations. It is my understanding that the current requirement will only increase the number of beds by eleven and given that the military build-up will include, at the very least, 8,000 additional Marines and 9,000 family members, is that an adequate enough requirement to meet the demands with increased personnel on Guam? I understand from your testimony that Navy implemented the Capital Investment Decision Model (CIDM) in 2008 which will impact

Fiscal Year (FY) 2010 projects. If the CIDM were implemented early, would that have potentially altered the requirements for the hospital?

Admiral ROBINSON. The CIDM, which was employed for the first time last year, identified replacement of the United States Naval Hospital on Guam as the highest priority for medical military construction funding. The CIDM is used to prioritize competing proposals and not to develop specific facility requirements. Navy medical planners, in concert with others, analyzed the specific requirements for the replacement facility and determined the appropriate mix of capabilities required to support the needs of the projected population. The planning process was continuously updated as the scope of the Guam military build-up was refined. It is unlikely that implementing CIDM prior to 2008 would have altered the requirement for the new hospital.

Ms. BORDALLO. Additionally, can you comment on the anticipated level of increase in specialty care that might be offered on Guam as a result of the increased military presence on Guam as well as renovations to the facility that will allow such services to be offered? Many of my constituents have concerns about the current level of services that are available at the Naval Hospital and see the military build-up as an opportunity to attract additional specialty care services to the island.

Admiral ROBINSON. The United States Naval Hospital, Guam replacement facility will support delivery of a broad range of primary and specialty care services. The new hospital will provide 42 inpatient beds for provision of intensive care, general medicine, surgery, orthopedics, obstetrics, urology, ophthalmology, proctology, otorhinolaryngology, behavioral health, and oral surgery. It will operate four operating rooms and two rooms dedicated to performing Caesarian Sections. Robust diagnostic imaging will include magnetic resonance imaging (MRI) and computerized axial tomography (CT) scan capabilities as well as full laboratory and pharmacy capacity. In addition to a Level III emergency room, outpatient capabilities will include a variety of primary and specialty care services, including diet and wellness, dermatology, nuclear medicine, physical therapy, and environmental health.

The new community-based Outpatient Clinic now under construction will increase the range of potential for sharing with the Department of Veterans Affairs (VA). Its location adjacent to the new hospital will increase both the visibility of the clinic and its accessibility to VA beneficiaries.

Ms. BORDALLO. To what extent has the Department of Defense worked with the Department of Veterans Affairs pursuant to Section 707 of H.R. 5658, the House-passed National Defense Authorization Act for Fiscal Year 2009? Are there any issues of concern regarding the development of these implementation guidelines?

Secretary CASSCELLS. The DOD and the DVA studied a combined federal health facility as identified in H.R. 5658, Section 707, but the DVA decided they could not support a joint effort. Therefore, planning and programming of Naval Hospital Guam replacement was performed with Presidential Executive Order 13214 (dtd 28 May 2001) and Public Law 108–136, Section 583 as the drivers for extensive collaboration with the DVA from a health facility perspective. The planned replacement of Naval Hospital Guam accounted for all workload currently performed in support of the robust resource-sharing agreements in place between Navy and the DVA for inpatient, specialty, diagnostic, and ancillary services. In addition, the DVA is currently constructing a new Community-Based Outpatient Clinic on a convenient site provided by the Navy to the DVA immediately adjacent to the Naval Hospital campus. The DVA designed their new outpatient clinic to enhance DVA primary care capabilities to better serve the Guam veterans.

Ms. BORDALLO. I am wondering why the Department of Defense has not designated Guam or the other territories, specifically Puerto Rico as a Prime Service Area for military retirees to be eligible to receive TRICARE Prime? If specialty care services will not increase to cover all the needs of our local retiree population isn't there a benefit to extending TRICARE Prime to the territories? I see this as a key quality of life measure and as a commitment to those who served our nation.

Secretary CASSCELLS. It is recognized under 32 CFR § 199.17, (a), (3), the Assistant Secretary of Defense (Health Affairs) has the authority to modify the scope of the TRICARE program as implemented outside the 50 States and the District of Columbia. Currently, TRICARE Prime is not available as an option for retired service members and their eligible dependents in the territories of Puerto Rico and Guam.

Navy Medicine recognizes the tremendous contribution and sacrifice that all of our current and prior military members and their families have endured to serve our Nation. They deserve a generous health care benefit in recognition of their important service. The extension of TRICARE Prime in Puerto Rico and Guam for retired service members and their eligible dependents may improve the health of those members as a result of improved access to care, and would create parity of

health care benefits with those beneficiaries residing in the 50 States and the District of Columbia.

If implemented, the broader challenge will remain in meeting the specialty care requirements in remote locations with limited local health care resources. The TRICARE program relies heavily on civilian-based provider networks to augment and support the Direct Care System (Military Treatment Facilities—MTFs) in meeting their mission. Any actions taken to expand or change the health care benefit in Puerto Rico and Guam must be carefully reviewed to consider the impact on existing resources, both civilian and military.

○