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STATEMENT BY

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THE JOINT TASK FORCE NATIONAL CAPITAL REGION MEDICAL: MASTER PLAN

BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

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Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss our plans for fully implementing the Base Realignment and Closure (BRAC) decisions as they relate to military medical transformation in the National Capital Region (NCR). I also thank you for your support of our military beneficiaries in the NCR, and around the world.

The decision to consolidate medical functions in the NCR is one of the single most transformative initiatives in the Military Health System (MHS), and will change how we deliver and integrate health care delivery in a joint environment. I am pleased to share my perspectives along with the other leaders who are instrumental in seeing this transformation through to completion – Vice Admiral John Mateczun, Commander of the Joint Task Force National Capital Region Medical, Dr. Dorothy Robyn, Deputy Under Secretary of Defense for Installations and Environment, Mr. Michael McCord, Principal Deputy Under Secretary for Comptroller, and Vice Admiral Michael Vitale, Commander, Naval Installations Command.

I want to provide the Committee an overview of the current state of the MHS, particularly as it relates to the many activities driven by BRAC underway in the NCR, and our near term plans to ensure the needs of our beneficiaries and expectations of our stakeholders are met and exceeded.

The MHS serves over 9.5 million beneficiaries – Active Duty personnel, retired personnel and their families, plus many men and women in our Reserve and Guard and their families. Within the NCR, the Department of Defense (DoD) is responsible for approximately 440,000 beneficiaries; 80,000 of whom are enrolled to our military medical treatment facilities (MTFs).

In addition to the enrolled population, the NCR serves as the principal referral center for casualties aeromedically evacuated from the Iraq and Afghanistan combat theaters. We have profound obligations to these wounded Service members and their families. It is when we make reference to creating "world-class" facilities and services, the needs and requirements of these heroes are foremost in our minds.

Implementation of the 2005 BRAC Commission recommendations has required a careful choreography of four interrelated planning factors – people, physical infrastructure, processes, and technology. Each factor has required substantial cross-Service coordination, particularly as it relates to assignment and oversight of personnel, and command authorities. Additionally, we have responded to the Defense Health Board recommendations regarding important facility upgrades to adhere to our commitment to build a facility that honors the sacrifice of those we will serve. The Department remains committed to completing this transition within the statutory deadline of September 15, 2011.

The major transition activities planned for completion in the next 17 months include:

- Closure of Walter Reed and relocation of many clinical activities to the Bethesda Naval hospital campus, creating the consolidated Walter Reed National Military Medical Center (WRNMMC).
- Relocation of other Walter Reed activities to a newly built community hospital at Fort Belvoir, Virginia.
- Closure of inpatient services at the medical center at Andrews Air Force Base, with a comprehensive ambulatory care clinic remaining in place.

This relocation of facilities and expansion of outpatient services will give eligible beneficiaries more proximate and convenient healthcare. The reduction of excess capacity and related overhead will release scarce personnel and resources to meet the changing needs of wounded warriors, active duty families, and retirees.

Both the Bethesda and Fort Belvoir sites are replete with construction equipment and crews. Our approach to medical facility design is new. Investments in evidence based design (EBD) concepts for our new facilities are critically important as they offer a better healing environment for patients and their families. The hospital at Fort Belvoir will be a showcase for this new approach. I visited Fort Belvoir last month and was impressed by the design concepts that incorporated to create an unmatched healing environment.

Evidence based design has been shown to have important benefits, medical facilities that have utilized this approach show fewer infection rates and shorter lengths of stay. In the end, I am confident that medical facilities will result in better services, quality, and access for our patients.

On the Bethesda campus, there are a number of other facilities being constructed or upgraded to reflect the very special role of this medical center to serve our wounded Service members. This includes the National Intrepid Center of Excellence, a Vision Center of Excellence, Wounded Warrior Transition Units, and other administrative offices.

Finally, one of the more challenging elements of this transition has been to develop a command and governance plan which ensures the vision of the BRAC Commission and of the Department is fulfilled. Specifically, we are creating a truly joint medical organization, comprised of Army, Navy, and Air Force medical personnel, united to serve our joint population. With the WRNMMC serving as the flagship medical facility, we are also working with our colleagues in the Department of Veterans Affairs and the National Institutes of Health to craft a highly collaborative relationship across clinical services delivery and medical research. Consequently, the joint leader for this service area must be empowered to make decisions and move resources on behalf of the patient served.

While the establishment of a Joint Task Force (JTF) is not a new construct, the application of this model for a United States-based geographic medical area of operation is new. Chairman Mullen and the Service Chiefs have worked tirelessly to establish a long-term leadership plan that provides the maximum authority to the JTF Commander, establishes clear accountability for performance, and ensures transparency in how we will oversee this organization going forward. I am confident the organizational model approved by Chairman Mullen and Deputy Secretary Lynn will work to provide our patients and our medical staffs with authority moved closest to the point of care.

Conclusion

I want to thank you again for this opportunity to discuss our efforts to offer the people we serve a set of medical facilities that will set new standards for design, service, and quality is a model for not just military medicine, but United States medicine, and which will improve our medical facilities in the NCR. I appreciate the ongoing support of this Committee, and your interest as we complete our master transition plan and finalize our governance model. I would be pleased to respond to any questions you may have.