



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable Carl Levin  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

AUG 31 2010

Dear Mr. Chairman:

The Department of Defense (DoD) provided the Comprehensive Master Plan (CMP) for the National Capital Region (NCR) Medical to Congress in response to section 2714(a) of the National Defense Authorization Act (NDAA) for FY 2010 on April 23, 2010. Section 2714(c) of the NDAA for FY 2010 requires DoD to submit a supplement to the CMP to Congress describing the schedule for completion of requirements identified in the CMP as well as updated cost information to provide sufficient world-class military medical facilities in the NCR, as defined under section 2714(e) of the NDAA for FY 2010.

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The cost estimate for construction projects identified in the CMP is \$829M and a proposed timeline for the projects estimates completion by 2018. The Department has also delegated the Joint Task Force National Capital Region Medical with NCR Budgetary Authority over the hospitals it currently operates (Walter Reed Army Medical Center, National Naval Medical Center, and DeWitt Army Community Hospital) beginning in FY 2011. This directly aligns to the Defense Health Board's recommendation that, "one official should be empowered with singular organizational and budgetary authority." The DoD will continue to provide Congress with periodic updates regarding the refinement and implementation of the CMP.



The Department expresses its appreciation to Congress for the steadfast interest and support throughout the transformation of Military Medicine in the NCR. Congressional oversight and actions have helped the Department with this complex process and have made immeasurable contributions to its ability to provide world-class healthcare. Next to the war itself, our Nation's wounded warfighters remain the Department's top priority.

A handwritten signature in blue ink, appearing to read "William R. Pryor", is positioned in the upper right quadrant of the page.

Enclosures:  
As stated

cc:  
The Honorable John McCain  
Ranking Member



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable James H. Webb  
Chairman  
Subcommittee on Personnel  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

AUG 31 2010

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Enclosures:  
As stated

cc:  
The Honorable Lindsey O. Graham  
Ranking Member



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable Daniel K. Inouye  
Chairman  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

AUG 31 2010

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As stated

cc:  
The Honorable Thad Cochran  
Ranking Member



DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010

The Honorable Ike Skelton  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

AUG 31 2010

Dear Mr. Chairman:

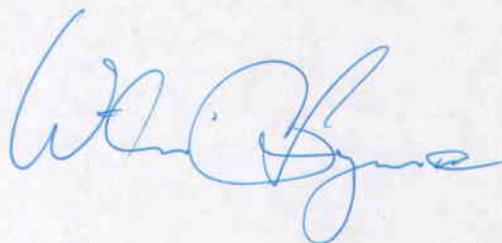
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**Enclosures:**  
As stated

**cc:**  
The Honorable Howard P. "Buck" McKeon  
Ranking Member



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable David Obey  
Chairman  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

AUG 31 2010

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Enclosures:  
As stated

cc:  
The Honorable Jerry Lewis  
Ranking Member



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable Norman Dicks  
Chairman  
Subcommittee on Defense  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

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Enclosures:  
As stated

cc:  
The Honorable C.W. Bill Young  
Ranking Member



**DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010**

The Honorable Susan Davis  
Chairman  
Subcommittee on Military Personnel  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

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Enclosures:  
As stated

cc:  
The Honorable Joe Wilson  
Ranking Member

# Supplement to the Comprehensive Master Plan for the National Capital Region Medical:

## Schedule for Completion of Requirements and Updated Cost Estimates





**Supplement to the Comprehensive Master  
Plan for the National Capital Region Medical:**

**Schedule for Completion  
of Requirements and  
Updated Cost Estimates**

**Report to Congress**

**August 2010**







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## ATTACHMENT

Attachment 1: Integrated Wounded, Ill, and Injured Warrior Care Concept of Operations



## EXECUTIVE SUMMARY

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The Comprehensive Master Plan (CMP) for the National Capital Region (NCR) Medical was provided to Congress on 23 April 2010. Section 2714(c) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010 requires the Department of Defense (DoD or Department) to submit a report to Congress describing the schedule for completion of requirements identified in the CMP as well as updated cost estimates to provide world-class military medical facilities, as defined under section 2714(e) of the NDAA for FY 2010, at the Walter Reed National Military Medical Center (WRNMMC).

The Department's development and approval of the CMP was a landmark step in the transformation of Military Medicine in the NCR and a reflection of the DoD's enduring commitment to continual improvement and provision of the best care for the nation's Military, particularly combat casualties, military families, and military retirees. Implementation of the CMP continues to capitalize on the unique and dense multi-Service healthcare market in the NCR paving the way for more effective and efficient healthcare delivery in the region.

Today the Department is pleased to provide the required supplement to its CMP in order to fulfill the requirements of section 2714(c) of the NDAA for FY 2010. This update illustrates the substantial and continued progress the DoD has made since its submission of the CMP in achieving those attributes of the new statutory world-class standard in the NCR beyond the requirements of the 2005 Base Realignment and Closure (BRAC) recommendations. Items discussed in this update include, but are not limited to, the schedule for completion and additional information on the facility and installation projects identified in the CMP, updated cost information in the CMP, the delineation of budgetary and organizational authorities, the development of an integrated Wounded, Ill, and Injured Warrior Concept of Operations (CONOPS), and the transition plans for civilian personnel currently employed at Walter Reed Army Medical Center (WRAMC).

Operational Control (OPCON) of WRAMC, National Naval Medical Center (NNMC), and DeWitt Army Community Hospital (DACH) has been assumed by the Commander, Joint Task Force National Capital Region Medical (JTF CapMed). The Commander, JTF CapMed (CJTF) will also exercise OPCON over the new WRNMMC at Bethesda and the new Fort Belvoir Community Hospital (FBCH) when they are established as joint commands after completion of the NCR Medical BRAC projects. In addition, beginning in FY 2011, JTF CapMed will be delegated as a Budgetary Authority to program, budget, and execute resources for WRAMC, NNMC, and DACH. With the delegation of this financial authority, CJTF will have both OPCON over its inpatient hospitals in the NCR and the commensurate budgetary authority to manage associated financial resources. This directly aligns to the Defense Health Board's (DHB) recommendation that "one official should be empowered with singular organizational and budgetary authority."

In order to ensure world-class care, management, and transition of seriously Wounded, Ill and Injured (WII or Wounded) Warriors at the joint hospitals in the NCR, the Department has developed an Integrated WII Warrior CONOPS that synchronizes all aspects of care including Military Service requirements, installation support, medical care, and other non-medical programs. This CONOPS will be the foundation for the development of detailed Standing Operating Procedures (SOPs) that are expected to be completed by Fall 2010 and which will continue to evolve with lessons learned. A transition exercises are being used to test the developing SOPs.

As part of the CMP, the Medical Master Facilities Plan (MMFP) indentified construction and renovations projects for WRNMMC at Bethesda to achieve the new statutory world-class standard. The MMFP itself continues to be refined and is scheduled to be completed by 31 December 2010. This supplement to the CMP provides additional information regarding the estimated cost of the projects and a general execution timeline. With the recent completion of Phase I of the MMFP, the Department has been able to more thoroughly refine cost estimates for these projects and now estimates the total cost to be \$829M. Costs will continue to be refined as design gets underway and updates will be provided to Congress after the MMFP is completed. In addition, while the MMFP projects are estimated to be completed by 2018, its timeline is dependent on the National Environmental Protection Act (NEPA) process (for which the Department has determined that, based upon project scope, an Environmental Impact Statement (EIS) will be required), as well as review by appropriate state and community organizations, and other factors. No projects can start before the completion of the NEPA process.

The DoD has taken several key steps to maintain the skilled civilian workforce of health professionals in the NCR, which is essential to the delivery of world-class healthcare in the region. In response to significant concerns expressed about workforce attrition at WRAMC after the BRAC closure the Department instituted a Guaranteed Placement Program (GPP) for permanent civilian personnel. The Department has tracked WRAMC attrition since 2008 and there have been no significant increases in departures. Letters to all permanent civilians at WRAMC, NNMC, and DACH were issued nearly three weeks ahead of schedule and more than 95 percent of NCR civilian employees had future jobs mapped to their desired geographic location. Hiring and reassignment strategies are in place with the goal of meeting all geographic preferences before the move. The DoD is utilizing appropriate civilian personnel authorities under Titles 5, 10, and 42 of the United States Code, DoD directives, and Executive Orders. These authorities will allow for the appropriate balance of regional consistency to support integrated healthcare delivery and the needed delegation of discretion to the Commanders and managers in the facilities to recruit, train, direct, reward and retain civilian employees in the region, as well as add significant career progression opportunities within the consolidated workforce.

A robust network of Information Management/Information Technology (IM/IT) systems continues to be developed and implemented to support the new WRNMMC at Bethesda and FBCH and enhance the provision of world-class healthcare within the NCR. Updates on the status of key milestones associated with IM/IT initiatives have been provided and includes data centers at both WRNMMC and FBCH, the Military Health System (MHS) network infrastructure, the migration of WRAMC systems, and the integration of smart suite technology.

Through 15 September 2011, the Department's primary focus for Military Medicine in the NCR remains casualty care, followed by the successful execution and facilitation of projects that must be accomplished in order to meet BRAC. The transition from four Service inpatient Medical Treatment Facilities (MTFs), including WRAMC, NNMC, DACH, and Malcolm Grow Medical Center (MGMC), to two inpatient MTFs is a mission that requires the relocation of more than 9,000 military and civilian staff, consolidation of more than 60 medical services, relocation and transition of nearly 470 beds across 3 hospitals, integration of care for approximately 750 WII Warriors, and primary care reassignment of nearly 19,000 beneficiaries currently enrolled to WRAMC and nearly 4,000 beneficiaries currently enrolled to NNMC. To ensure all issues are identified, addressed and monitored across the transition, the Department has implemented several enabling activities that are discussed in this update. The Department has observed and consulted with hospitals that have successfully executed facility transitions and held wargame exercises to refine relocation plans. The DoD has awarded a \$322M Initial Outfitting and Transition (IO&T) wrap-around contract to General Dynamics Information Technology (GDIT), who has assembled a team of several of the most accomplished industry leaders in the country to support transition efforts. JTF CapMed and NCR stakeholders have identified tens of millions of dollars in long lead equipment and equipment for reuse. They are working with GDIT to refine requirements for nearly \$200M of medical, non-medical, IM/IT, and furniture items for GDIT to procure, ship, install, test, and turn over. In addition, equipment outfitting of the new clinical construction has already begun.

The Department expresses its appreciation to Congress for its steadfast interest and support throughout the transformation of Military Medicine in the NCR. Congressional oversight, as well as the efforts of the DHB, have helped the Department throughout this process and have made immeasurable contributions to its ability to provide world-class healthcare. DoD will continue to provide Congress with periodic updates regarding the refinements and implementation of the CMP.



## 1.0 INTRODUCTION

---

The Comprehensive Master Plan (CMP) for the National Capital Region (NCR) Medical was provided to Congress on 23 April 2010. Section 2714(c) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010 requires the Department of Defense (DoD) to submit a report to Congress describing the schedule for completion of requirements identified in the CMP as well as updated cost estimates to provide world-class military medical facilities, as defined under section 2714(e) of the NDAA for FY 2010, at the Walter Reed National Military Medical Center (WRNMMC).

The Department's development and approval of the CMP was a landmark step in the transformation of Military Medicine in the NCR. This transformation began with the approval of the Base Realignment and Closure (BRAC) recommendations for the NCR nearly half a decade ago. Since then, the Department has taken the opportunity to significantly expand the face of this transformation and has initiated several enhancements to ensure that beneficiaries, particularly Wounded Warriors, will receive the best care and recovery services available when the new WRNMMC and Fort Belvoir Community Hospital (FBCH) open in 2011.

In July 2009, the NCR BRAC Health Systems Advisory Subcommittee of the Defense Health Board (DHB) provided an independent review of WRNMMC and FBCH, and established a working definition of a world-class medical facility that incorporated the following six domains: basic infrastructure, leadership and culture, processes of care, performance, knowledge management, and community and social responsibility. This definition was later codified in section 2714(e) of the NDAA for FY 2010. With few exceptions, the DHB panel concluded that FBCH would achieve this new world-class definition. The panel made several recommendations for WRNMMC to meet the new standard, the majority of which have been incorporated as part of the execution of the NCR Medical BRAC projects. The CMP addressed those recommendations that could not be completed by 15 September 2011 due to the Bethesda installation's capacity to absorb additional construction in addition to the current projects. The CMP specifically included the following important achievements:

- World-Class Facilities - identified additional construction and renovation requirements at WRNMMC to achieve the new statutory world-class standard.
- Organizational Authorities - directed the Commander, Joint Task Force National Capital Region Medical (CJTF) to assume Operational Control (OPCON) over Walter Reed Army Medical Center (WRAMC), National Naval Medical Center (NNMC), and DeWitt Army Community Hospital (DACH).
- Bethesda Installation Support - defined the facilities that constitute WRNMMC and defined the supporting relationship between the Bethesda installation and the new WRNMMC to ensure appropriate mission support.

- Joint Hospitals - reaffirmed the direction to establish WRNMMC and FBCH as joint hospitals subordinate to the Joint Task Force National Capital Region Medical (JTF CapMed) following completion of the NCR Medical BRAC projects.
- Civilian Personnel - reaffirmed that civilian personnel at WRAMC, NNMC, and DACH will transition to a single DoD civilian manning model to support joint hospitals in the end state as well as stated permanent civilian employees would be notified by 01 July 2010 of the work locations at WRNMMC or FBCH.
- Active Duty Force Mix – established an Active Duty force mix for the new WRNMMC and FBCH.

The Department is now pleased to provide Congress with a supplement to the CMP as required by section 2714(c) of the NDAA for FY 2010. This supplement to the CMP illustrates the substantial and continued progress that the DoD has made in achieving of the statutory world-class medical facility standard in the NCR beyond the requirements of the 2005 BRAC recommendations. Items discussed in this supplement include, but are not limited to, the delineation of budgetary and organizational authorities, the development of an integrated Wounded, Ill, and Injured Warrior Concept of Operations (CONOPS), additional information on the facility and installation projects identified in the CMP, and the transition plans for civilian personnel currently employed at WRAMC.

## 2.0 OPERATIONAL AUTHORITIES

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As stated in the CMP, the Department has modified the existing command relationship of CJTF over three Military Service Medical Treatment Facilities (MTFs) (WRAMC, NNMC, and DACH) from Tactical Control (TACON) to OPCON. This change in the command relationship ensures that the authorities of CJTF are commensurate with the responsibilities assigned to JTF CapMed by the Department and reinforces unity of effort and command. It also supports the successful execution of NCR Medical BRAC closures and moves by allowing JTF CapMed to more effectively oversee and manage these three subordinate Military Service MTFs. Moreover, it will enable a seamless transition of operations from WRAMC and set the conditions to establish WRNMMC and FBCH as joint MTFs subordinate to JTF CapMed following completion of the NCR Medical BRAC projects. JTF CapMed will continue to retain TACON over the outpatient MTFs in the NCR Joint Operations Area (JOA) throughout and following this transition.

The continued maintenance of Military Service component Administrative Control (ADCON) responsibilities is imperative throughout the transformation of Military Medicine in the NCR to support the continued integration of the NCR military healthcare market and provide greater quality of care and access for patients. The JTF CapMed has issued an Operations Order (OPORD) that identifies Military Service ADCON responsibilities. The OPORD will enable the necessary flexibility and agility to direct and employ assets and forces throughout the transition.



## 3.0 BUDGETARY AUTHORITIES

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To provide superlative care in leading-edge facilities and achieve the promise of an integrated delivery system, CJTF must be empowered with sufficient alignment of budgetary authorities to match the OPCON already assumed over WRAMC, NNMC, and DACH. Beginning in FY 2011, JTF CapMed will be delegated NCR Budgetary Authority along with OPCON and mission accountability. This directly aligns with the DHB's recommendation that "one official should be empowered with singular organizational and budgetary authority," as well as fulfills congressional intent. It will provide for unity of effort, allow for effective health system planning and be a critical enabler to achieving an integrated healthcare delivery system in the NCR.

These NCR Budgetary Authorities will allow CJTF to direct the funds allocation for WRAMC, NNMC, and DACH, as well as WRNMMC and FBCH when they are established after completion of the NCR Medical BRAC projects. To avoid redundant administrative requirements, the funds will flow through the Military Services to the three MTFs at the direction of CJTF. In addition, JTF CapMed will fully participate in programming, budget, and execution along with the Military Services.

Commander Naval Installations Command (CNIC), via Naval Support Activity (NSA) Bethesda, and Army Installation Management Command (IMCOM) will deliver all base operating services on the Bethesda and Fort Belvoir campuses. CNIC is currently working with the Navy's Bureau of Medicine and Surgery (BUMED) to negotiate a budget-based transfer in support of the current level of services at Bethesda.



## 4.0 SUPPORTING THE MISSIONS OF THE BRANCHES OF THE ARMED FORCES SERVED

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The JTF CapMed is responsible for healthcare operations and contingency medical response in the NCR. Service Members assigned to JTF CapMed or its subordinate commands must also support Military Service specific (Army, Navy, Marine Corps, and Air Force) medical requirements and deployments. To de-conflict demand signals between JTF CapMed and Military Service responsibilities, the DoD directed JTF CapMed to enter into an agreement with the Services through a Global Force Management Memorandum of Understanding (MOU) to address and clarify those responsibilities. This MOU is near approval and will:

- Clarify the responsibilities between the Military Services and JTF CapMed when the Military Services request personnel assigned to JTF CapMed or its subordinate commands to attend Service-specific training, fill a scheduled Service deployment request, other Service request, or Secretary of Defense approved Deployment Order.
- Provide a way for Services to continue to train their forces at the world-class facilities in the NCR and for the Services and the joint staff to access those forces when necessary.
- Balance the need to care for wounded warriors in the NCR with the need to provide fully trained and ready forces for deployment.
- Require scheduling of force deployments and training (where possible) especially in steady state situations, but acknowledges that the nature of warfare and of humanitarian assistance operations may necessitate unscheduled deployments.
- Recognize that Military Service components are responsible for ensuring forces are adequately manned and trained, while the CJTF is responsible for organizing and employing those forces to accomplish the assigned mission within this JOA.



## 5.0 INTEGRATED WOUNDED, ILL, AND INJURED CONCEPT OF OPERATIONS

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Next to the war itself, casualty care remains the Department's top priority. The new WRNMMC at Bethesda and FBCH will anchor this effort in the NCR. Warriors will not be moved from the Warrior Transition Unit at WRAMC until appropriate support and recovery services are in place at Bethesda and Fort Belvoir. The CMP described these services which include a substantial expansion of fully-compliant Americans with Disabilities Act (ADA) lodging, a fitness center, and the overall development of a warrior-friendly campus. This update to the CMP discusses the progress the Military Services have made in identifying the levels of support required for their respective WII Programs as well as an integrated WII CONOPS the Department has developed for the region. The WII CONOPS describes support for WII service members and families in the NCR JOA and includes Military Service requirements, installation support, medical care, and other non-medical programs. It also provides the framework for a seamless transition across seven critical patient transfer nodes along the care continuum. The integrated WII CONOPS has been included in Attachment 1 to this report.

Creating a holistic healing environment for Warriors and families is integral to the renewal of spiritual, physical, and psychological wellness throughout the continuum of care. The cornerstone of this environment is a seamless interface between the hospital providing medical services, the Installation providing environmental support, and the Military Services providing command liaison and Military Service specific administrative services. The interface between these elements must be carefully designed as gaps may lead to mission failure while overlaps may lead to redundant efforts, avoidable inefficiencies, and friction. Clearly defined responsibilities for the Military Services, installation, and the hospital, as well as a common operating platform are essential elements to sustaining effective operations. The Integrated WII CONOPS provides a roadmap to achieve this end and is guiding the development of detailed Standing Operating Procedures (SOPs) for the medical and non-medical care of WII warriors in the NCR by the Fall of 2010. The SOPs will describe the functions included in the integrated WII CONOPS in greater detail and how they would apply in a day-to-day joint environment and will continue to be refined.

With the closure of WRAMC, WII Warriors requiring care in the NCR will receive treatment at WRNMMC or FBCH. WRNMMC will serve as a tertiary referral center for those patients requiring care for high risk, complex and problem-prone diagnoses and for those cases for which there is limited capability in the Military Health System (MHS). Warriors requiring other acute subspecialty care will be medically regulated directly to FBCH. The fundamental and overarching premise in the regulation to NCR facilities will be matching the Warrior's medical requirements to care capability and the necessary environment to deliver the optimal outcome. Medical services exclusive to the Bethesda campus will be Neurosurgery, Cardio-Thoracic Surgery, acute amputee care, severe traumatic brain injury (TBI), and complex battle trauma.

At both the Fort Belvoir and Bethesda installations, construction and deliberate planning are underway to create an environment that offers full spectrum support to Warriors and families. Lessons learned in providing care and support to more than 15,000 WII Warriors and families

over the past nine years have provided valuable experience to interdisciplinary teams of medical and non-medical personnel including WII Program Managers, installation representatives, and volunteer support organizations that are actively engaged in developing a Warrior campus to effectively complement medical operations. At the heart of this campus will be a Warrior Transition Center (WTC) that will house a Warrior Family Coordination Center (WFCC) and a Warrior Family Assistance Center (WFAC), among other functions. The WFCC will serve as the backbone to integrate Warrior activity and provide a seamless interface between the Military Services, the installation, and the MTF. The WFAC will be designated to be a “one-stop shop” dedicated to the non-medical needs of Warriors and families.

## **5.1 Military Service, Installation, and MTF Responsibilities**

Successful warrior care depends on close coordination and collaboration between the MTF, the installation, and the Military Services. Responsibilities of each are outlined below:

- **Military Service Responsibilities:**
  - Command and Control, including Uniform Code of Military Justice (UCMJ), Transfer Authority, Movement and Family Support
  - Personnel Accountability
  - Execute Service Specific Personnel Action
  - Execute Service WII Program
  - Ensure Personnel Availability for continuity of Healthcare and Rehabilitation
- **Installation Responsibilities:**
  - Provide Base Operations, Lodging, and Transportation
  - Ensure Campus is WII Friendly and Compliant with Americans with Disabilities Act Accessibility Guidance (ADAAG)
  - Operate Day Care, Fitness Center, Exchange, and Morale Welfare & Recreation Activities
  - Contribute to a Healing Environment
- **MTF Responsibilities:**
  - Provide Patient and Family Centered Clinical Care and Rehabilitation
  - Ensure Continuity of Care through the Services
  - Operate a a WFCC
  - Conduct a timely and responsive Medical Evaluation Board (MEB) system
  - Respond to Service Specific MEB, Physical Evaluation Board (PEB) and other administrative concerns

## 5.2 Patient Transfer Nodes

Military Service, installation, and MTF representatives have been integral in developing the CONOPS for comprehensive WII care on the Bethesda campus. Seven patient transfer nodes along the care continuum have been identified for the development of this integrated WII CONOPS including departure from Landstuhl Regional Medical Center, Germany (LRMC); reception at Joint Base Andrews, Maryland; reception and in-processing at NCR MTF; inpatient support; inpatient and outpatient activities and support; outpatient activities and support; and transition activities and support. The role of Non-Medical Attendants (NMAs) and the issuance of Travel and Transportation Orders (TTOs) for family members to support WII Warriors are described as contributors to this continuum as well. Each node represents patient movement and as such, a potential risk or vulnerability in maintaining quality, safety, and/or continuity of care. An interdisciplinary, inter-Service team is engaged in detailing a risk assessment at each node. From the assessment, gaps and overlaps have been identified and mitigation strategies are under development. From this work, discrete SOPs are being developed for both WRNMMC and FBCH. Rehearsal and “load testing” of the policies and procedures is scheduled through a series of table top exercises in August 2010 and September 2010.

## 5.3 Warrior Transition Center

Within a program focused on development of a Warrior Campus for healing, the heart of the campus will be the WTC, which will house a WFAC and a WFCC, among other functions. The WTC is show in Figure 1 below as the center building with warrior lodging facilities on both sides.

**Figure 1: WRNMMC Warrior Transition Center**



Warrior Family Coordination Center – To ensure seamless coordination and collaboration between the MTF, the installation, and the Military Services, a WFCC is programmed to support both WRNMMC and FBCH in FY 2011. Successful Warrior care depends on coordination, communication and collaboration between the MTF, installation (Naval Support Activity, Bethesda/Fort Belvoir), and Military Services. The WFCC will serve as the center for integrating

Warrior activities. With a footprint in the WTC, the WFCC will serve as the backbone of integrated Warrior activity providing a seamless interface between the MTF, the Military Services, and the installation. As a common operating platform for all stakeholders (such as Volunteer Support Organizations, Warriors and Families, Service administrative elements, WII Programs, Installation, medical regulating authorities), it will serve as the touch point of synchronized activity required for the successful delivery of comprehensive Warrior care.

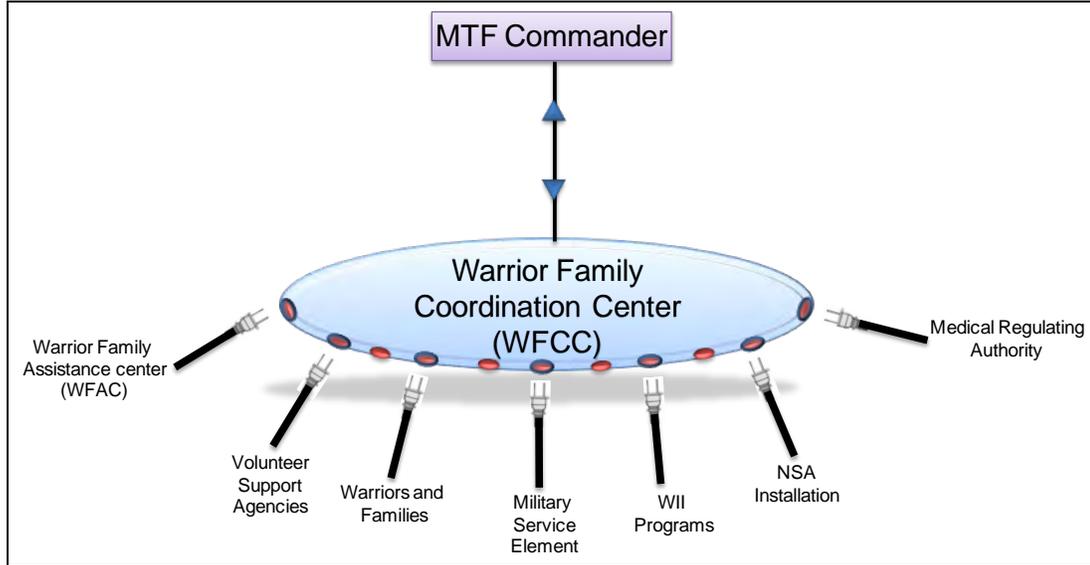
**Figure 2: Fort Belvoir Warrior Complex**



*Figure ES-2 Bird's Eye View of WT Campus Looking East*

Scope of WFCC responsibility includes early identification and resolution of barriers to care; sustaining a seamless and effective interface between the MTF, installation, and Military Services on Warrior issues; leveraging opportunities to enhance a healing environment throughout the campus; timely and effective response to Warrior and family issues; building strong partnerships with volunteer organizations; supporting Service equities in management of WII Programs; promoting equitable distribution of services to Warriors and families; and fostering cultural integration among the Services. The Center will operate 24 hours per day, 7 days per week with a permanently assigned staff serving as a rapid reaction force ensuring early visibility, intervention, and resolution of issues. A diagram of how medical and non-medical support will be coordinated at the WFCC is depicted below in Figure 3.

**Figure 3: Warrior Family Coordination Center Coordination Model**



Warrior Family Assistance Center – Also within the WTC will be a WFAC which will provide a “one-stop shop” for non-medical support to all Warriors from all Military Services. Located in close proximity to the MTF and Warrior lodging, the WFAC will provide counseling, subject matter expertise, and a wide range of services including government travel, Child and Youth Services, Social Work Services, Veterans Affairs counseling, Identification (ID) card and Defense Eligibility Enrollment Reporting System (DEERS) enrollment, employment assistance, emergency lodging, information referral, and community outreach services. The WFAC will be staffed with Active Duty, Reserve, and National Guard representatives from each of the Services as well as DoD civilians to provide and coordinate non-medical resources and services. At initial reception and throughout the continuum of care, WFAC services will be available and strongly encouraged to help Warriors and families navigate the complexity of recovery.

Other Support Services in the Warrior Transition Complex – The WTC will also house a disability evaluation cell linking PEB Liaison Officers, Case Managers, and Medical Officers who are dedicated to processing MEBs within a single office with a single process. Locating this service near to the Warriors and within close proximity to Administrative Service areas will streamline processing. Four separate Service-level WII Programs will have footprints and operate within the complex to manage their respective WII Programs and execute Service responsibilities for command and control of Warriors. A drop-off childcare center providing hourly care and a dining facility within the building will provide full support to Warriors and Families in the Warrior Complex.

#### **5.4 Contingency Planning for Warrior Care**

Medical requirements and necessity will continue to be the primary factors in determining treatment location for any Warrior. Current operations at both WRAMC and NNMC include proactive oversight of downrange activity and anticipatory planning to meet the demands of casualty flow. MTF commanders are the primary decision makers in regulating casualties in

and through the NCR. The reviews that led to the Final Environmental Impact Statement (FEIS) for the Bethesda campus established the requirement for accommodating 350 WII Warriors at WRNMMC. The trend of more recent aggregate data continues to support a planning factor of 350 Warriors requiring complex tertiary inpatient and outpatient care when the new WRNMMC opens. Multiple reviews have been conducted since 2007 and each review has provided similar outcomes in terms of percentages and volume of Warriors requiring tertiary level care.

While current demand analysis is an integral component to operations planning at the MTF and throughout the NCR Integrated Delivery System, not all contingency scenarios can be known or planned for (such as full scale military medical deployments, natural disasters, catastrophic events, or combat surges, which can create emergency conditions straining capacity and requiring immediate response and action.)

JTF CapMed, Military Service Regional Component Commands, MTFs, TMA Regional Operations North, and Health Net Federal Services, the TRICARE Management Activity Managed Care Support Contractor for the North Region (Health Net), have developed an NCR approach to contingency planning and analysis. Each contingency scenario or emergency condition identified by the MTF will be assessed to determine the impact on:

- MTF enrollment capacity
- MTF specialty care capability and right of first refusal
- Civilian provider network
- Enrolled beneficiary Primary Care Manager (PCM) change requirements
- TRICARE Service Center operations and relocation requirements

Health Net will take appropriate planning actions with each MTF to ensure the MTF Commander is provided tailored timely contingency support and services. To optimize the planning effort, the MTF will advise Health Net of known deployment and contingency scenarios that impact MTF capacity and specialty care capability. This process will enable Health Net to assist in backfill planning, to appropriately size the provider network, to properly support the MTF, and to minimize disruption to MTF enrolled beneficiaries.

The primary objective in any contingency scenario is to continue to optimize the direct care system and maintain the maximum amount of capability in the MTF as possible. If a surge of Wounded Warriors require care in the JOA, CJTF can reallocate the active duty force mix within the JOA. If that is not possible, active duty or reserve force mix can be requested from outside of the JOA. Aside from active duty and reserve force multipliers, the following vehicles can be employed with varying lead time required:

- Clinical Support Agreements (CSA): Managed Care Support Contract (MCSC) program to provide contracted medical personnel (staffing) to MTFs through task order issuance to Health Net
- External Resource Sharing Agreements (ERSA): MCSC program to fund MTF initiatives for reduction in purchased care expenses and facilitate MTF providers to

deliver health care services in civilian Network Facilities via fee-for-service (paid claims) arrangements

- Military Health System Support Initiative (MHSSI): TMA/TRICARE Regional Office (TRO) North program to fund MTF initiatives for recapture or reduction in purchased care expenses
- Overseas Contingency Operations (OCO): Services program to fund backfill of critical health care providers' positions during periods of deployment
- Other Contracting (North Atlantic Region Contracting Office Sole Source, Army Direct Care Medical Services (ADCMS): Army program to provide contracted medical personnel (staffing) to the Regional Medical Commands through Multiple Award Task Order Contracts or through other contracting vehicles
- The U.S. Department of Veterans Affairs (VA)/DoD Sharing Agreements: Department of Defense program that allows for the sharing of health care providers and facilities between Military Health System Support (MHSS) and VA resources

WII warriors that require medical care at WRNMMC or FBCH will always be given priority to remain in the Direct Care system, and JTF CapMed will manage the capability to care for casualties from theater as first priority.



## 6.0 INTEGRATED VETERANS AFFAIRS SERVICES IN THE NATIONAL CAPITAL REGION

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Today, the MHS provides the best healthcare available to warfighters in a variety of complex and dangerous environments. On the battlefield, Warriors sustain the most serious types of injuries, many of which can result in long-term mental and physical impairment to Service members and can have a profound effect on their families. The MHS is the only health system in the nation that provides a continuum of care for Warriors that delivers comprehensive world-class care from the point of injury anywhere in the world throughout the healing and recovery process.

Although the DoD provides world-class healthcare and recovery support programs for WII Warriors and their families, the complete healing reintegration and transition process can be extremely difficult and complicated. The VA operates and manages a host of medical facilities and programs that provide a wide range of benefits to Service members and their families including medical treatment, disability benefits, education and training, vocational rehabilitation and employment, home loan guaranty, dependant and survivor benefits, and life insurance and burial benefits. The DoD has embedded VA staff directly into its MTFs to ensure seamless access to these critical VA benefits that are integral to the healing, recovery, and transition process.

The VA currently utilizes shared space at WRAMC, NNMC, and DACH to house VA personnel who work with Wounded Warriors and other active duty beneficiaries. At WRAMC, there are eight billets for Veterans Benefits Administration (VBA) personnel and 11 billets for Veterans Health Administration (VHA) personnel. At NNMC, there are four (two are part-time) VBA billets and six VHA personnel. There are also two VBA billets at DACH.

Through JTF CapMed, the Department is working with each of the VA points of contact to establish the facility and VA space requirements for the new MTFs to ensure access to appropriate VA services for all Warriors and their families. Space requirements have been allocated at WRNMMC for the required VA personnel and DoD is in the process of determining the space allocation for VA personnel at FBCH. In addition, FBCH will incorporate a VA Community Based Outpatient Clinic as a partner in service.





## **7.1 Data Centers**

A data center on the Bethesda campus will host all shared systems and applications, with a data center at FBCH serving as the Continuity of Operations (COOP) site for the Joint Medical Network (JMED). In August 2009, the Chief Medical Information Officers in the region—in close coordination with the clinical providers—agreed that there are five mission-critical systems (Armed Forces Health Longitudinal Technology Application [AHLTA], Composite Health Care System [CHCS], Essentris, Radiology, and Email) that must be operational 24 hours a day, 7 days a week.

The design and construction for the WRNMMC Data Center are completed. Plans for outfitting of racks and cabling are underway, network equipment will be installed, and the data center will stand up in September 2010.

The FBCH data center is on schedule. The next step is for the construction contractor to close in the walls during the Summer of 2010. The new data center will require the purchase and installation of several pieces of hardware. FBCH IM/IT personnel finalized the equipment list for the new data center and are coordinating with the IO&T vendor for purchasing and installation. Standing up a data center also requires running the fiber from the outside to the data center. This began recently and is scheduled to be completed Summer 2010. All work remains on schedule to complete the construction and stand up the FBCH data center by Spring 2011.

## **7.2 Military Health System Network Infrastructure**

The Department is integrating WRNMMC and FBCH into a joint infrastructure that will support the sharing of critical clinical information among MTFs in the JOA as well as with the VA and other external agencies. This MHS Network Infrastructure is currently on schedule to be completed by the Spring of 2011. The draft architecture design for the MHS Network Infrastructure is under review by the Tri-Service Infrastructure Management Program Office (TIMPO). Once complete, the Chief Information Officers (CIOs) in the region will review the information for approval. The current design provides that WRNMMC will extend its Local Area Network (LAN) to FBCH and this network will become a part of the MHS collaborative forest. There will be a redundant OC-12 Point of Presence established at FBCH for failover contingency. This will allow for seamless collaboration between all facilities utilizing the JMED.

## **7.3 Migration of WRAMC Systems**

The WRAMC base closure process involves migrating and transitioning the Walter Reed Healthcare System (WRHCS)—composed of its clinical, business, and IM/IT functions—to two newly constructed, JTF CapMed facilities (WRNMMC and FBCH). Migration of WRAMC Systems is on-track to support the operation of FBCH and WRNMMC when they open in September 2011. The consolidation and migrating of clinical and business systems between WRAMC, DACH, and NNMC is an ongoing process. JTF CapMed, along with WRAMC, DACH and NNMC, developed a list of all systems currently being used at each facility during the Fall of 2009. During the Winter of 2009, JTF CapMed facilitated discussions with the Integrated Chiefs of each clinical department to determine the system of record for the future state. During this phase, duplicate systems were identified and redundant systems were

scheduled to be discontinued. This effort allowed JTF CapMed to develop a list of 159 systems that will currently need to migrate from WRAMC to WRNMMC.

The next step will be to complete the Defense Information Assurance Certification Accreditation Process (DIACAP) for all systems moving on to the Navy network. It has been determined that the majority of WRAMC's systems moving to WRNMMC need a DIACAP. DIACAPs will begin once a contract is awarded and will continue until completion.

#### **7.4 Synchronous Optical Network**

The Department is working to transition the current IM/IT infrastructure in the NCR, a DoD Non-classified Internet Protocol Router Network, to a Synchronous Optical Network (SONET), which is optimal for telecommunication backbones composed of fiber optics. This will enable capabilities such as an active directory and e-mail for the NCR that will utilize the Unified Medical Domain allowing the Department to synchronize its efforts in the NCR with its plans for the entire MHS. It will also facilitate the development processes and technologies that will streamline the exchange of health records between VA and other network partners. The SONET will be operational in time to support WRNMMC and FBCH when they open.

#### **7.5 Smart Technologies**

A growing body of evidence indicates that hospitals can achieve healthier and safer environments for patients and staff by identifying and improving inefficient processes and by linking evidence based design (EBD) to important patient outcomes. EBD is the process of basing decisions about the built environment on credible research to achieve the best possible outcomes. EBD can be utilized by those planning and designing healthcare facilities to base decisions on research and critical thinking. EBD applies to all types of building design, but is uniquely suited for healthcare settings given the unusually high stakes and because it involves major issues of safety and improved clinical outcomes. To support facility EBD, there is a substantial requirement for IM/IT. The Department has considered EBD principles that support patient and family-centered care.

DoD is leveraging the principles of patient and consumer EBD in the planning and implementation of technology that will be deployed throughout all MTFs in the NCR JOA. For example, it is incorporating "Smart Suite" technology—to help improve care and clinician efficiency with smart beds, bed-side entertainment, patient education, two-way communication devices, high resolution audiovisual technology, and the ability for patients to control temperature and lighting at the bedside—into facilities planning. Below are the main components of a smart suite:

- Smart beds enhance the ability to deliver safe, quality care through real-time/active patient monitoring of bed status, patient position, and activity that alerts care providers when patients need assistance and facilitates communication between patients and the care team through nurse call integration. Smart beds incorporated in Smart Suites optimize patient and provider workflow where patient, providers, and point of care technology interact intelligently to facilitate care delivery at the bedside.

- Electronic room signage outside entrance to the room will have a customizable secure display capable of showing basic ADT information such as room number, dietary status, specific care precautions (Isolation status/latex allergy), and assigned caregiver.
- Electronic clinical dashboard solution that, upon room entry, presents a unified intuitive view of patient's data aggregated from different sources to include the electronic health record as well as data captured by devices/equipment connected to the patient to include vital sign monitors, glucometers, physiological monitors, IV infusion devices, ventilators, and the bed.
- USB-enabled integration engine will ensure new/legacy medical devices capturing clinical data, including waveform category device data; will connect to the electronic health record.
- Patient Education, Training, Entertainment System integrates with the facilities' CATV solution and Nurse Call system to provide interactive telecommunication services that allow patients to stay in touch with his/her care team and include access to patient education, components of the electronic health record, entertainment, and services for patients/families.
- Real Time Locating System (RTLS) tracks patients, staff, and equipment. The Enterprise Positioning Solution (EPS) integrates RTLS and clinical data to provide up to the minute data on the position and status of patients, staff, beds and equipment in the patient's room.

By the completion of BRAC, the Department will outfit 108 rooms at FBCH and approximately 196 rooms at WRNMMC with smart suite technology. The remainder of the 345 patient rooms will be outfitted as projects from the CMP expand approximately 50 double patient rooms to 100 single patient rooms and other non-BRAC renovations are executed. Both WRNMMC and FBCH will also be outfitted with wireless capability.

## 8.0 PERSONNEL MANAGEMENT

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Three Department decisions are fundamental to the future of the world-class medical personnel continuing a tradition of world-class care in the NCR. First, the August 2007 decision to establish a Guaranteed Placement Program (GPP) for the civilian workforce at WRAMC ensured the sustainment of operations at WRAMC and the retention of a highly skilled civilian workforce representing more than half of the civilian talent base in the NCR for further assignment to WRNMMC at Bethesda and FBCH. In January 2009, the Department made two additional decisions—one directing a DoD Civilian Manning Model be used and the other directing WRNMMC and FBCH be established as joint MTFs in the NCR with joint manning.

### 8.1 Notification of placement for Civilian Personnel

The Department has taken several actions to retain the skilled civilian workforce in the NCR, which is imperative to operating the new WRNMMC at Bethesda and FBCH. To date in monitoring the effectiveness of these actions, there has been no significant increase in departures of civilian personnel at WRAMC. Uses of retention incentives and the GPP, particularly the charter of the Civilian Human Resource Council, have been successful in maintaining that same success at NNMC and DACH. Written notification letters of future assignments have been issued to more than 4,000 current permanent civilian employees at WRAMC, NNMC, and DACH nearly three weeks ahead of schedule. Those letters completed the first phase of planning for the civilian transition to WRNMMC and FBCH and fulfilling the GPP commitment to the WRAMC workforce. The Department is pleased to have been able to match more than 95 percent of NCR civilian employees to their desired geographic location of employment and has already employed hiring and reassignment strategies with the goal of meeting all geographic preferences before the move from WRAMC.

The next phase of the transition will be the implementation of a rigorous management process to ensure that current civilian employees are kept informed about their future work assignments, new hires are mapped appropriately to future positions, and necessary modifications are made to ensure the proper skills mix and the optimum geographic placement for the employees. The process will be linked to the final manning document (see section 9.3) to ensure that necessary workforce shaping is accomplished to meet overall authorizations and Environmental Impact Statement (EIS) constraints. Following the establishment of a mapping maintenance plan, a new regional position management and staffing processes will be implemented to ensure collaborative planning and hiring in support of a smooth transition of permanent staff matched to the requirements of WRNMMC and FBCH.

### 8.2 DoD Civilian Personnel Authorities

In order to fully execute the provisions of the GPP for WRAMC, DoD is utilizing appropriate civilian personnel authorities under Titles 5, 10, and 42 of the United States Code, DoD directives, and Executive Orders. These authorities, which can be further delegated to the Commanders of the new joint hospitals as appropriate, will allow for the balance of regional consistency to support integrated healthcare delivery with the needed delegation of discretion to the Commanders and managers in the facilities to recruit, train, direct, reward and retain civilian

employees in the joint hospitals, as well as add significant career progression opportunities within the consolidated workforce. The authorities are also essential to fully executing the GPP using regional policies and procedures designed to maximize the movement of current employees to preferred locations in 2011 while minimizing workforce instability in the region.

Planning for the conversion of Army and Navy civilians to transition into a single DoD civilian workplace model is well underway. It has been essential to consider the best match of Human Resources (HR) servicing capacity to provide support to the transitioning employees and managers. Either the Army or the Navy is currently scheduled to be selected as the HR Service provider for civilian employees at JTF CapMed and the new joint hospitals by the end of August 2010. This will mark the beginning of a partnership with one of the two largest HR Service providers in DoD, providing the necessary HR institutional knowledge and infrastructure to execute the Project Plan for the civilian transition that will include the transition out of National Security Personnel System (NSPS) into a new Performance Management System, the development of regional HR policies, and procedures and the identification of Service best practices to be implemented in the joint hospitals.

Based on these factors, the timeline would include a phased realignment to the new hospitals based on the clinical transition plan. Orientation on changes to personnel and timekeeping processes and preparation for the transition would be accomplished during the April to June 2011 timeframe with time allotted to meet bargaining obligations with labor unions at WRAMC, NNMC, and DACH. This early transition will support the movement of a single workforce with a common administrative culture to support its success in the new joint hospitals.

### **8.3 Manpower Document**

An Intermediate Manpower Document (IMD) is being developed and will be used to facilitate and provide flexibility for the development of the ultimate Joint Table of Distribution (JTD). JTF CapMed and the Military Services are refining a draft Memorandum of Agreement (MOA) to commit resources in support of the IMD and formally realign manpower resources upon BRAC transition. The document is expected to be approved by CJTF and the Service Chiefs in the near future, marking the completion of the final IMD.

The IMD is an authoritative database that supports the underlying manning documents for each Service. It will allow the compilation of all personnel requirements for the eventual JTD, while maintaining more flexibility for changes during the transition and as experience is gained operating the new hospitals. The IMD is continuing to undergo refinement until it makes its final transition to a JTD following Full Operational Capability (FOC) of WRNMMC and FBCH. From that point forward, the JTD is anticipated to undergo the same annual re-validation review as any other joint manpower document.

## 9.0 WALTER REED NATIONAL MILITARY MEDICAL CENTER MASTER FACILITIES PLAN

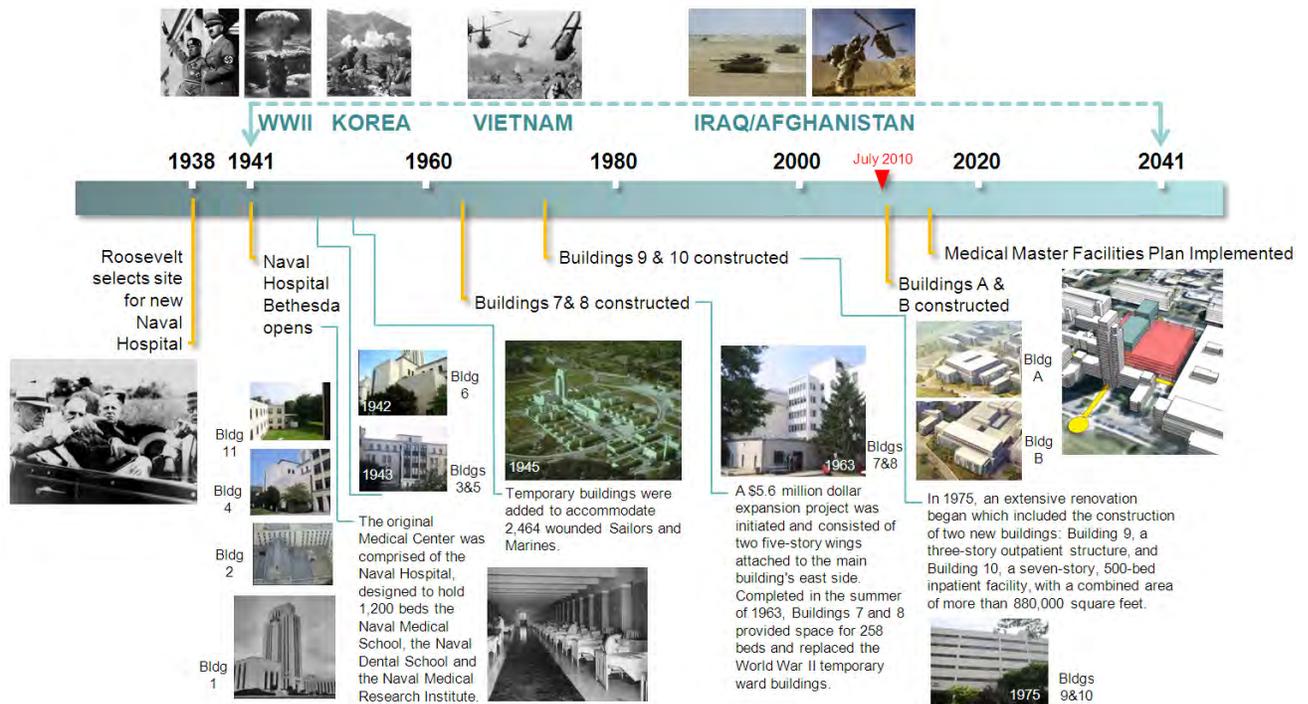
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The CMP included a Medical Master Facilities Plan (MMFP) for the new WRNMMC and the Bethesda campus that will achieve the “basic infrastructure” requirement of the new world-class medical facility definition, as developed by the DHB and codified under section 2714(e) of the NDAA for FY 2010. As the new facility projects are completed and technology and care processes evolve into the future, the MMFP will support the CMP in the development of a world-class integrated healthcare delivery system in the NCR. The CMP identified \$781M in new facility construction and renovations requirements. This cost estimate has increased by \$48M to total \$829M in funding requirements for new facility construction, renovations, installation upgrades and supporting equipment and design. Cost estimates will continue to be refined with the completion of the MMFP in December 2010 and as design gets underway. A proposed timeline estimates major construction to begin in FY 2012 and to be completed by FY 2018.

### 9.1 Medical Master Facility Planning Process

Basic infrastructure is considered one of the six domains of a world-class medical facility, as defined by the DHB and codified in section 2714(e) of NDAA for FY 2010. The execution of the MMFP for WRNMMC is another major milestone in the storied history of the NNMC complex at Bethesda. Much of the infrastructure not addressed by BRAC investments is historic in nature, dating back to original construction (the Vietnam War era). Some of these buildings have outlived their useful life as medical treatment and support structures, and are aging and inefficient, both from the perspective of space management and operational costs. They also lack the basic physical flexibility, including structural grid and size of useable floor plate, to accommodate current medical systems and processes, much less future technologies and changes in practice. Therefore, upon completion of the BRAC expansion to accommodate functions being relocated from WRAMC, this next phase of construction will address these legacy structures that will sustain the WRNMMC infrastructure at a world-class level, and will establish the conditions for continuous improvement for the coming decades. A timeline of a century of distinguished service (1938-2041) is shown in Figure 5.

**Figure 5: Bethesda - A Century of Distinguished Service**



Phase I - As part of the completed Phase I of the MMFP, an analysis of both opportunities and constraints related to the redevelopment of the Bethesda Central Campus area has been completed. This analysis included an examination of existing site conditions, the condition of existing buildings, and the capacity and condition of the existing utility infrastructure. The proposed Program for Design (PFD) project has undergone further refinement and operational concerns, including an evaluation of the relocation of functions and staff during construction. A visioning “charrette” was conducted to solicit initial feedback on input on the design concept from clinicians, installation and hospital facility operations and safety experts, and various subject matter experts in order to refine guiding principles and goals for the future design initiative for this project undertaking. Feedback from the participants, both operational and technical, will be assessed and addressed in the completion of the MMFP by December 2010, in the development of project design guidelines, and throughout the design process.

Analysis of existing and required utility support has informed project costs (narrative provided in Appendix A), but will continue to be refined through the completion of Phase II. All of these have combined to produce a future vision for the comprehensive clinical expansion. Details of these analyses as well as a description of the proposed expansion project follow. It is important to note that as this is a Master Facilities Planning effort, no design effort has been (nor can be) undertaken at this point. As a result, solutions for many legitimate issues and concerns will remain undefined until detailed design has commenced. Additionally, based upon further development of the MMFP, and during detailed design efforts, adjustments to fundamental departmental adjacencies and locations (both in proposed construction and in existing facilities) may be required to optimize space and operations at WRNMMC.

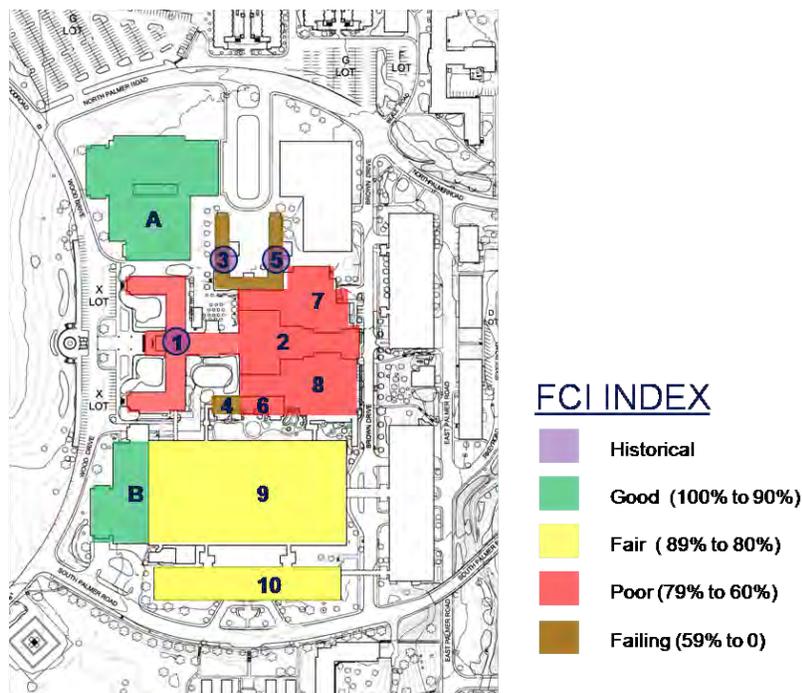
Phase II - Phase II of the MMFP will; complete DD Form 1391, Military Construction Project Data; further define the PFD through interviews with impacted activities; sequence project elements and the integration of supporting Special Projects; integrate the WRNMMC MMFP with the Bethesda installation and other tenant functions; provide more detail for utility upgrades; perform way-finding and access study; recommend facility improvements and vehicular transit; lodging requirements and capacity study and perform design charrettes and review sessions; and develop more detailed acquisition and execution timelines. Phase II will be completed by December 2010.

## **9.2 Condition of Existing Facilities**

The condition of the existing facilities is based on age, the accumulation of deferred maintenance and the need for renewal and recapitalization. In the CMP, the calculation of a rating of the condition of the facilities was discussed for each facility that compares the cumulative liabilities to the replacement value of the structure. An assessment of the repairs and improvements needed for each building was captured by BUMED in a previous study (Vanderweil Facility Advisors 2006). A BUMED sponsored update of this Facility Condition Index (FCI) study is underway, to be completed by September of this year (2010). The replacement value of the facilities is based on the square foot unit cost for the type of use and total area for each building. The resulting ratio is called the FCI. A facility with an FCI from 90% to 100% (e.g. less than 10% maintenance and repair liability, relative to replacement value) is considered to be in “good” condition. An FCI from 80 to 89% indicates “fair” condition. An FCI from 60% to 79% indicates “poor” condition and 59% and below constitutes a “failing” rating. Buildings A and B (the new BRAC outpatient and inpatient facilities under construction) will be rated in the highest category when opened.

As was discussed in the CMP, Buildings 9 and 10 were rated as being in “fair” condition; Buildings 1, 2, 6, 7, and 8 as “poor” condition; and Buildings 3, 4, and 5 in “failing” condition. Navy special project renovations will begin this summer to bring Buildings 3 and 5 to a “good” condition. The CMP proposed to demolish Buildings 2, 4, 6, 7, and 8 and replace them with new construction. Figure 6, shows the FCI levels at NNMC.

Figure 6: NMC FCI Levels



### 9.3 Facilities Design Concept

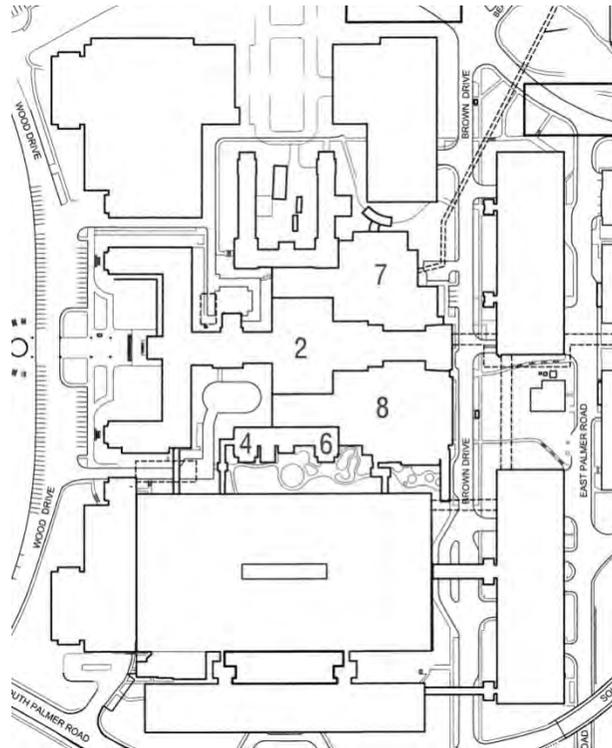
The objective of the MMFP is to improve the qualitative standard of its operation, not to enlarge or grow the clinical capacities of the medical center in staffing or workload volume. A number of possible siting approaches to providing improved facilities were considered during the planning process, with the following criteria as priorities:

- Optimize overall campus function and quality of care
- Improve patient, family, and staff experience
- Provide opportunities for future development at the campus
- Minimize disruption to existing clinical operations

One of the major drivers of new construction is the need to expand clinical services in the major hospital areas. The balance of patient bedrooms not renovated by BRAC must be converted to single occupancy, based upon patient and family centered care standards, and other clinical and support spaces must be expanded appropriately to meet world-class standards. This results in a requirement for an estimated 120,000 square feet of existing function to be reconstructed elsewhere. A concept requiring the demolition of Buildings 2, 4, 6, 7, and 8 to be replaced with five levels (plus basement) of new construction designed to provide high quality clinical, education, and support space has been selected for further development. Not only does this new construction accommodate the displaced activities, it also provides expansion of patient and family support services, and for the rightsizing and reconstruction of activities presently located in these buildings. Initial demolition of Buildings 2, 4, 6, 7, and 8 may take place in

phases interspersed with increments of the new clinical construction, or as a single phase, deemed the most rapid and economical approach. The final MMFP will carefully review factors such as impact to cost, displacement, and disruption. Buildings 2, 4, 6, 7, and 8, which are being considered for demolition, are depicted in Figure 7.

**Figure 7: Demolition of NNMC Buildings 2, 4, 6, 7, and 8**



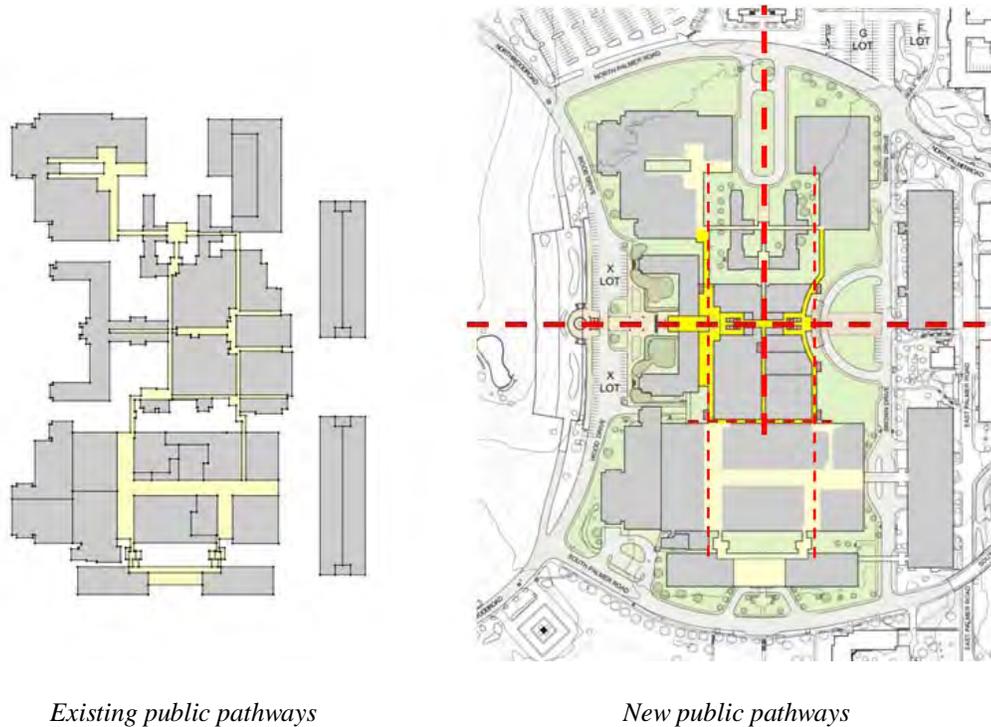
The technical challenges present in the initial strategy include:

- Exact locations and functions of existing site utilities, particularly those serving buildings that will remain
- Difficulties associated with the removal of existing structures and new construction in close proximity to important clinical functions
- Site circulation and parking challenges during implementation process
- Pedestrian circulation internal to WRNMMC

Improvements to patient, family, staff and public movement – Critical to the selection of the central campus area for the development of new facilities is the opportunity it provides to create enhanced wayfinding systems in the medical center. Currently, pathways of major pedestrian movement throughout the campus is somewhat circuitous, particularly those that connect the clinical and inpatient facilities in the south with the new outpatient facilities in the north. The MMFP concept provides a new direct public link between the mall entrances of Building 9 with the public lobby of Building A, the new outpatient center in the north of the

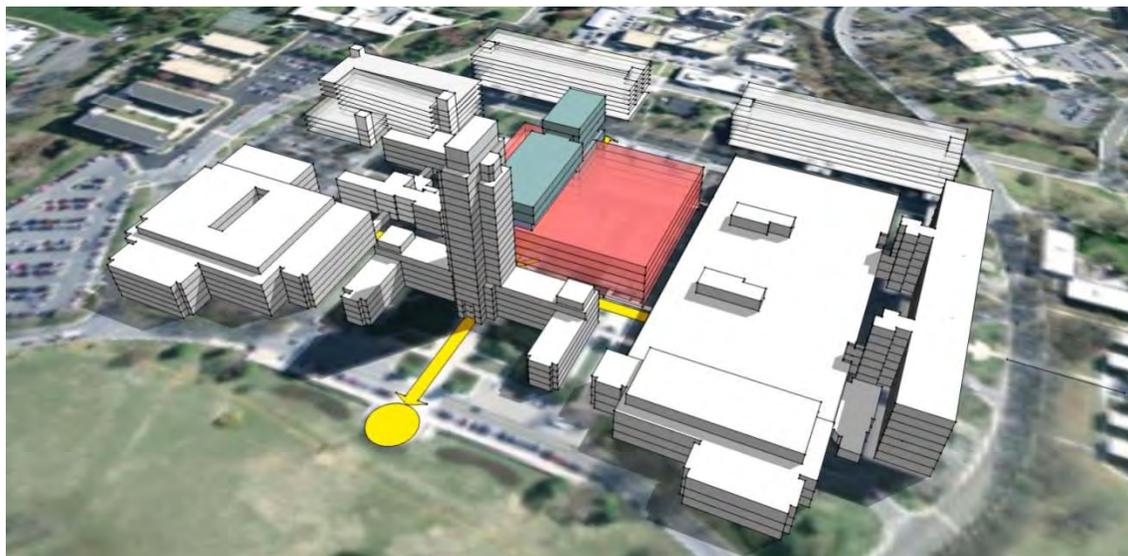
campus. The link will be a generously sized, daylight-infused pathway running directly north-south along the face of Building 1. Other linear pathways will be established to create a straightforward grid of simple, direct connections which will provide staff and patients with a more navigable medical center at every level. These will be integrated with new columns of vertical movement, completing a system of linkage between new and existing facilities. This is depicted in Figure 8.

**Figure 8: WRNMMC Linear Pathways**



The Facility Concept – The proposed facility will consist of five levels of building above grade, each with a floor plate of approximately 95,000 gross square feet (gsf), with a basement level and a mechanical penthouse. An enclosed pedestrian connector will link Building 9 and the new Building A. The new clinical expansion space will be bisected with an east-west axis connecting the ceremonial entry to Building 1 with the entry to the new clinical services building and beyond to the patient/family parking structures. Floor-to-floor height within the new building will be ample to allow for the integration of future technologies and will link, via sky bridge or direct access, with complimentary components located in Building 9. The existing and newly constructed operating rooms in Building 9 will link at the third level with the ambulatory surgery space scheduled for the new building. This is depicted in Figure 9.

**Figure 9: WRNMMC Central Clinical Expansion Concept**



Technology - Technological advancements continue to be made in healthcare at an accelerating pace. A brief listing of such advances includes simulation centers for the modeling and training of staff in medical procedures, the digitization of medical records, telemedicine, remote surgery consultation, enhanced diagnostic technologies, and the electronic remote-monitoring of patients by medical staff. Providing future flexibility in the construction of any new or renovated spaces will be critical as technology continues to evolve in the future. The final MMFP will provide a series of specific recommendations regarding the incorporation of medical technologies.

Parking - The MMFP concept proposes additional parking capacity. Since existing structured parking is located to the east and north of the medical center, a concept was pursued to provide for a new parking structure to the west of Building 1 (see Figure 10), so that parking facilities are available at the perimeter of the complex. Building 1, as well as the landscape to the west (the “view shed”) is protected as historically significant. The concept provides a parking structure of approximately 500 spaces underground, with little visual impact on the landscape. This concept would locate the new parking conveniently, and would also have the potential to revitalize the historic main entrance to Building 1 as a major portal into the Medical Center. Issues related to subsurface conditions and the acceptability of the visual impact to the historic landscape and total parking count will be further explored in Phase II of the MMFP and during design to advance this concept.

**Figure 10: WRNMMC Underground Parking Concept**



#### **9.4 Medical Master Facilities Plan Cost Update**

In the CMP, the MMFP identified requirements which were categorized into the following four areas: a Comprehensive Clinical Expansion on the Central Campus area, Installation Upgrades, Medical Center Technology Upgrades, and Installation and Medical Center Environment Projects.

Since the submission of the CMP on 23 April 2010 and with the recent completion of Phase I of the MMFP, the Department has been able to more thoroughly refine cost estimates for these projects. They have been reviewed by an independent cost consultant using updated Cost Estimating Guidance for Programming Medical Projects and draft Unified Facilities Criteria (UFC) 3-701-01 and 3-701-10. Based upon this more deliberate project analysis, coupled with the input of construction consultants, particularly with regards to the complexity of construction sequencing and execution, the cost of this initiative is currently projected to be approximately \$829M, a total increase of \$48M above the estimate identified in CMP. Although the scope of the new construction has been increased to allow for a grossing factor that is consistent with other MHS projects (incorporating patient and family centered care, increased natural light, additional circulation space), the application of updated blended unit prices and revised escalation factors minimized the impact to overall project cost. Cost estimate for the projects are listed below in Table 1.

**Table 1: WRNMMC Medical Master Facility Plan Cost Estimate**

MILCON (in \$M)		Operations & Maintenance (in \$M)	
<b>WRNMMC Central Clinical Expansion</b>		<b>Medical Technology Upgrade</b>	
Design	\$56	SMART Suites/Beds	\$10
Temporary Facilities and Parking Garage	\$69	Real Time Location System	\$3
New Construction/Replacement/Demolition	\$492	Equipment Relocation and Acquisition	\$10
	Subtotal \$617		Subtotal \$23
<b>Bethesda Installation</b>		<b>Installation and Medical Center Environment</b>	
Design	\$10	Master Planning	\$2
Child Development Center	\$18	Campus Wayfinding and ADA Accessibility	\$11
Utility Upgrades	\$47	Pedestrian Improvements	\$2
Base Installation Appearance Plan	\$6		Subtotal \$15
Traffic and Parking Improvements	\$4	<b>WRNMMC Central Clinical Expansion</b>	
	Subtotal \$85	Initial Outfitting and Transition	\$89
<b>MILCON TOTAL</b>	<b>\$702</b>	Subtotal	<b>\$89</b>
		<b>O&amp;M TOTAL</b>	<b>\$127</b>

Further development of project requirements has included allowances for phasing impacts on construction costs and schedule removal of hazardous materials, and for constructing special foundations. Additionally, new cost factors associated with achieving construction standards established for force protection, Sustainable Design and Development, Leadership in Energy and Environmental Design (LEED) and Energy Policy Act of 2005 have been applied. Any Operations and Maintenance funding requirements would be considered to be additive to the annual Sustainment, Restoration, and Modernization (SRM) investment in maintenance and repair and improvement projects at WRNMMC and NSA Bethesda. The operational requirements for medical functions and existing tenant activities will be further investigated, and space utilization examined in Phase II of the MMFP. These projects will continue to be further outlined as the MMFP continues to be refined, and will be developed to support world-class standards and to achieve the “highest and best use” of all of the WRNMMC infrastructure.

Costs will continue to be refined throughout the completion of the MMFP and the design process, prior to official submission of DD Form 1391 project documentation, and will inform the FY 2012 Program Objective Memorandum process.

### 9.5 Projected Construction Schedule and Acquisition Strategy

The construction of a project of this scope and scale, located in the heart of an operational medical center, poses a number of issues that must be addressed in estimating the pace of project execution. First, over the next 15 months, the staff and leadership of NNMC, WRAMC, NSA Bethesda, and JTF CapMed must be focused on the successful completion of the BRAC transition and integration into the new WRNMMC and FBCH. As was learned in the

development and design of both WRNMMC and FBCH, staff involvement is vital to a successful outcome. Secondly, the scale, scope and complexity of this initiative requires comprehensive review and analysis to fully satisfy the requirements of the NEPA, and of the local review boards such as the Maryland State Historic Preservation Office (SHPO) and the National Capital Planning Commission (NCPC).

The expectation is that the plans included in the MMFP will require an EIS. While there is no intent to increase patient workload with the improvements to the hospital, there are other factors that must be considered in determining the proper NEPA action for a given project. The magnitude of the proposed construction brings other environmental factors besides traffic into play. The proposed new construction is not currently part of the present Installation Master Facilities Plan, and its location behind Building 1, which is a historical landmark, must be considered and refined carefully. In addition, the NEPA actions related to the MMFP cannot be considered in isolation, as NEPA law requires that the cumulative impact of individual projects be considered in deciding the appropriate NEPA action. Finally, the location of NSA Bethesda must be considered when assessing the environmental impact and the need for the more stringent analysis an EIS entails. NSA Bethesda is situated in a heavily congested urban setting, and there has already been considerable impact on the surrounding community with the present construction. The typical timeline for a full EIS could approach 36 months.

Due to the complexity of construction in this limited area and the need for very complete analysis and project development prior to commencing demolition and construction, it is proposed that this project be developed by a deliberate design-bid-build methodology, for which full design could take upwards of 30 months. The aspects of demolition, laydown, construction, and access issues associated with the site must be carefully explored and analyzed during design in order to ultimately save time and avoid unnecessary cost impact.

Even before design is underway, close coordination will be required with stakeholders such as the NCPC and Maryland SHPO to deliver a design solution that is sensitive to the historic infrastructure and protected view shed, while being balanced with the requirements to upgrade conditions and capabilities of the buildings in the central part of the medical complex. Other stakeholder groups, including the local community, will be engaged in the review process through public hearings associated with the three review mechanisms outlined above. The public is provided opportunity to comment on the plans prior to the filing of the Record of Decision (ROD) at the close of the NEPA environmental review process.

A significant challenge is to maintain the continuity of operations at the medical center during the construction process. The medical center has been undergoing renovations and new construction for the past several years and the staff, patients, and families will be required to endure an additional disruption to the campus. Issues such as parking, traffic disruptions, noise and vibrations must be carefully controlled to mitigate effects on patients, visitors, permanent residents, staff, and the adjacent community. Process flow for medical operations as well as logistics for material delivery must be carefully choreographed with the construction activities.

Table 1 shows a proposed high level project timeline for projects identified in the MMFP. This timeline represents the most logical schedule relative to construction, but must be further informed by the DoD budgeting process:

**Table 2: WRNMMC Medical Master Facilities Plan Timeline**

WRNMMC Medical Master Facilities Plan Project Timeline	
Fiscal Year	Projects
2011	Complete project programming and supporting documentation, and prepare design for Request For Proposal (RFP).
2012	Commence project design. Prepare/complete NEPA documentation and other regulatory reviews, as required. Execute appropriate supporting O&M projects such as central sterilization and dining facility upgrades through the Navy Special Project Program. Prepare RFPs for FY 2013 Design/Build project components.
2013	Complete project design and NEPA documentation and other regulatory reviews, as required. Award Design/Build project components (e.g. parking garage, temporary facilities, Child Care Center expansion, utility upgrades).
2014	Relocate impacted activities to temporary/interim locations. Award construction of major medical construction project and commence demolition of Buildings 2, 4, 6, 7, 8 and utility relocation.
2015	Complete connection between Buildings 9, 1, and A, including patient services and amenities. Complete demolition and begin project superstructure.
2016	Continue major new construction.
2017	Complete major new construction and perform initial outfitting and relocations to new facilities. Commence backfill renovations.
2018	Projects Complete.

As part of the central clinical expansion, the Department must provision temporary space for medical and supporting functions and staff. It may also become necessary to temporarily relocate selected healthcare WRNMMC services, in order to support demolition and new construction. Swing space for up to 100,000 gsf for relocated functions during the construction period has been included in the current cost estimates. Several options to provide the necessary interim space will be leveraged, including temporary buildings on-site, leased space off-site, or partnerships/memoranda of agreement/contracts with other government entities.

## 9.6 Program for Design for WRNMMC Central Clinical Expansion

A departmental level PFD has been created that serves as the underpinning for the proposed central clinical expansion project. While the basic scope of services and associated spatial requirements are established, further refinements will continue over the course of the medical facility master planning process with additional data collection and discussion with clinical staff, the DHB, and other stakeholders. The primary objectives of the comprehensive clinical expansion project include:

- Provide patient and family-centered single bedrooms in Building 10
- Incorporate EBD principles
- Improve patient/market focus in key areas, including women’s services, ambulatory surgery, vision care and others

- Enhance the Simulation Center
- Address patient wayfinding issues
- Provide patient and visitor amenities commensurate with the proposed scale and beneficiary population of WRNMMC
- Enhance logistical and information technology support

The Comprehensive Clinical Expansion Project consists of approximately 563,000 gsf of new construction and 120,000 gsf of existing building renovations and includes the following specific functions as shown in Table 2:

**Table 3: WRNMMC Clinical Expansion Program for Design & Planning**

WRNMMC Central Clinical Expansion Program for Design		
Activity	Specific Functions	gsf
Clinical	Women's Health; Vision Center; Ambulatory Surgery; Adult Behavioral Health; Partial Hospitalization; Dental Readiness Clinic; Outpatient Executive Medicine; Infectious Disease; Health Readiness.	266,000
Medical Education and Support	Simulation Center; Health Professional Education; Medical Center Auditorium; National Navy Dental College; Navy Medical Manpower Personnel Training and Education.	112,000
Public and Patient Amenities	Chaplain Services; Patient Services and Information; Retail – postal, banking, convenience, hair care; Convenience Food Service; Public Lounges.	94,000
Supporting Activities	Visual Information; Navy Dosimetry Center; Health Physics; National Cancer Institute; Public Health; Records; Security; Personnel Support; Manpower; Operational Readiness; USUHS.	91,000
Renovations	Vacated spaces in Buildings A, 9, and 10 available for renovation/expansion/backfill, including conversion of space to provide approximately 100 single bedrooms based upon the industry standards for patient and family centered care.	120,000
Parking	500 Spaces of new surface or underground parking.	
	New Construction	563,000
	Renovation	120,000
	<b>Total New Construction and Renovation</b>	<b>683,000</b>

## 10.0 EXECUTION OF TRAFFIC MITIGATION PROJECTS

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The BRAC movement will add staff and patient workload to the existing Bethesda and Fort Belvoir campuses to create the new WRNMMC and FBCH in two already congested urban environments. The Department is committed to being an active member of the local communities, fully considering the effect the realignment of operations may have on the surrounding neighborhoods. Over \$305M (approximately \$259M for Fort Belvoir and \$47M for Bethesda) has been invested or requested by DoD in traffic upgrades and mitigation projects at both installations.

### 10.1 Bethesda

As discussed in the CMP, the Department has requested a total of \$26M of BRAC funding in FYs 2010 and 2011 for on-campus traffic mitigation projects for NSA Bethesda. These projects include:

- Renovation of new Entry Points at the five entrances to the Campus (North Wood Road Gate, South Wood Road Gate, University Road Gate, Gunnel Road Gate, and Grier Road Gate), which will provide more secure installation ingress and egress consistent with Anti Terrorism guidelines. The design build contract for North Wood Road Gate and South Wood Road Gate was awarded to Clark Balfour Beatty Joint Venture in the Spring of 2010. Anticipated construction for North Wood Road Gate will be from July 2010 to April of 2011, and South Wood Road Gate will be from April of 2011 to August of 2011. Contract award for the University Road Gate is expected to occur in July of 2011 with completion of construction in mid to late 2011. Gunnel Road Gate and Grier Road Gate contracts will be awarded at a future date in 2011 with anticipated completion in 2012.
- Widening of several roads within the compound, such as Perimeter Road and the intersection of RB Brown Drive and Palmer Road North, and on-site queuing areas to permit efficient routing of freight deliveries and increase overall safety and road capacity for on-base vehicular traffic. These projects are included in the University Road Gate contract.
- A new Pass & ID facility at North Gate and a new Commercial Vehicle Inspection Station at the University Gate.
- Additional inbound and outbound lanes to facilitate efficient flow of traffic on and off campus.

The Navy has also submitted two Defense Access Road (DAR) requests related to BRAC growth at Bethesda totaling \$21M. The first DAR request was for \$1M and involved vehicular traffic improvements (signal analysis, additional left turn lane and additional storage in the existing turning lane) at the intersection of North Wood and MD355. It was determined that DAR certification was not necessary for the Navy to implement this project since construction did not require right-of-way. The Navy is pursuing these improvements to the North Wood Road

intersection as part of Maryland State Highway Administrations intersection improvement project and NSA Bethesda's on-base traffic mitigation project.

The second DAR request for \$20M involved improving pedestrian access to the Medical Center Metro Station at MD355 and South Wood Road by de-conflicting vehicular traffic entering and exiting South Wood Road gate from pedestrian traffic travelling between the Metro station and NSA Bethesda. Specifically, the DAR request was for "bank of elevators on the East side of Rockville Pike (MD 355) providing direct pedestrian access to Medical Center Metrorail Station." In July of 2009, the Washington Metropolitan Area Transit Authority (WMATA) released a final Station Access Improvement Study for enhanced pedestrian access to and from NSA Bethesda and the Medical Center Metro. Contained within this report were five potential pedestrian alternatives: intersection improvements, east side elevator access, shallow pedestrian tunnel, east side elevator access, and pedestrian tunnel and pedestrian bridge. In December of 2009, Montgomery County initiated the NEPA process to determine the best method for pedestrians to safely navigate across MD355. Through this NEPA process various alternatives are being considered, some beyond the previous WMATA alternatives. Montgomery County hopes to narrow the options of preferred alternatives in the Summer of 2010 with the estimated completion of the NEPA process in August/September of 2010.

This effort does not include improvements to vehicle intersections adjacent to and in the area of Bethesda. The Maryland State Highway Administration is conducting the NEPA analysis for those intersection improvements including the following locations: MD355/Cedar Lane, MD355/Jones Bridge Road, MD185/Jones Bridge Road, and MD187/Old Georgetown Road. The Maryland State Highway Administration anticipates construction beginning in the Summer of 2011.

## **10.2 Fort Belvoir**

Transportation improvements are required to address existing area traffic and access issues exacerbated by the BRAC relocation of 8,500 individuals to Fort Belvoir North Area (FBNA) in Springfield, Virginia, 6,400 individuals to Fort Belvoir's new Mark Center property in Alexandria, Virginia, and 3,000 individuals to Main Post Fort Belvoir, Virginia. The Department is developing comprehensive Transportation Management Plans for the three Belvoir campuses, scheduled for completion in September 2010, which will review mass transit, public transit, and shuttle services along with vanpooling and ridesharing as appropriate for each location.

As discussed in the CMP, multiple BRAC-related transportation improvement projects in the Fort Belvoir vicinity total more than \$259M. Major improvements include \$125.1 to address the Fort Belvoir Main Post and \$134.1M to address FBNA - formerly known as the Engineering Proving Ground. This funding includes all necessary supporting construction, such as buried utilities, gates, lights, wetland mitigation, etc., to support building the roads.

### **Fort Belvoir Main Post (\$125.1M)**

- Main Post Road Improvements (\$86.4M – Army BRAC funding) – Existing roads improvements; Road widening (three roads); Gunston Bridge widening and lengthening; Upgrade three gates; Accommodates future US Route 1 widening.
- Main Post Road Improvements (\$34M DAR funding/\$4.7M In Kind Contribution) – Mulligan Road improvements; replaces Beulah Street and Woodlawn Road; includes 27 acres of land in kind contribution for Right Of Way dedication; US Route 1 intersection improvements; Telegraph Road improvements.

### **Fort Belvoir North Area (\$134.1M)**

- Fairfax County Parkway (\$36M DAR funding/\$27.9M In-Kind Contribution) – I-95 Southbound ramp to FBNA, I-95 HOV/HOT Ramp, FBNA interchange, DAR Engineering and ROW acquisition, in-kind land contribution for completion of Fairfax County Parkway.
- Roads (\$44.2M Army BRAC funding/\$26M DoD BRAC funding) – Backlick/Barta intersection improvements; New Barta Road with bridges; New Heller Road (Phase 1 and 2) and bridges.



## 11.0 NATIONAL CAPITAL REGION MEDICAL BASE REALIGNMENT AND CLOSURE TRANSITION

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The transformation of Military Medicine in the NCR will significantly enhance healthcare delivery in the region. Anchored by the BRAC recommendation to transition operations from WRAMC to WRNMMC and FBCH and through an evolving integrated delivery system, this transformation will achieve better economies of scale, eliminate redundancies, and enhance clinical care as well as provide a more seamless and robust continuum of care to support the recovery of WII warriors and their families in the region. The transition to the new WRNMMC and FBCH is a process requiring the relocation of more than 9,000 military and civilian staff, consolidation of more than 60 medical services, relocation and transition of nearly 470 beds across three hospitals, integration of primary care for approximately 750 WII Warriors, and primary care reassignment of nearly 19,000 beneficiaries currently enrolled to WRAMC and nearly 4,000 beneficiaries currently enrolled to NNMC. The primary components of the BRAC transition can be broken into the following movements:

- DACH to FBCH transition
- NNMC staff movement to FBCH
- NNMC internal transition into new and renovated space
- WRAMC transition to WRNMMC and FBCH
- Staff movement from MGMC to WRNMMC and FBCH
- WII Warrior moves from WRAMC to NSA Bethesda and Fort Belvoir.

The Department is taking deliberate and prudent action to ensure the BRAC transition of operations from WRAMC is executed safely and effectively.

Practical Observation and Experience – JTF CapMed, along with staff representing all NCR medical Service components, have consulted with the University of California, Los Angeles Medical Center, St. Joseph’s Medical Center and other hospitals to incorporate best practices, lessons learned, and experiences from recent patient moves at those facilities into BRAC transition planning. Valuable knowledge and insight has also been gained by observing patient moves first hand at facilities such as at Mercy Medical Center in Merced, California.

Effective Management, Oversight, and Planning – The JTF CapMed BRAC Transition Program Management Office (PMO) is the key synchronization agent for the BRAC transition. Its roles are primarily those of program management, oversight, and coordination. The PMO coordinates communication and activities between the key stakeholders in order to ensure that all involved in the BRAC transition are working as a team with the same battle rhythm towards achieving the expected benefits of the BRAC transition. Also, Deputy Commanders for Integration and Transition (DCITs) at WRAMC, NNMC, DACH, and MGMC lead and execute the MTF specific transition plans. The PMO is managing all the phases and plans required for the transition.

Continual Rehearsal and Refinement – In February 2009, a wargame exercise with all key NCR stakeholders indentified a single consolidated move in the fourth quarter of FY 2011, with review of possible clinical services for early transition, as the most effective method to transition core operations and inpatients from WRAMC to WRNMMC and FBCH. This directly aligns with industry best practices and with what hospitals around the country have done recently to move patients and operations to new facilities. In June 2010 another wargame was conducted to refine synchronization and timing of all staff, equipment, and patient transitions during the consolidated move projected for the Summer of 2011. It also identified how clinical services will support the WII Warrior transitions to FBCH and WRNMMC and risk mitigation measures for the transition when initiated. Additional wargame exercises will be held to achieve the necessary fidelity to effectively plan and execute the first clinic moves, which are the internal moves to Buildings A and B at WRNMMC. In addition, “Day in the Life” exercises will involve extensive planning processes and the preparation of multiple scenarios that portray actual hospital operations for staff as they prepare to function at the new hospitals.

Seasoned and Skilled Execution – The Department awarded a \$322M wrap-around contract to General Dynamics Information Technology, Inc. (GDIT) to manage the outfitting of equipment at the new hospitals and the transition of WRAMC operations. GDIT has partnered with several of the most accomplished industry leaders in hospital transition. Services under the contract include provisioning and installing materiel; provisioning and installing furniture and furnishings in accordance with government-provided architectural and engineering requirements of the facilities; provisioning and installing medical, non-medical, and IM/IT equipment and systems; and providing comprehensive medical equipment transition and relocation services for other materiel as required, such as government documents, office files, medical records, professional books, etc. JTF CapMed and NCR stakeholders have worked with GDIT to develop a detailed key activities timeline and transition working plans for WRAMC, NNMC and DACH. Work continues to develop individual, function-based transition plans that will cumulatively form a comprehensive project transition plan. JTF CapMed and NCR stakeholders have identified tens of millions of dollars in long lead equipment and equipment for reuse. They are working with GDIT to refine requirements for nearly \$200M of medical, non-medical, IM/IT, and furniture items for GDIT to procure, ship, install, test, and turn over.

### **11.1 NCR Medical BRAC Transition Strategy**

The WRAMC BRAC Transition Strategy is being developed in four phases. Phases I through III contain activities that lead to the closure of WRAMC and the establishment of the two joint facilities, WRNMMC and FBCH by 15 September 2011. Phase IV is the sustainment phase that addresses healthcare integration beyond the BRAC deadline.

Phase I - Construction and Clinical Renovation: Phase I includes new construction at NSA Bethesda and Fort Belvoir and renovation of existing spaces and subsequent internal movement of clinical services within NNMC. This phase is concurrent with Phases II and III. The first clinical service under the IO&T contract to be ready for equipping (RFE) is NNMC’s Main Radiology which began in July 2010. In addition, new construction at FBCH is included in Phase I and the last renovated and constructed space in FBCH and NNMC marks the end of Phase I.

Phase II - Internal Movements: Phase II began in July 2010 and will run concurrently with Phase I until Phase III begins. Phase II begins with IO&T activities such as first equipping, installation, and internal moves. Within Phase II, there are sequentially-required tasks (construction completion, IO&T, movement of staff, and clinical operation of services). At NNMC and NSA Bethesda, clinical and administrative spaces are being renovated and the first RFE dates were in July 2010. Phase II includes the same IO&T activities in the south as spaces become available. This phase ends with the completion of the DACH to FBCH transition activities that prepares the staff for the First Patient Day (FPD) where provision of care is delivered.

Phase III - Clinical Functions, Staff, and Patient Movement: Phase III will begin with the movement of the first clinical service into the FBCH. This phase continues with the movements of clinical capabilities across the NCR: NNMC staff movement to FBCH; NNMC internal transition into new and renovated space; WRAMC transition to WRNMMC and FBCH; staff movement from MGMC to WRNMMC and FBCH; and WII Warrior moves from WRAMC to NSA Bethesda and Fort Belvoir. MGMC reduces the turbulence during the transition period by providing additional capacity to the NCR. Of particular focus in Phase III is the movement of inpatients and WII Warriors. The completion of staff and patient movement to functional clinical space, while maintaining high patient safety standards, will mark the end of this phase.

Phase IV – Sustainment: Phase IV begins with the completion of 2005 BRAC requirements and continues as JTF CapMed continues to solidify systems and processes for the integration of healthcare delivery in the JOA. This phase is marked by the completion of an After Action Report (AAR), change recommendations to Joint Medical policies and doctrine, and the establishment of a strategic management process to sustain and continually improve world-class delivery of healthcare.

## **11.2 Transition Planning Model**

One key enabling activity recently being conducted as part of Phase II is developing the Transition Planning Model. JTF CapMed has selected a hospital transition planning model that has been effectively utilized in a number of hospital relocations and is recognized as an industry standard. This model is highly detailed with the ability to be customized to the specific structure, culture, and operational requirements of the NCR. The Transition Planning Model consists of three phases; each successively applied to form the transition approach, to prepare the required specific plans, and then to perform the actual transition operations culminating in the movement of staff and operations to the new facilities. The three phases of the transition planning model are Design, Planning, and Implementation.

Design Phase – The design phase commenced with the contract award and involved a critical review of several aspects of transition support. Specifically, the following have been performed:

- Transition Assessments were completed at DACH, NNMC, and WRAMC to review and validate essential requirements in the transition support program and process.

- Transition Structure was reviewed at each MTF to determine the responsibility and impact of all Government transition activities and confirm the best application of Project Team transition staff and resources to support the transition requirements.
- Transition Plan and Documentation has been completed, which determines the specific planning components essential to project success. This included the development of the Transition Key Activity Timeline and Transition Working Plan for each of the facilities. The Transition working plan will be updated monthly to track project progress.
- Transition Budget requirement reviews have been conducted. These are the budget requirements to support transition planning and activities to ensure adequate readiness for major transition events such as “Day in the Life” exercises and other transition support requirements.
- Transition Process Guiding Principles have been issued by JTF CapMed for use by GDIT and the NCR MTFs as they develop and execute their transition plan.

Planning Phase – The planning phase involves very detailed work to prepare specific plans (mentioned in section 12.3) that support the transition process. Currently, the planning phase is underway and will be completed over a several month timeframe in advance of actual transition of operations. The planning phase involves operations, occupancy, and human component Planning.

Implementation Phase – The implementation phase executes the plans developed in the planning phase. There is both a pre-occupancy and post-occupancy component of this phase. In the center of these two components is the actual patient move which truly commences operations in the new facilities. This phase is where key events and activities will be executed. Currently, in the planning phase, these activities are being defined and developed. It is important to manage the multitude of activities and tasks in order to accomplish the transition objectives.

### 11.3 Transition Plans

Fourteen individual function-based transition plans are at the core of the BRAC transition efforts and will cumulatively form a comprehensive project transition plan. They are being planned and executed across the planning and implementation phases discussed above in a collaborative and synchronized manner with JTF CapMed, WRAMC, DACH, NNMC, and a multitude of other NCR stakeholders. Below are brief descriptions of each of the plans.

System and Process Reference Manual – Provides information on how the key operation and physical systems and processes of the new facility and organization will operate. The development of this manual is underway at FBCH, NNMC, and WRAMC. The Logistics Team at all three facilities have been meeting since April 2010 to develop their integrated plan.

Operational Implementation Plans – Delineate how a department or clinic will operate in the new facility. MTF transition facilitators have been oriented and are supporting the development of these plans that will ultimately culminate into the System and Process Reference Manual.

Patient/Family Transition Impact Mitigation Plan – Assures that patient and family needs, safety, and informational requirements are considered, planned for and met as the transition process is implemented. Patient and Family Experience working groups at FBCH and WRNMMC have initiated the development of this plan and it will continue to evolve as the other plans take more definitive shape.

Transition Communication Plan – Focuses on messages specific to the physical move; engenders understanding, excitement and ownership among the staff. JTF CapMed and the DCITs are developing and coordinating this plan among the NCR stakeholders.

Transition Orientation and Training Plan – Details all activities required to successfully familiarize the staff to the physical plant, systems, equipment, and operational changes in the new facility so they can perform their duties. Education and Orientation working groups at FBCH and WRNMMC have started the initial process of developing all aspects of training required to support staff in the joint facilities.

Hospital Orientation Program – Provides an orientation that ensures all staff knows how to work in the new facility, including safety features, way finding, security, etc.

Departmental/Unit Orientation Program – Orients staff on how to function as a member of the department and unit that they have been assigned to.

Day in the Life – An exercise held prior to the move that is the culmination of the orientation and training programs, demonstrating staff have the knowledge to care for patients in the new facility. In preparation for planning and implementation of Day in the Life exercises, staff from each of the three MTFs observed a Day in the Life exercise that the IO&T contractor conducted at a partner hospital in Rockingham Memorial Hospital, Harrison, Virginia.

Occupancy Readiness Plan – Develops the activities necessary to ensure the building is ready for occupancy, including plant and system retests, cleaning, stocking, and final security check. The Occupancy Readiness working groups were established in May 2010 at FBCH and WRNMMC and their plans are being developed.

Occupancy Master Plan – This is the final, combined list of all activities necessary for the physical move, including the move sequence. The draft Occupancy Master Plan is under review. Efforts continue in the development of the departmental mapping necessary to propose the occupancy phasing and scheduling.

Department and Clinic Move Plans – Provides the specifics about how each department and clinic will move, includes interfaces necessary to support the move, how the department will provide services during their move, and other move related activities for the department/clinic/function. Operational working groups have oversight and will be informing these plans.

Patient Move Plan – Addresses all aspects of moving patients, including processes, staff involvement, care protocols, infection control, etc. The Patient Move Working Group at Bethesda and the Operational Planning Team at Fort Belvoir are addressing all the aspects of moving patients, including processes, staff involvement, care protocols and infection control.

WII Warrior Move Plan – Addresses how Warriors will be relocated from their current location to the new facilities; plan includes continuity of care plans, staff and family involvement, etc. WRAMC is developing a plan that addresses how WII Warriors will be relocated from their current location to the new facilities; plan includes continuity of care, staff and family involvement, etc.

Staff Move Manual – Provides information on preparing for the physical relocation; the manual includes timelines, preparation of voice and data equipment, packing and labeling, etc. Facilitated by the IO&T support and coordinated with all the stakeholders, this will provide information on preparing for the physical relocation; resource manual that includes timelines, preparation of voice and data equipment, packing and labeling, etc.

#### **11.4 Primary Care Reassignment**

A TRICARE Prime/Plus Reassignment Plan has been developed for final implementation 90 days prior to integration. In addition, a robust Reassignment Strategic Communication Plan has been developed and will be implemented in the near future. By 30 September 2010, each enrollee currently assigned to WRAMC and NNMC will receive a letter identifying the projected facility in which they will receive their primary care. Communication with beneficiaries will continue through integration.

## **12.0 QUARTERLY CERTIFICATION THAT FUNCTIONS AT WALTER REED ARMY MEDICAL CENTER HAVE NOT BEEN MOVED TO BETHESDA AND FORT BELVOIR**

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Section 1674(c) of the NDAA for FY 2008 requires the Department to certify on a quarterly basis that patients, staff, bed capacity, functions or parts of functions at WRAMC have not been moved or disestablished until the expanded facilities at NNMC and DACH are completed, equipped, and staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at WRAMC during FY 2006.

On 30 December 2009 and 23 April 2010, as part of the CMP, the Department certified that patients, staff, bed capacity, functions, or parts of functions at WRAMC had not been disestablished or moved to the expanded medical facilities at Bethesda and Fort Belvoir.

As part of this submission, the Department certifies that patients, staff, bed capacity, functions, or parts of functions at WRAMC have not been disestablished or moved to the expanded medical facilities at Bethesda and Fort Belvoir.



## 13.0 CONCLUSION

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Beside the war itself, casualty care remains the Department's top priority. It is committed to continually improving and providing the best healthcare and recovery services available in the world for WII Warriors and their families, as well as all other beneficiaries of the MHS. The DoD is pleased to provide information on the transformation of Military Medicine in the NCR that has pioneered practices, methods, and models that have ultimately strengthened the MHS at large. The Department expresses its sincere appreciation to Congress for its steadfast commitment to oversight and support throughout this process and the DHB panel, which have both been critical to progress in this area, and looks forward to a continued partnership. Periodic updates regarding the refinement and implementation of the CMP will be provided to Congress.



## APPENDIX A: WALTER REED NATIONAL MILITARY MEDICAL CENTER UTILITY INFRASTRUCTURE

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The supporting utility infrastructure is a collection of many separate renovation projects strung together over a number of years. The result is a collection of systems that function at different levels of efficiency and provide varying levels of capacity for the different functions located within the medical complex. As an example, steam capacity to the existing facilities is considered more than adequate while the ability to produce chilled water for cooling and other uses is considered a challenge. There are several renovation projects underway to address these shortcomings.

The master planning team's approach to planning for the long-term provision of necessary services to the central medical core is to evaluate existing conditions, including both central plant capacity and the distribution system, identify likely utility requirements for the proposed redevelopment of the medical facilities and formulate strategies to address any shortcomings in capacity and distribution, all while providing the necessary flexibility to account for future conditions.

The assessment of existing conditions is currently underway and will be completed by September of 2010. Both the preliminary project schedule and budget have included estimates that acknowledge the potential for a moderate level of utility system upgrades.

Based on the proposed redevelopment project, the following utility service loads have been estimated for future development: For medical equipment sizing, the estimated load is approximately 10.1 MW with chillers and 6.7 MW with remote chillers. For a medical facility with chillers, this will require one 3000kVA, 4160 volt double ended substation for the chillers, and three 2500kVA, 480 volt double ended substations for the remaining loads. For a hospital without chillers, three 2500kVA, 480 volt double ended substations would be required.

Emergency generator loads are more difficult to estimate but are typically about two-thirds the normal loads. For a hospital with chillers, this would require four 2500 kW generators to provide N+1 redundancy. For the hospital without chillers, three 2500 kW generators would be required to provide N+1 redundancy. An additional generator may be required at the remote chiller plant.

With the addition of 560,000sf of new buildings and the demolition of 325,000sf of existing buildings, the net increase in campus load will be approximately 4.6 MW.

For mechanical cooling, the proposed 560,000 gsf building will require approximately 4,000 tons of air conditioning capacity. This load will be delivered by 30" chilled water supply and return lines. The required volume of chilled water is a little on the low side for 30" piping, but is too large for the next size smaller size. The piping would allow ample capacity for future buildings. The estimated cooling load for this building is 600 tons.

Chilled water capacity will be added to the existing central utility plant. Alternatively, if a chilled water plant was constructed in the new building, it would have four 1,500 ton chillers to provide N+1 redundancy. Four cooling towers matching the capacities of the chillers would be installed on the roof of the building. To optimize energy efficiency, one of the chillers might be replaced with an energy recovery chiller that could use waste heat to generate domestic hot water. Larger chillers would be proposed if they were installed in the existing central utility plant. It may be possible to install two 2,000 ton chilled water machines use some capacity from the existing system for redundancy.

The buildings in the core of the campus and scheduled for demolition currently use an estimated 1,000 tons of cooling. This cooling capacity would become available for other buildings once the demolition is complete.

For mechanical heating, the heat and process loads in the proposed 560,000 gsf building amount to 25 MMBH (million BTUs per hour) and would require a 16" steam line (or two 12" services) and 6" condensate return. If the boilers are installed in the building; three 250 hp packaged fire-tube boilers would be specified to meet the load and provide a measure of redundancy. Larger, water-tube boilers would be specified for boilers installed in the central utility plant.

For plumbing, the building would require an eight inch domestic water service and would have two or three 6" sanitary sewer connections. The fire water service for the building would most likely be an eight inch line. The combined fire protection/domestic water service would be a 12" service and would be separated immediately after entering the building.

The U.S. Green Building Council (USGBC) has developed a system of standards for both new construction and renovations that evaluate the impact of construction activity (both materials and processes) on the long-term sustainability of the environment. These standards come with a rating system that quantifies the sustainability of specific strategies and serve as a measuring tool for the outcome of the actions taken. All new construction associated with the redevelopment of the central medical core campus will meet, at a minimum, the "LEED Silver" standard of performance for sustainability, as established in these guidelines.

Executive Order 13514 was issued in October of 2009 and established the federal government's policy of providing for an integrated strategy of sustainability in the built environment and the reduction of greenhouse gas emissions for all federal facilities. This Order established specific performance requirements in a number of areas including the reduction of greenhouse gases, reduction in energy usage through conservation and implementation of alternative energy sources, reduction in potable water consumption, and the construction of high-performance buildings. The redevelopment of the central core campus will include construction practices and buildings, both new and renovated, that meets or exceeds these federal mandates.

## APPENDIX B: ACRONYM LIST

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AAR	After Action Report
ADA	Americans with Disabilities Act
ADAAG	Americans with Disabilities Act Accessibility Guidance
ADCMS	Army Direct Care Medical Services
ADCON	Administrative Control
AHLTA	Armed Forces Health Longitudinal Technology Application
BRAC	Base Realignment and Closure Commission
BTU	British Thermal Unit
BUMED	Navy Bureau of Medicine and Surgery
CHCS	Composite Health Care System
CIO	Chief Information Officer
CJTF	Commander, Joint Task Force National Capital Region Medical
CMP	Comprehensive Master Plan
CONOPS	Concept of Operations
COOP	Continuity of Operations
CSA	Clinical Support Agreements
DACH	DeWitt Army Community Hospital
DAR	Defense Access Road
DCIT	Deputy Commander for Integration and Transition
DD	Design Development
DEERS	Defense Eligibility Enrollment Reporting System
The Department	Department of Defense
DHB	Defense Health Board
DHP	Defense Health Program
DIACAP	Defense Information Assurance Certification Accreditation Process
DoD	Department of Defense
EBD	Evidence Based Design
EIS	Environmental Impact Statement
ERSA	External Resource Sharing Agreements
FBCH	Fort Belvoir Community Hospital
FBNA	Fort Belvoir North Area
FCI	Facility Condition Index
FEIS	Final Environmental Impact Statement
FIAR	Financial Improvement Audit Readiness
FOC	Full Operational Capability
FPD	First Patient Day
FSRE	Financial Statement Reporting Entity
FTE	Full Time Equivalent

FY	Fiscal Year
GDIT	General Dynamics Information Technology
GPP	Guaranteed Placement Program
gsf	gross square feet
HR	Human Resources
ID	Identification
IM/IT	Information Management/Information Technology
IMCON	Army Installation Management Command
IMD	Intermediate Manpower Document
IO&T	Initial Outfitting and Transition
JMED	Joint Medical Network
JOA	Joint Operations Area
JTD	Joint Table of Distribution
JTF CapMed	Joint Task Force National Capital Region Medical
kVA	Kilovolt-Ampere
kW	Kilowatt
LAN	Local Area Network
LEED	Leadership in Energy and Environmental Design
LRMC	Landstuhl Regional Medical Center, Germany
MCSC	Managed Care Support Contract
MEB	Medical Evaluation Board
MGMC	Malcolm Grow Medical Center
MHS	Military Health System
MHSS	Military Health System Support
MHSSI	Military Health System Support Initiative
MILCON	Military Construction
MMFP	Medical Master Facilities Plan
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MTF	Medical Treatment Facility
MW	Megawatt
NCPC	National Capital Planning Commission
NCR	National Capital Region
NDAA	National Defense Authorization Act
NEPA	National Environmental Protection Act
NMA	Non-Medical Attendant
NNMC	National Naval Medical Center
NSA	Naval Support Activity
NSPS	National Security Personnel System
NMCM	Non-Medical Case Manager
O&M	Operations and Maintenance

OASD/HA	Office of the Assistant Secretary of Defense for Health Affairs
OCO	Overseas Contingency Operations
OPCON	Operational Control
OPORD	Operations Order
PB&E	Program, Budgeting, and Execution
PCM	Primary Care Manager
PEB	Physical Evaluation Board
PFD	Program for Design
PMO	Program Management Office
POM	Program Objective Memorandum
RFE	Ready for Equipping
RFID	Radio-frequency identification
ROD	Record of Decision
RTLS	Real Time Location System
sf	square feet
SHPO	State Historic Preservation Office
SONET	Synchronous Optical Network
SOP	Standard Operating Procedure
SRM	Sustainment, Restoration, and Modernization
TACON	Tactical Control
TBI	Traumatic Brain Injury
TIMPO	Tri-Service Infrastructure Management Program Office
TMA	TRICARE Management Activity
TRO	TRICARE Regional Office
TTO	Travel and Transportation Order
UCMJ	Uniform Code of Military Justice
UFC	Unified Facilities Criteria
USGBC	U.S. Green Building Council
USUHS	Uniformed Services University of the Health Sciences
VA	U.S. Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
WFAC	Warrior Family Assistance Center
WFCC	Warrior Family Coordination Center
WII or Wounded	Wounded, Ill, and Injured
WMATA	Washington Metropolitan Area Transit Authority
WRAMC	Walter Reed Army Medical Center
WRHCS	Walter Reed Healthcare System
WRNMMC	Walter Reed National Military Medical Center
WTC	Warrior Transition Center



## ATTACHMENT

Attachment 1: Wounded, Ill, and Injured Warrior Care Concept of Operations



# **Integrated Wounded, Ill, and Injured Warrior Care**

## **Concept of Operations**

# **INTEGRATED WOUNDED, ILL, AND INJURED WARRIOR CARE CONOPS**

## **1. BACKGROUND.**

The findings of the 2005 Defense Base Realignment and Closure (BRAC) Commission, recommended relocating patient care activities from the Walter Reed Army Medical Center (WRAMC), Washington DC, to the National Naval Medical Center (NNMC), Bethesda and Fort Belvoir, VA. The Walter Reed National Military Medical Center (WRNMMC) would be established on the Bethesda campus and provide primary, subspecialty, and complex tertiary medical services. A new Fort Belvoir Community Hospital (FBCH) would be constructed to replace the current DeWitt Army Community Hospital (DACH), and would provide primary and acute subspecialty patient care services. Malcolm Grow Medical Center at Joint Base Andrews, MD would become an ambulatory care center. The BRAC recommendation subsequently became law and WRAMC will close by September 15, 2011. Medical services including comprehensive Warrior care will transition from WRAMC to WRNMMC and FBCH.

The completion of National Capital Region (NCR) Medical BRAC projects at Bethesda and FBCH will represent an important milestone for The Defense Department and military medicine in the region. WRNMMC, Bethesda and FBCH will ultimately be established as the Department's first Joint hospitals and will report directly to Joint Task Force, Capital Region Medical (JTF CapMed). This document provides a concept of operations (CONOPS) that the military, civilian, and contractor staffs will follow to ensure the BRAC recommendations are implemented. The CONOPS focuses on integrated Warrior care and support, and outlines the planning and activities that must occur in order for the transition to be successful. Without historic documents to use as a blueprint, this CONOPS will evolve as lessons are learned and new decisions must be made.

Today WRAMC, NNMC and Malcolm Grow Medical Center provide a continuum of care for wounded warriors that are among the best healthcare and recovery services available anywhere. The 2005 Walter Reed BRAC recommendation was the Department's first step in a larger effort to transform, realign, and significantly enhance functions in the NCR to achieve capabilities and levels of interoperability at the new WRNMMC, Bethesda and FBCH that do not exist in the region today. Both Bethesda and Fort Belvoir will sustain the highest level of Warrior transition services to support the Nation's wounded Warriors and their families. Next to the war itself, casualty care remains the Department's top priority. The military health system as well as DoD military treatment facilities (MTF) in the NCR will continue to provide the best healthcare and recovery services for war fighters and their families. The new WRNMMC, Bethesda and FBCH will anchor this medical effort in the NCR.

## **2. VISION.**

A premier integrated system of warrior care and services built on principles of patient/family centered care, quality, compassion, and safety.

### 3. MISSION.

**Warrior Care.** Comprehensive casualty care remains the first priority for the Commander, Joint Task Force Capital Region Medical (CJTF CapMed) and a major mission for the MTFs in the NCR. Within a framework of patient/family-centered care, dedicated teams of medical professionals employ cutting-edge technology, state-of-the-art innovation, and partnerships with volunteer organizations to optimize recovery and return Soldiers, Airmen, Sailors, and Marines to productive activities of daily living. Whether the goal of an individual Warrior receiving care in the NCR is to return to the force or transition to civilian life, the Warrior will be supported by a world-class care system consisting of the Services, WRNMMC, FBCH, and the Bethesda and Fort Belvoir installations.

With the closure of WRAMC, Warriors arriving in the NCR will receive treatment at WRNMMC or FBCH. WRNMMC will serve as a tertiary referral center for those patients requiring intense care for high risk, complex and problem-prone diagnoses. Warriors requiring acute non-tertiary care may be medically regulated directly to FBCH. The primary principle in regulation will be matching medical requirements to care capability. Medical services exclusive to the Bethesda campus will be Neurosurgery, Cardio-Thoracic Surgery, acute amputee care, severe traumatic brain injury (TBI), and complex battle trauma. Quality, compassion, continuity of care and safety must remain constant throughout the continuum of care regardless of severity of injury.

Since 2001, more than 15,000 WII Warriors from the CENTCOM area of operations have received medical treatment in the NCR which serves as a primary casualty reception site for returning casualties. There is significant experience in the NCR in both the management of casualty flow as well as “load tested” treatment protocols ensuring world class medical care to returning Warriors even under surge conditions. Marked advances in casualty treatment at all echelons of care have yielded unprecedented rates of survival and recovery.

The journey from battlefield to stateside care is only the beginning of a long road for some returning Warriors facing extensive rehabilitation for life altering injuries. As an integrated healthcare delivery system, there is an extraordinary opportunity to integrate capabilities in the NCR to meet the holistic needs of Warriors. While the ultimate objective may be to transfer Warriors to treatment facilities closest to their homes, extensive tertiary outpatient rehabilitation may result in residential treatment for a year or longer in the NCR.

As reflected in the publication of the “Final Environmental Impact Statement” (FEIS) and the “Comprehensive Master Plan for the National Capital Region Medical,” the WRNMMC campus is designed to accommodate 350 WII Warriors.

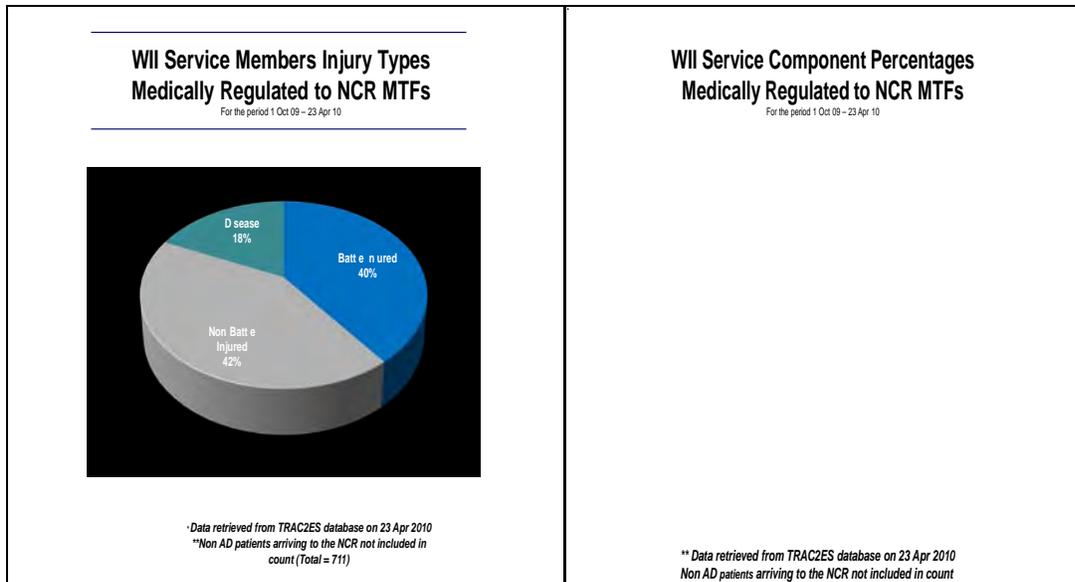


Figure 1.

Figure 2.

**Creating an optimal healing environment.** The delivery of world-class care extends beyond the physical walls of the hospital. The collective voices of Warriors and families over the past nine years of war have indicated that support services and the quality of the environment are critical elements affecting overall recovery and perceptions of a holistic approach to care. Transportation, spiritual support, language /interpreter services, child care services, support for families and visitors, recreation facilities and medical claims processing are recurring concerns expressed by Warriors and families. The stressors associated with deployment, combat operations, and separation from families and loved ones that they initially faced are magnified in the face of acute injury, illness, or long periods of rehabilitation for life altering disabilities. Full spectrum support services and optimal healing environments complement the provision of medical care, foster independence and resiliency, enhance satisfaction and demonstrate a commitment to holistic care.

At both Fort Belvoir and Bethesda, construction and deliberate planning are underway to create an environment that offers full spectrum support to Warriors and families. With the experience gained in providing care and support to more than 15,000 Warriors and families over the past nine years, interdisciplinary teams of medical and non-medical personnel including WII Program Managers, installation representatives, and volunteer organizations are actively engaged in developing a Warrior campus concept to complement medical operations. At the heart of this campus will be a Warrior Transition Center (WTC) housing a Warrior Family Coordination Center (WFCC) and Warrior Family Assistance Center (WFAC).

To ensure seamless coordination and collaboration between the MTF, the Installation, and the Services, a WFCC is scheduled to support both WRNMMC and FBCH in FY 2011. The WFCC will serve as the center of integration for Warrior activity. A new organizational construct, the center will operate 24 hours per day, seven days per week within the WTC. It provides a common operating platform for unity of effort by the MTF, Installation, and Services in their respective medical, environmental, and administrative, and command responsibilities in support of Warriors and Families.

The WFCC will be manned by a permanently assigned uniformed staff and operate within the WTC. It will serve as an operational arm for all Warrior and family issues with organizational accountability to the MTF Commander. The Director will report directly to the Commander, and will be empowered with responsibility and authority to manage Warrior and family matters. The scope of responsibility includes: early identification and resolution of barriers to care, sustaining a seamless and effective interface between the MTF, Installation, and Services on Warrior issues, leveraging opportunities to enhance a healing environment throughout the campus, timely and effective response to Warrior and family issues, building strong partnerships with volunteer organizations, supporting Service equities in management of WII Programs, promoting equitable distribution of services to Warriors and families, and fostering interoperability among the Services.

Elements of the WFCC will be assigned for duty in summer 2010 to assume oversight responsibilities for BRAC related Warrior activity including development of standard operating procedures, coordination of initial outfitting in the WTC, and synchronization planning and execution of movement of Warriors from WRAMC to Bethesda and FBCH in FY11. Warriors will not be moved from WRAMC until conditions are appropriate on the receiving NNMC and FBCH campuses.

The WFAC is intended to be a “one stop shop” dedicated to the needs of Warriors and families. Located in close proximity to the hospital and Warrior lodging, the center will provide counseling, subject matter expertise, and a wide range of services including: government travel, Child and Youth Services, Social Work Services, Veteran Affairs counseling, ID card and DEERS enrollment, employment assistance, emergency lodging, information referral and community outreach services. The WFAC will be staffed with Active Duty, Reserve, and National Guard representatives of the Services as well as Department of Defense civilians to provide and coordinate non-medical resources and services. From initial reception throughout the continuum of care, WFAC services will be available to help Warriors and families navigate the complexity of recovery.

In FY11, four Service WII programs will be operating in coordination with a Joint medical construct. Service elements and program representatives will co-locate in the WTC to manage their respective WII programs and execute Service responsibilities for command and control of Warriors. An integrated disability and evaluation cell is scheduled for the WTC on the Bethesda campus. The resource will centrally co-locate Patient Administrative Evaluation Board Liaison Officers (PEBLOs), Case Managers, and Medical Officers within the Warrior complex. Proximity to Service elements and Warrior support activities will streamline communication and enhance processing. Integrated protocols are under development to guide Warriors efficiently through the complicated Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes.

One of the roles of the Installation is to provide “quality of life” services for Warriors and families including lodging, housing, childcare, family support, transportation, and Morale, Welfare, and Recreation (MWR) activities. At WRNNMC, coordination of these services will be incorporated into the WFAC.

On the Belvoir campus, Army Installation Management Command (IMCOM) will continue to provide services through the Soldier Family Assistance Center for Warriors (SFAC) of all Services receiving treatment at FBCH. Installations will manage lodging and support for 350 Warriors on the Bethesda campus and 400 Warriors on the Fort Belvoir campus. At both sites, new construction is in progress and lodging will co-locate with administrative and Service elements. Facilities are programmed to be Warrior ready to comply with BRAC transition timelines. Installation representatives from Army IMCOM, USA MEDCOM, Walter Reed Garrison, and Naval Support Activity (NSA), Bethesda are actively engaged in requirements based transition planning to ensure seamless transition of service support from WRAMC to Bethesda for FY11.

**Proposed Personnel and Square Footage Requirements.**

SERVICE PROVIDED	PERSONNEL REQUIRED	SQUARE FOOTAGE ESTIMATED
Army Warrior Transition Unit (WTU)	157	15,807
Army HQs Element	36	Included in 15,807
Warrior Family Coordination Cell (WFCC)	16	564
Patient Administration Division (PAD/Disability Evaluation System (DES))	34	4,180
Warrior Family Assistance Center (WFAC)	32	7,300
USMC Wounded Warrior Regiment (WRR)	30	3,228
Navy Case Managers (for USMC WRR)	5	Included in 3,228
Navy Safe Harbor	3	360
Navy Casualty Assistance Call Officer (CACO)	2	Included in 360
Air Force Wounded Warrior (AFWW)	8	600
Special Operations Command Element (SOCOM)	3	216
TRICARE	3	480
<b>TOTAL</b>	<b>329</b>	

Figure 3.

4. RESPONSIBILITIES.

Successful warrior care depends on close coordination and collaboration between the MTF, the Installation, and the Services.

a) Service Responsibilities:

- 1) C2 to include UCMJ, Transfer Authority, Movement and Family Support
- 2) Personnel Accountability
- 3) Execute Service Specific Personnel Actions

- 4) Execute Service WII Programs
- 5) Ensure Personnel Availability for continuity of Healthcare and Rehabilitation

b) Installation Responsibilities:

- 1) Provide Base Operations, Lodging, and Transportation
- 2) Ensure Campus is WII Friendly and Compliant with Americans with Disabilities Act Accessibility Guidance (ADAAG)
- 3) Operate Day Care, Fitness Center, Exchange, and Morale Welfare & Recreation Activities
- 4) Contribute to a Healing Environment

c) MTF Responsibilities:

- 1) Patient and Family Centered Clinical Care and Rehabilitation
- 2) Ensure Continuity of Care through the Services
- 3) Operate a Warrior Family Coordination Center
- 5) Conduct a timely and responsive medical evaluation board (MEB) system
- 5) Be Responsive to Service Specific MED/PEB and Other Administrative Concerns

5. PATIENT TRANSFER NODES.

Seven patient transfer nodes along the care continuum have been identified for inclusion in the integrated WII CONOPS. Each node represents patient movement and as such, a potential risk or vulnerability in maintaining quality, safety and/or continuity of care. An interdisciplinary, inter-Service team is engaged in performing a risk assessment at each node. From the assessment, gaps and overlaps have been identified and mitigation strategies are under development. Overlap of functions can lead to redundancy resulting in loss of efficiency and potentially effectiveness. Gaps can lead to mission failure. From this work, discrete standing operating procedures are being developed for both WRNMMC and FBCH. Rehearsal and “load testing” of the policies and procedures is scheduled in a series of table top exercises in August 2010.

## **Node 1 – Departure from LRMC.**

**Patient Movement.** The patient movement planning and execution process is identified in Joint Publication 4-10, “Health Service Support.” Global patient movement is the responsibility of the US Transportation Command (USTRANSCOM). It operates the Global Patient Movement Regional Command (GPMRC), and maintains the TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES), an automated information system in support of global patient movement to provide in-transit visibility. Patient movement within the Continental United States (CONUS) is the responsibility of US Northern Command (USNORTHCOM).

The Deployed Warrior Medical Management Center (DWMMC) is pivotal to the success of Warrior and family movement from LRMC to definitive medical care destination. The DWMMC expeditiously coordinates patient movement and medical care of Warriors requiring medical evacuation from the theatre of operations. The DWMMC medical and administrative functions begin when the Warrior arrives at LRMC and end after the Warrior departs.

The Soldier Transfer and Regulating Tracking Center (STARTC) is an Army specific resource providing an intermediary oversight role for of Army Warriors matching medical requirements to destination location. Regulating is related to volume of casualty flow. When an Army Warrior Transition Unit reaches 90 percent of its total population, the STARTC selects an alternate destination to best meet the needs of the Army Warrior. Per protocol, WII Warriors and family members are transported from LRMC via government air evacuation or commercial contract carrier. If a government flight is available, the Warrior and family are added to the manifest, and if a government flight is not available and medical condition permits, the Warrior is booked on a commercial flight and the information is annotated in the Theater Medical Data Store and TRAC2ES.

**Medical Regulating.** Medical regulation of patients into the NCR will follow existing GPMRC/Theater patient Movement Requirements Center (TPMRC)/STARTC policies and procedures. If medical capability and capacity are available at both WRNMMC and FBCH, a regulating authority for the NCR, will recommend treatment location. The goal is notification of Warrior, families, and gaining treatment facility prior to flight departure from Ramstein Air Force Base (AFB). An active interdisciplinary workgroup is developing a CONOPS for medical regulation in the NCR. Timeline for completion is August, 2010. Protocols will be reviewed in upcoming Warrior rehearsal exercises.

**Notifications.** Service liaisons embedded at LRMC serve as a key link in the notification process of Warrior status to families, losing commands, gaining commands and stateside counterparts. The goal of all Services is timely and accurate notification prior to the Warrior’s departure from LRMC. In FY11, NCR WFCCs will be added to the notification protocol to facilitate coordination efforts for all Warriors and families programmed for arrival in the NCR.

**Travel and Transportation Orders (TTO).** All Services are authorized to prepare travel and transportation orders (TTO), formerly called invitational travel orders, for up to three family members of Warriors who are seriously ill/injured (SI) or very seriously ill/injured (VSI), in accordance with Joint Travel Regulations. The Service Secretary may authorize additional TTOS

for family members. The Casualty Office of the WII member's service approves the requests, generated by medical authorities, for the presence of the next of kin, and will assist with arranging Government-funded travel. TTOs cover the cost of travel to and from the WII Warrior's hospital, hotel costs, meals and incidental expenses. Those on TTOs are paid a per diem rate for meals and incidental expenses.

The definition of family member includes: 1) the Warrior's spouse; 2) the Warrior's children (including stepchildren, adopted children, and illegitimate children); 3) the Warrior's parents or persons in loco parentis to the Warrior, including fathers and mothers through adoption and persons who stood in loco parentis to the Warrior for at least one year immediately before the Warrior entered the Service, except that only one father and one mother or their counterparts in loco parentis may be recognized in any one case; 4) the Warrior's siblings; or 5) any of these individuals who is also a Service member.

The WII Warrior may also designate individuals other than family members for TTOs. If the designated individual is also a Service member, he or she will be provided the same travel and transportation as family members and other civilian designees. The Warrior may change the designation at any time. If a WII Warrior is unable to designate an individual, the attending physician/surgeon and MTF Commander may designate someone who has a personal relationship with the Warrior.

Routine TTOs for family members of Warriors who are not SI/VSI may be prepared by the Warrior's Service element representative upon request of his/her attending physician. These orders are issued for family members who travel to the NCR of their own accord, and whose presence is later authorized.

**Resource Coordination.** Upon notification of inbound mission, the receiving medical facility will ensure all resources necessary for receiving patients at Andrews Air Force Base are available including appropriate medical transport teams and transport vehicles. Based on information provided on the Patient Movement Request (PMR) and/or direct physician communication with LRMC, Attending Medical Officers will be identified for each patient and Bed Managers will assign inpatient room assignment. Service representatives will reserve lodging for outpatient Warriors and families arriving from LRMC.

## **Node 2 – Reception at Joint Base Andrews**

All inbound Warriors are triaged by an Air Force flight medical officer prior to departure from Joint Base Andrews, formerly Andrews AFB. Accepting transport teams receive clearance, a patient status handoff, and all pertinent medical documentation prior to departure to the MTF. Continuity, compassion and safety are requirements for this critical transfer of care, and Warriors will be protected from inclement weather during the transfer from aircraft to ground transportation. Nutrition support is provided by the Aero-medical Staging Facility on arrival to Andrews as required. Warriors are accompanied by qualified medical teams to either WRNMMC or FBCH, and infection control procedures will be strictly followed. Service representatives greet family members accompanying Warriors on arrival and assist with transportation as needed.

**Baggage and Belongings.** The ground crew at Joint Base Andrews will coordinate with the aircraft crew to ensure all checked baggage and carry-on belongings accompany the Warrior to the MTF. The Service representative will assist family members with transporting their checked baggage and carry-on belongings.

**Remain Overnight (RON) Patients.** Occasionally, Warriors with psychiatric conditions who require care on a locked ward may arrive at Joint Base Andrews, en-route to other locations. Medical regulating of these Warriors, when they must RON in the NCR, will be planned 3-4 days in advance so the Patient Administration (PAD) offices at WRNMMC or FBCH can coordinate for bed availability and staffing. The PAD will also coordinate housing for family members or attendants of RON Warriors.

### **Node 3 – Reception and In Processing at MTF**

**Clinical Reception.** Based on the existing manifest and changes identified at the flight line, the MTF is fully prepared to receive casualties and family members prior to the team departing Joint Base Andrews. With nine years of experience, well developed protocols exist for the safe, compassionate and effective management of inbound casualties. The reception team includes medical officers, nursing personnel, manpower transport pool, chaplain, PAD personnel, Service and WII Program representatives.

The process of reception is tightly controlled to ensure a smooth transfer of safe, compassionate, and high quality patient care. As they arrive at the facility, each Warrior is quickly assessed by a medical officer for disposition to inpatient status, movement to a treatment area, or a move to outpatient status. PAD maintains accountability of Warrior status and the admission process. Infection control screening and precautions are initiated as indicated by medical condition. Information on Warriors with dietary restrictions is forwarded to Nutrition Care. Transport teams secure belongings and move those requiring inpatient admission, accommodated by appropriate levels of medical support. Outpatients are screened, provided follow-on appointment, and turned over to Service representatives.

**Non-Medical Support.** The MTF staff will ensure the Warrior's baggage is placed in the same room as the Warrior or in a secured storage area in the MTF. Service elements provide orientation to post/base resources as well as Service level contact information on arrival to the MTF. In the course of initial contact, Warrior and family needs are assessed to customize support and assistance to meet individual needs. The same procedure is applied when Warriors and/or family members arrive at the MTF on public or private modes of transportation. Communication is essential at this node for both Warriors and families. For many, the journey has been long, stressful and complicated by uncertainty of the future. All staff – medical, administrative, and Service are assessing Warriors and families for physical, spiritual, and emotional needs. Compassion and safety are paramount as Warriors and families integrate into the community.

## **Node 4 – Inpatient Support**

**Case Management.** The Case Manager (CM) is an integral member of the multi-disciplinary team caring for Warriors. As the liaison between the medical team, the Warrior, and families, the CM ensures continuity of quality, safe and compassionate care, assists in mutual and realistic goal setting, reduces fragmentation or overlap in services, and educates throughout the continuum of care. Each Warrior is assigned a CM on admission to the MTF. The CM reviews the care received and takes part in the interdisciplinary discharge planning process. The CM follows the well defined six step CM process: assessment, planning, implementation, coordination, monitoring, and evaluation of care as defined by the Case Management Society of America standards of practice.

The six step process ensures the development and implementation of a sound treatment plan that is coordinated with complex and sometimes fragmented healthcare systems. Additionally the process provides a structure for assessment of adherence to the plan and evaluation of outcomes. If care requirements necessitate a transfer of care outside the MHS, the CM ensures continuity by coordinating movement to include a comprehensive handoff to the receiving CM. The CM is the linchpin ensuring compassionate, quality and safe healthcare care and rehabilitative services for Warriors at all echelons of care.

Of special interest to the continuity of care is the role of the joint DoD/VA Federal Recovery Coordination Program (FRCP). The FRCP is managed by the Veterans Administration to provide long term support and care coordination for Warriors who have catastrophic illnesses or injuries, and will likely be medically retired or separated from the military. The CM coordinates with the VA Liaison for Healthcare at the MTF for assignment of a Federal Recovery Coordinator (FRC)

to Warriors needing long term, possibly life-long, support. These Warriors are generally diagnosed with a spinal cord injury, severe burns, an amputation, visual impairment, TBI or post traumatic stress disorder (PTSD), or are considered at risk for a psychosocial complication. The FRC is supported by a memorandum of agreement between the VA and the MTF.

### **Servicemembers' Group Life Insurance Traumatic Injury Protection Program (TSGLI).**

The Warrior's Service level WII Program manager will provide instructions for applying for TSGLI to the Warrior, or family member or other person designated by the Warrior if the Warrior is unable to understand or is incompetent. The TSGLI payment is designed to help traumatically injured Warriors and their families with the financial burden associated with recovery. Each branch of the military has a TSGLI Branch Certifying Official who can answer specific questions.

**Medical Treatment for Family Members.** Non beneficiary family members are authorized to receive medical care or counseling on a Space Available basis in Primary Care Clinics when:

- The family member is on TTO to care for the Warrior
- The family member is issued non-medical attendant orders to care for the Warrior
- The family member is receiving per diem payments from DoD while caring for the Warrior

### **Transition from DoD Care and Treatment to VA Care, Treatment and Rehabilitation.**

The interdisciplinary discharge team/recovery team which includes the Recovery Care Coordinator (RCC), CM, and other medical/non-medical support staff consider the desires of the Warrior and family when determining the location for the Warrior's care, treatment, and rehabilitation. Transition preparation occurs with sufficient advance notice and information such that the upcoming change in location or caregiver is anticipated by the Warrior and family.

The primary care manager directs the transfer of a Warrior to the VA (based on the medical needs of the Warrior) by directly communicating with appropriate medical and non-medical staff of the gaining facility. If care requirements necessitate a transfer of care, the CM ensures continuity by coordinating movement to include a comprehensive handoff to the receiving CM. This coordination/handoff process happens whether a patient is transferred within or outside the military healthcare system.

Prior to a Warrior transitioning to the VA or a civilian facility, the RCC and/or CM must ensure that all appropriate care coordination activities, both medical and non-medical, have been completed. These include:

- Scheduling the Warrior's initial appointments with the Veterans Health Administration system or civilian facility
- Transmitting the Warrior's military service record and health record to the VA, along with the Warrior's authorization for the transmittal in accordance with Public Law 104-191. The RCC and/or CM will include the Warrior's permanent address and contact information, DD Form 214, "Certificate of Release or Discharge from Active Duty," PEB results, transitional health care entitlements, applications made by the Warrior for VA healthcare, compensation and vocational rehabilitation, disability, and other benefits.

**Child and Youth Services.** Children of WII Warriors will receive priority for childcare services on the installation. The provision of hourly drop off care is a priority that has been identified by all the Services. Installations are actively engaged in requirements based assessment. A child care center is programmed for the new Warrior complex under construction at Bethesda. School age children requiring school placement will be assisted through the Child and Youth Services office located in the WFAC.

### **Node 5 – Inpatient to Outpatient Activities and Support**

**Discharge Planning.** Interdisciplinary discharge planning begins with an inpatient admission. The Army has developed a "Full Spectrum Discharge Process", a four phased process that identifies "tailored" outpatient support to meet the special needs of the Warrior and continues through the outpatient recovery phases until there is a warm handoff to VA resources or the Warrior returns to duty. The Army identifies a Warrior's discharge during Phase I and performs "tailored" housing assessments for Warriors and families.

During Phases II –IV comprehensive plan elements include self assessments; goal setting; life skills for home management, budgeting and transportation; work and education are integrated throughout the Warrior’s outpatient care plan and monitored by the Triad of Care (Squad Leader, Primary Care Manager, Case Manager). The staff receive specialized “full spectrum training” that includes leadership, behavioral health, occupational health, and resiliency to assist Warriors and families to move through the continuum of care. This Full Spectrum Discharge Process supports the Warrior's Comprehensive Transition Plan/Comprehensive Recovery Plan that facilitates the transition from illness/injury to return to productive life.

**Patient Assessment.** All Warriors will receive a medical assessment prior to discharge. Medical staff will prepare prescriptions for Warriors. CMs will ensure Warriors and/or their families understand discharge instructions and monitor.

**Role of the RCC.** The Marine Corps, Air Force, and Navy WII programs assign RCCs to assist Warriors throughout their hospitalization course with nonmedical support issues, establishing valuable relationships of trust and support. The RCCs become active members of the interdisciplinary discharge teams immediately during the inpatient hospitalization phase to facilitate and coordinate the Warrior’s and family’s transitioning into the outpatient environment. The Army assigns a dedicated Squad Leader to each Army Warrior at the time of entry to the Warrior Transition Command. As part of the Triad of Care the Squad Leader has a dedicated focus on administrative and nonmedical support to the Warrior and family until the Soldier is discharged from the Warrior Transition Command.

The RCC and CM collaborate with the interdisciplinary discharge team/recovery team and the WII Warrior and family to develop a comprehensive recovery plan (a.k.a. transition plan). This plan may be customized for Service specific needs, but all will contain identified points of contact and a list of support and resources available to the Warrior and family (including the location of the support and resources). Generally the plan will focus on the Warrior’s future and will include all dimensions of his or her life: recovery, military, professional, educational, spiritual, and family. The RCC and/or CM will work with the Warrior to create action steps for accomplishing the plan’s goals that must be specific, measurable, and achievable within an agreed upon and achievable time frame.

**Convalescent Leave.** Convalescent leave is a nonchargeable absence granted after a Warrior’s hospitalization for illness or injury, and is necessary in the care and treatment prescribed for recuperation and convalescence. When convalescent leave is granted by the MTF, the hospital commander is the approving authority, and the Warrior must return to the MTF upon completion of the leave. When leave is granted by the Warrior’s unit, the unit commander is the approving authority, and the Warrior must return to the unit for duty at completion of the leave. Generally, the Warrior’s primary care provider or surgeon or other physician may recommend convalescent leave. The MTF commander’s and Service elements will establish procedures for granting convalescent leave.

**Outpatient Lodging.** In coordination with the interdisciplinary treatment team, the Service element coordinates outpatient lodging arrangements with the WFCC prior to a Warrior’s discharge from the MTF. Consideration must be given to any special requirements of the Warrior

and/or family members that could become a barrier to care, recovery, or interrupt activities of daily living, such as the need for ADA compliant lodging.

**Other Support.** Warriors who arrived at the MTF without military uniforms will be issued replacement uniforms by their respective Service. Warriors who arrived at the MTF without civilian clothing will be issued a voucher for one-time use at the Exchange to purchase clothing.

## **Node 6 – Outpatient Activities and Support**

**Primary Care Management.** In achieving the vision of a world-class healthcare system, the outpatient environment must mirror the commitment to excellence, compassion, and safety found within the walls of the MTF. Two key factors influencing Warrior and family satisfaction with outpatient services are access and the quality of care rendered. At the point of entry into the medical system, all Warriors are assigned a Primary Care Manager (PCM) responsible for provision of primary care medical needs. Regardless of the requirements for specialty care, comprehensive primary care services are required for all Warriors from the initial treatment phase through the transition of returning back to duty or into the community.

PCMs and Service representatives are developing an SOP to standardize the approach to primary care management for Warriors of all Services at both WRNMMC and FBCH. Timeline for completion of this initiative is August, 2010. Recommendations will be incorporated into the upcoming dedicated Warrior rehearsal exercises scheduled in August 2010. Centralized systems support MTF Commanders in monitoring internal processes to successfully comply with standards and business rules of the TRICARE Management Agency.

The Warrior Clinic's mission is to provide comprehensive primary care services to all Warriors receiving care from the initial treatment phase through the transition of returning back to duty or into the community. Standardizing practices found in commonalities of Service specific clinical protocols and policies create best practices suited to meeting the needs of Warriors and family clinical care in a joint environment.

**Follow-up Appointments and Access to Care.** CMs and/or RCCs are responsible for scheduling and coordinating follow-up medical care appointments. WII Warriors will have priority access to care.

**Non-medical Attendants (NMA).** An NMA is an able-bodied member of the WII Warrior's family, or an individual designated by the Warrior, whose presence has been confirmed as necessary the Warrior's attending physician and whose presence will contribute to the health and welfare of the Warrior. Generally the request is based on how well the Warrior can perform activities of daily living. NMA orders cover a 30 day period, and a new request must be submitted for every 30 day period. Case Managers will explain the roles and responsibilities of the NMA to the individual performing those duties. NMA orders cover per diem only. Family member NMAs may rotate their duties to other family members.

A designated NMA may not be the same individual designated for TTOs and the allowances covered by those orders. Normally only one NMA is authorized, but additional family members

may be approved by the MTF Commander. Children are not eligible for NMA status. They are only authorized travel as a breast-feeding infant, or when traveling with a Warrior with an immediate life-threatening condition who is traveling to undergo a potentially life-threatening surgical procedure.

The NMA may accompany a WII Warrior on a military patient movement mission when approved by the Warrior's MTF Commander, and the Patient Movement Requirements Center has concurred. NMAs are issued travel orders authorizing the same category of movement as the Warrior. NMAs must pay the full meal rate for meals consumed when travelling in the aero-medical evacuation system. The transportation authorized for a qualified NMA for a Warrior is round-trip transportation between the home of the NMA and the location at which the Warrior is receiving treatment. It may also include transportation, while accompanying the Warrior, to locations where the Warrior is subsequently transferred for further treatment, and travel to the Warrior's permanent duty station. The Service Secretaries may authorize per diem or reimbursement for travel expenses. Authorized travel includes transportation-in-kind, reimbursement for commercial travel, or a monetary allowance.

Service elements are responsible for orienting the NMA with the duties and responsibilities of the role of the NMA as well as providing ongoing assessment and outcomes as part of the Warriors individualized treatment plan.

**Full Non-medical Support.** Many Warriors become outpatients after many months of recovering as an inpatient. As an outpatient, the responsibilities for performing activities of daily living expand and the Warrior will transition to increasingly independent living. The RCC, CM, and Triad of Care will assist the Warrior and family by coordinating services and resources the Warrior may need in order to successfully reintegrate into the community.

**Transportation.** Transportation for the Warrior population is an essential requirement for maintaining activities of daily living as well as fulfilling the medical appointments and treatment obligations. These are requirements within treatment and transition plans. Service elements and WII Program representatives coordinate requirements through installation representatives in the WFCC. The Installation has primary responsibility to provide local transportation requirements for Warriors.

## **Node 7 – Transition Activities and Support**

**Outpatient to Return to Duty (RTD).** This group of Warriors will include those who will be found fit for duty through the Physical Disability Evaluation System (PDES), and those Warriors who will recover fully and will not require board action. They will be returned to duty in accordance with the policies and procedures of the respective Service. Warriors who will be RTD will be assisted by the Service element for duty station assignments, orders, training, etc. The RCC and CM will continue to assist at the Warrior's request.

**Outpatient and Board Processing.** Warriors who have reached optimal medical care and still fail to meet the Service's retention standards, will be guided through the complex PDES by PEBLOs, RCCs, and the VA's Military Service Coordinators (MSC). Physicians who prepare

the PDES record will be assigned to a joint PDES Administrative Clinic. The PEBLOs will provide administrative oversight of the process and will serve as a direct liaison to the Warriors. The MSC will counsel the Warrior on completing the VA/DoD Joint Disability Evaluation Board Claim in order for the VA to determine the Warriors' eligibility for disability benefits.

A Warrior who is found not fit for duty through the PDES may request to continue on permanent limited duty status or active duty in the Ready Reserve. The Service element will assist these Warriors with completing forms, procuring documents, submission and any other actions that are required for the request. The Secretary of the Military Department concerned may grant such requests based on a determination that the needs of the Service and the RSM's service obligation, special skills, experience, or reclassification justifies the continuation. Transfer of the RSM to another Service may also be considered.

**Outpatient to Release from Active Duty (REFRAD).** RC Warriors will be assisted by the Service element for REFRAD orders, final pay, service records, etc, and will coordinate with the Warrior's National Guard or Reserve unit as needed. RCCs and CMs will continue to assist the Warrior at his or her request. The PAD will explain any medical care entitlements such as transitional health care, conversion health policy, or other health benefits available through the Department of Defense as explained in section 1145 of title 10, United States Code.

**Outpatient to Veteran Status (Retirement or Separation or Separated Without Benefits (SWOB) ).** Warriors who retire or separate, including SWOB, will be assisted by the Service element for orders, final pay, service records, etc. The Service element will ensure the Warrior receives the Service's mandatory pre-separation counseling, has the opportunity to attend the VA benefits briefing (if applicable), and is available to participate in the Disabled Transition Assistance Program (TAP)(if applicable), and the Department of Labor TAP Employment Workshop. RCCs and MSCs will continue to assist the Warrior at his or her request.

## 6. CONTINGENCY PLANS.

Capacity analysis is integral to planning operations at the MTF. Not all contingency scenarios can be foreseen and unexpected last minute deployments, natural disasters, and patient surges can create emergency conditions requiring immediate response and action. JTF CAPMED, Regional Component Commands, MTF's, TRICARE Regional Operations North, and Health Net Federal Services (the TRICARE Management Activity Managed Care Support Contractor for the North Region), have developed a consistent and common approach to contingency planning and analysis. Each contingency scenario or emergency condition identified by the MTF will be assessed to determine the impact on:

- MTF enrollment capacity
- MTF specialty care capability and right of first refusal
- Civilian provider network
- Enrolled beneficiary PCM change requirements
- TRICARE Service Center operations and relocation requirements

Health Net will take the appropriate planning actions with each MTF to ensure the MTF Commander is provided tailored timely contingency support and services. To optimize the planning effort, the MTF will be requested to advise Health Net of known deployment and contingency scenarios that impact MTF capacity and specialty care capability. Armed with this knowledge, the necessary functional components will develop an appropriate response to the scenarios. This process will enable Health Net to assist in backfill planning, appropriately size the provider network, properly support the MTF and minimize disruption to MTF enrolled beneficiaries. These scenarios may be annotated in site specific contingency plans, at the MTF Commander's discretion and a JOA contingency plan at the CJTF's discretion.

The primary objective in any contingency scenario is to continue to optimize the direct care system and maintain the maximum amount of care in the MTF as possible. If there is a surge of wounded Warriors requiring care in the JOA, the CJTF can distribute the work force within the JOA. If that is not sufficient or possible, active duty or reserve forces can be requested from outside of the JOA. Aside from Active Duty and Reserve force multipliers, the following vehicles can be employed with varying lead time required:

- Clinical Support Agreements (CSA): Managed Care Support Contract (MCSC) program to provide contracted medical personnel (staffing) to MTFs through task order issuance to Health Net.
- External Resource Sharing Agreements (ERSA): Managed Care Support Contract (MCSC) program to fund MTF initiatives for reduction in purchased care expenses AND to facilitate MTF providers to deliver health care services in civilian Network Facilities via fee-for-service (paid claims) arrangements.
- Military Health System Support Initiative (MHSSI): TMA/TRO North program to fund MTF initiatives for recapture or reduction in purchased care expenses.
- Other Contingency Operations: (OCO): Services program to fund backfill of critical health care providers' positions during periods of deployment.
- Other Contracting (NARCO Sole Source, Army Direct Care Medical Services (ADCMS): Army program to provide contracted medical personnel (staffing) to the Regional Medical Commands through Multiple Award Task Order Contracts or through other contracting vehicles.
- VA/DoD Sharing Agreements: Department of Defense program that allows for the sharing of health care providers and facilities between MHSS and VA resources.

## GLOSSARY

ADAAG A/E	Americans with Disabilities Accessibility Guidance Air Evacuation
C2 CJTF CONOPS CONUS	Command and Control Commander Joint Task Force Concept of Operations Continental United States
DACH DWMMC	DeWitt Army Community Hospital Deployed Warrior Medical Management Center
FBCH FEIS FRC	Fort Belvoir Community Hospital Final Environmental Impact Statement Federal Recovery Coordinator
GPMRC	Global Patient Movement Regional Command
IMCOM	Installation Management Command
JTF CapMed JOA	Joint Task Force Capital Medical Joint Operations Area
LRMC	Landstuhl Regional Medical Center
MCSC MEB MRO MWR	Managed Care Support Contract Medical Evaluation Board Medical Regulating Office Morale, Welfare & Recreation
NMA NNMC NCR	Non-medical Attendant National Naval Medical Center National Capital Region
OCO	Other Contingency Operations
PAD	Patient Administration Division
PEB	Physical Evaluation Board
RC RCC RTD	Reserve Component Recovery Care Coordinator Return to Duty
SFAC	Soldier Family Assistance Center

SOP	Standard Operating Procedure
STARTC	Soldier Transfer and Regulating Tracking Center
SWOB	Separated Without Benefits
TPMRC	Theater Patient Movement Requirements Center
TRAC2ES	TRANSCOM Regulating and Command & Control Evacuation System
TTO	Travel and Transportation Orders
USTRANSCOM	Transportation Command
VA	(Department of) Veterans Affairs
VI	Very Ill/Injured
VSI	Very Seriously Ill/ Injured
VR&E	Vocational Rehabilitation & Employment
WFAC	Warrior Family Assistance Center
WFCC	Warrior Family Coordination Center
WII	Wounded, Ill, and Injured
WRAMC	Walter Reed Army Medical Center
WRNMMC	Walter Reed National Military Medical Center
WTU	Warrior Transition Unit
WWP	Wounded Warrior Program