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STATEMENT BY

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

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COMMITTEE ON ARMED SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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