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STATEMENT BY
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THE SURGEON GENERAL

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WALTER REED ARMY MEDICAL CENTER OUTPATIENT CARE

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Statement By
Lieutenant General Kevin C. Kiley

Mr. Chairman, Congressman Hunter, and distinguished members of the subcommittee, thank you for the opportunity to discuss recent media reports about the living conditions, accountability procedures, medical care, and administrative processing of Soldier-patients receiving recuperative or rehabilitative care at Walter Reed Army Medical Center (WRAMC) as outpatients. The leadership and staff of WRAMC are committed to providing world class care for our wounded warriors and we are all upset by the problems detailed in the Washington Post series.

Let me begin by informing you that in the past two weeks I have directed three separate investigations into various problems raised by the Washington Post articles. First, prior to the articles being published, I asked the US Army Criminal Investigation Division to open an investigation into allegations of improper conduct by Dr. Michael Wagner, the former Director of WRAMC's Medical and Family Assistance Center (MEDFAC). The Washington Post published these allegations on Tuesday, 21 February 2007. In addition, I directed two more investigations. The second investigation will look specifically at the execution of command responsibility by the WRAMC Medical Center Brigade and the WRAMC Garrison Command to ensure safe, healthy living conditions for our recovering Warriors. The final investigation will look into WRAMC's internal Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) processing. The intent of these investigations is to uncover systemic breakdowns in our processes and to improve our system of care for wounded warriors. Once these investigations are complete, we will report back to you on our findings and our actions.

Since 2002, WRAMC has provided highly personalized health care by treating more than 6,000 Soldiers from Operation Enduring Freedom and Operation Iraqi Freedom. Nearly 2,000 of these Soldiers suffered battle injuries, more than 1,650 of whom started their care at WRAMC as inpatients – receiving life-saving medical treatments, needed surgeries and physical therapy – then progressed to outpatient status living near the hospital. A team of 4,200 medical professionals treat these

wounded warriors and dedicate their lives and hearts to helping our Soldiers. On average, more than 200 family members also join them to help with recovery, provide emotional support, and offer a strong hand or a warm hug to carry them through difficult days.

The requirement to assign Soldiers to Medical Holding Units (MHU) is dictated by internal Department of Defense regulations. The Army policy for assigning Soldiers to MHUs is intended to support the needs of the individual Soldier and his/her family. Soldiers with long-term debilitating conditions such as spinal cord and brain injuries or terminal cancer fall into this category and require intensive medical and administrative management only available at the MHU. In certain circumstances a Soldier may be assigned to a MHU while undergoing outpatient treatment when the Military Treatment Facility Commander determines that continuous treatment is required and that the Soldier cannot be managed by his or her unit, i.e., is unable to perform even limited duty at the unit.

Army military treatment facilities have two types of MHU. Active component Soldiers whose medical condition prevents them from performing even limited duty within their unit are assigned to a medical hold company. Each Army hospital with inpatient capability is authorized a medical hold company. Generally speaking, a majority of Soldiers assigned to medical hold companies have medical conditions that will eventually lead to separation from service or medical retirement. Since 2003, reserve component Soldiers who cannot deploy, are evacuated back to the US during their units' deployment, or return home with a medical condition are assigned to a medical holdover company. At WRAMC, both companies are organized under the Medical Center Brigade, which also has command responsibility for permanent party and students assigned or attached to WRAMC.

The current conflict is the longest in US history fought by volunteers since the Revolution. Two dozen Soldiers arrive each week and remain on the campus an average of 297 days for active duty, and 317 days for Reserve and National Guard. Often the very first thing they ask when they are able to speak is "When can I get back to my guys?"

The rehabilitation process at Walter Reed is also unique in its focus to restore these wounded Soldiers not just to a functioning level in society, but to return them to the high level of athletic performance they had before they were wounded for continued service in

the US military if possible. This is the stated goal of the WRAMC program, as well as the newer program at the Center for the Intrepid which was modeled after the Walter Reed successes.

The amputee population deserves special note as an example of these initiatives. There have been a total of 552 Soldier members who have suffered major limb amputation in the war. Of these, 432 of the patients were cared for at WRAMC: 394 service members from OIF (68 with multiple amputations) and 38 service members from OEF (6 with multiple amputations). There have been 35 amputee patients with major limb loss who were found fit for duty (17 that are Continuation on Active Duty/Continuation on Active Reserve and 18 remaining to complete the Medical Board process). Five of the 17 Soldiers have returned to serve on the front lines in CENTCOM. All of the Soldiers were monitored and supported by MH or MHO companies during their rehabilitation at Walter Reed.

It is important to note that, with the exception of burn patients, WRAMC cares for most of the critically injured Soldiers. Our Brooke Army Medical Center and its new state-of-the-art rehabilitation center, cares for many critically injured Soldiers with units or home-of record in the South West. The complexity of the injuries and illnesses suffered by these Soldiers often results in a recovery period that is longer and more challenging than those cared for at most other Department of Defense facilities. This places significant stress on the Soldier-patient, their families, and the staff providing care. The media reports about inadequate living conditions brought to light frustrations with billeting and the administrative processes necessary to return these warriors to duty or to expeditiously and compassionately transition them to civilian life. I would like to address three problem areas reported in the Washington Post series: Living conditions in Building 18; accountability management of outpatient-Soldiers; and, administrative processing of medical evaluation boards (MEB) and physical evaluation boards (PEB).

Billeting Issues and Living Conditions in Building 18

As Soldiers are discharged from inpatient status, many need to remain at WRAMC for continued care. Historically, the combination of permanent party Soldier barracks, off-post lodging, and three Fisher Houses have been sufficient to meet the

normal demand for billeting Soldiers assigned to the MHU at WRAMC. Beginning in 2003 the population of active and reserve component Soldiers assigned to WRAMC's MHU increased from 100-120 before the war to a high of 874 in the summer of 2005. To accommodate this increase in outpatient-Soldiers, WRAMC made use of all 199 rooms in the Mologne House – a non-appropriated fund hotel on the installation opened in 1996; 86 rooms in two buildings operated by the Mologne House; 30 rooms in three Fisher Houses; and, 15 contract hotel rooms in the Silver Spring Hilton. With the exception of building 18, all of these facilities have had extensive renovations performed over the last 10 years and have amenities similar to many modern hotels.

In the summer of 2005, WRAMC began housing the healthiest of the outpatient-Soldiers in Building 18 – a former civilian hotel across the street from the main WRAMC campus. Building 18 was constructed in 1969 and leased periodically by WRAMC until the government acquired the building in 1984. Between 2001 and 2005, more than \$400,000 in renovations were made to Building 18. In 2005, a \$269,000 renovation project made various improvements in all 54 rooms to include replacing carpeting and vinyl flooring. Additional upgrades to the central day room included a donation of a pool table and the command purchase of couches and a large flat screen TV.

The healthiest of our outpatient-Soldiers are assigned rooms in Building 18 after careful screening by the chain of command, case managers, and treating physicians. Patients who have trouble walking distances, have PTSD, or have TBI are not allowed to live in Building 18.

Building 18 has 54 rooms. Whenever a new Soldier was assigned a room, the building manager directed the Soldier and his/her supervisor to identify any deficiencies or damage in the room and initiates work orders to repair identified problems. Additionally, residents and their chain of command may submitted work orders through the building manager at any time. This entire process is being reassessed to ensure proper accountability. Since February 2006, more than 200 repairs were completed on rooms in Building 18, repairs continue to be made, and a rapid renovation is planned.

In spite of efforts to maintain Building 18, the building will require extensive repairs if it is going to continue to remain in service. Upon reading the Washington Post articles, I personally inspected Building 18. As noted in the article, the elevator and

security gate to the parking garage are not operational. Twenty-six rooms had one or more deficiencies which require repair. Two of these rooms had mold growth on walls. Thirty outstanding work orders have been prioritized and our Base Operations contractor has already completed a number of repairs. We are also working closely with US Army Installation Management Command, the Army Corps of Engineers, and our Health Facility planners to replace the roof and renovate each room.

There are currently no signs of rodents or cockroaches in any rooms. In October 2006, the hospital started an aggressive campaign to deal with a mice infestation after complaints from Soldiers. Preventive medicine specialists inspected the building and found rooms with exposed food that attracted vermin. Removing the food sources and increased oversight by the chain of command has since brought this problem under control, although such problems require vigilant monitoring, which is on-going.

Accountability and Information Flow to Outpatient-Soldiers

As of 16 February 2007 WRAMC had a total of 652 active and reserve component Soldiers assigned or attached to two MHUs. Currently there are 450 active component Soldiers assigned or attached to WRAMC's Medical Center Brigade. There are 202 reserve component Soldiers assigned or attached. Platoon sergeants and care managers are key to accounting for, tracking, and assisting Soldiers as they rehabilitate, recuperate, and process through the disability evaluation system. Prior to January 2006, WRAMC only had a single medical-hold company to provide command and control, and accountability for all of those Soldiers. Since January 2006, the hospital created new organizational structures to decrease the Soldier-to-platoon sergeant and Soldier-to-case manager ratio from one staff member for every 125 Soldiers to 1 platoon sergeant and 1 case manager for approximately 30 Soldiers.

Platoon sergeants and case managers attend staff training every Thursday. The training consists of various topics ranging from resource availability to Soldier services. Weekly Thursday training is supplemented with a platoon sergeant/case manager orientation program. Departing platoon sergeants work along side their replacement for approximately one week. Reserve component case managers attend a one week training program at Fort Sam Houston Texas for an overview of the Medical Holdover

Program, MEB/PEB process, customer service training and the duties of a case manager. Upon arrival at WRAMC, these case managers undergo a month-long preceptor program. Once hired by WRAMC, these case managers undergo a one-week training program to address organizational structure, MEB/PEB process, case manager roles and responsibilities, use of data systems, administrative documentation, convalescent leave and available resources in the hospital and on the installation, as well as expectations and standards. There is also a weekly clinical meeting held with physician advisory board and case managers for chart reviews and recommendation for the medical evaluation board process. Where ever possible we are working to streamline and merge platoon sergeant and case manager training to make it identical for all new personnel such as incorporating the preceptor concept for both Medical Hold and Medical Holdover units. We will also enhance the weekly training to introduce topics that are not only important to the platoon sergeant and case manager but address recurring issues/concerns raised by Soldiers and family members.

We are conducting a 100% review of the discharge planning and handoff process to ensure the transition from inpatient to outpatient is seamless and patients understand the next step in their recovery. This discharge will now include a battle handoff to a platoon sergeant. We are also in the process of hiring additional case managers and will submit plans to increase other critical positions in the Medical Center Brigade, which will reduce the current staff to outpatient ratio to more manageable levels, allowing more personalized service to the recovering soldier and family member in making appointments, completing necessary paperwork and navigating the complex disability evaluation systems.

The Medical Family Assistance Center (MEDFAC) will co-locate functions performed by Human Resources Command, Finance, and Casualty Assistance into the Medical Family Assistance Center allowing service in one location. In the near term, WRAMC will expand the staff to support the family members and relocate the operations to a more centralized 3,000 SF space in the hospital providing an improved environment for the families to obtain assistance.

The Medical Center Brigade recently established a Soldier and Family Member Liaison Cell to receive feedback from Soldiers and family members. A recent survey of

Soldiers and family members in January 2007 indicated that less than 3% of the outpatient-Soldier population voiced complaints about administrative processes. The command will continue to enhance the structure of the Soldier and Family Member Liaison Cell. We have requested three Family Life Consultants from the Family Support Branch of the Community and Family Support Center, Installation Management Command (IMCOM) to expand the resources available to identify areas of interest as well as provide counseling support to Soldiers and family members. We also will expand the current survey feedback process to include an intake survey for Soldiers and family members, a monthly Town Hall meeting and survey for ongoing issues, and an outtake survey upon the departure of Soldiers and family members. This feedback will be reviewed by the WRAMC Commander and other key leaders.

The Mologne House has approximately 30 personnel on staff that speak Spanish. These personnel work in all departments and a number of them are in management positions. These personnel have been assisting the Spanish speaking Soldiers and their families since the hotel opened. The Mologne House is taking steps to ensure the desk has a Spanish speaking staff member on call 24 hours a day to assist those in need of translation services.

Patients arrive at WRAMC by aero-medical evacuation flights three times a week, (Tuesday, Friday and Sunday). Additionally, some patients arrive at WRAMC on commercial flights for medical care. Family members may arrive with the Soldier or through their own travel itinerary. Soldiers and family members who arrive on MEDEVAC flights are met by an integrated team of clinical staff, MEDFAC, Red Cross, Patient Administration, Unit Liaison NCOs, and Medical Center Brigade representatives. Inpatients are triaged for further evaluation and disposition. Outpatients remain on the ambulance bus and are sent to the Mologne House with a representative from the Medical Center Brigade for billeting. Family members are met by MEDFAC and Red Cross and are escorted to the Mologne House for lodging.

Currently, there are 51 GWOT inpatient casualties. Our census ranges between 30 and 50 depending on the volume of air evacuations (high of 359 in July 2003 to low since OIF began of 64 in November 2005). Roughly half of the patients come as inpatients, and half as outpatients. Outpatients are processed through the Medical

Center Brigade for accountability and billeting when they arrive. Inpatients are accounted for by the hospital's patient administration office. We believe as many as one in five patients may be at risk to miss some of the administrative in processing at the Medical Center Brigade when they are discharged from the hospital, because of the timing of their discharge, their underlying medical condition, or miscommunication. I have directed a complete review of the discharge planning and the development of a new handoff process between the hospital and the Medical Center Brigade. This will include the development of a "GWOT Discharge Validation Inventory" that will be completed by the attending physician, discharging nurse, discharging pharmacist, social worker, brigade staff and hospital patient administration. The checklist will be validated by the Nursing Supervisor, Attending Physician, Deputy Commander for Clinical Services (DCCS) or Deputy Commander for Nursing (DCN).

Each Soldier receives a handbook upon assignment or attachment to Med Hold or Med Holdover. The Med Hold handbook is provided to Soldiers when they are assigned or attached by their respective PLT SGT. Newly arriving family members receive a Hero Handbook as well as a newcomer's orientation binder. Family members attend weekly new arrival meeting and a weekly town hall meeting where information is exchanged to answer questions or discuss ideas. Physical Evaluation Board Liaison Officers conduct monthly training sessions on the MEB/ PEB process for Soldiers and family members. A Case Management booklet with frequently asked questions is also provided to Soldiers.

Administrative processing of MEBs and PEBs

The MEB/PEB process is designed with two goals in mind – (1) to ensure the Army has a medically fit and ready force and (2) to protect the rights of Soldiers who may not be deemed medically fit for continued service. This process was designed to support a volunteer Army with routine health occurrences and it is essentially a paper process. We can and will improve this process in order to ensure that it can support a wartime Army experiencing large numbers of serious casualties.

The average reserve component Soldier assigned to Medical Holdover at WRAMC has been with us for approximately 289 days. We know from past experience

they will be with us, on average, for 317 days from the time they are assigned to the Medical Holdover Company. The primary reason for this lengthy stay is the requirement that each Soldier be allowed to achieve “optimal medical benefit” – in other words, heal to the point that further medical care will not improve the Soldier’s condition. All humans heal at different rates and this accounts for the longest part of the process.

Once the treating provider determines the Soldier has reached the point of optimal medical benefit the provider will initiate an MEB. This is a thorough documentation of all medical conditions incurred or aggravated by military service and ultimately concludes with a determination of whether the Soldier meets medical fitness standard for retention. If the treating provider and the hospital’s Deputy Commander for Clinical Services agree the Soldier does not meet medical fitness standards, the case is referred to the PEB.

The PEB is managed by US Army Human Resources Command and is comprised of a board of officers, including physicians, who review each MEB. The role of the PEB is to evaluate each medical condition, determine if the Soldier can be retained in service, and, if not retainable, assign a disability percentage to each condition. The total disability percentage assigned determines the amount of military compensation received upon separation. It is important to note that the MEB/PEB process has no bearing on disability ratings assigned by the Department of Veterans Affairs (DVA), but thorough and complete documentation of medical conditions is essential for expeditious review by the PEB and will also aid the Soldier in completing DVA documentation requirements.

The Washington Post articles provide anecdotal experiences of Soldiers and families who have had medical records and other paperwork lost during the MEB/PEB process. All medical records at WRAMC are generated electronically. However, paper copies must be printed since the PEB cannot access the electronic medical record used by Department of Defense hospitals.

There are currently 376 active MEB/PEB cases being processed by the WRAMC PEBLOs. The average time from initiation of a permanent profile to the PEB is 156 days. The MEB is processed through the PEB and Physical Disability Agency for an average of 52 days (including the ~15% of cases returned to the hospital for further

information). Thus, the total time from permanent profile to final disability rating is currently 208 days. At present, WRAMC has 12 trained PEBLO counselors. We are hiring an additional 10 counselors and 4 MEB review physicians to expedite the medical board process. It takes at least 3 months to train a PEBLO counselor and these employees are the main interface between the Soldier and the MEB/PEB system. As you might imagine, PEBLO counselors need to have excellent interpersonal and communication skills to perform well in a system that can be very stressful for the Soldier, family, and counselor.

In closing, let me again emphasize my appreciation for your continued support of WRAMC and Army Medicine. The failures highlighted in the Washington Post articles are not due to a lack of funding or support from Congress, the Administration, or the Department of Defense. Nor are they indicative of the standards I have set for my command. Walter Reed represents a legacy of excellence in patient care, medical research and medical education. I can assure you that the quality of medical care and the compassion of our staff continue to uphold Walter Reed's legacy. But it is also evident that we must improve our facilities, accountability, and administrative processes to ensure these systems meet the high standards of excellence that our men and women in uniform so richly deserve. Thank you again for your concern regarding this series of articles.