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“IS THIS ANY WAY TO TREAT  
OUR TROOPS?  
THE CARE AND CONDITION  
OF WOUNDED SOLDIERS AT  
WALTER REED”

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WRITTEN TESTIMONY OF  
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MARCH 5, 2007

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## PURPOSE

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In response to the recent publicity surrounding conditions at Walter Reed Army Medical Center, this paper is written and compiled to offer an accurate description of the problems and conditions associated with the management of the patient population housed at Walter Reed. Specifically, the issues and needs of those outpatients that are assigned or attached to the Medical Hold (MH) and Medical Holdover (MHO) Companies are outlined; coupled with a discussion of several solution-based initiatives and programs that have attempted to address the issues.

The information contained in this paper is by no means exhaustive, and offers a singular perspective (from a collection of “frontline” workers) regarding the systemic issues that exist as barriers to effective and efficient management of the outpatient population in the Medical Hold and Medical Holdover Companies.

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## BACKGROUND

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Although recent publicity has focused attention on the problems associated with service members getting effective, efficient and appropriate care while at Walter Reed Army Medical Center, it would be inaccurate to state that such problems have gone “unnoticed” by command staff and hospital personnel. It is more accurate to state that the problems described in this paper were not seen as a “priority” in terms of addressing the needs of the wounded. Furthermore, the problems noted in the series of articles by The Washington Post offer only a partial examination of what outpatients in the Medical Hold (MH) and Medical Holdover (MHO) Companies have to confront in their daily living while receiving medical care and treatment at Walter Reed. Although there is consensus that physical plant conditions have contributed to the problems faced by service members in the MH/MHO Companies, it is neither the sole, nor the most significant factor related to the care and activities of daily living of patients assigned or attached to MH/MHO Companies. Other factors such as systemic dysfunction (including problematic, intra-systemic relationships/integration); poor patient interface with the system; and a lack of understanding regarding the needs of this patient population (and their family members) by military command have also contributed significantly to the problems experienced by this population.

### Historical Context

Since the beginning of the Global War on Terrorism (GWOT), there has been an increasingly diverse and complex outpatient population housed at Walter Reed. Although current numbers put

the outpatient population at just under 700, this is less than the numbers reported in previous years (at one point in 2004, the number in the MH/MHO Companies numbered closer to 1,000). Not only was this patient population larger than could be housed on post (maximum 200-250 soldiers), but the needs and injuries were complicated and included both bodily and psychological injuries.

In response to a system overwhelmed by the numbers of patients, as well as the complexity of their needs, the staff within the Department of Psychiatry (specifically the Psychiatric Continuity Service (PCS)) engaged in discussions with both hospital and brigade commands to address issues associated with managing the needs of those soldiers assigned or attached to the MH/MHO Companies. These discussions were prompted by critical incidents which had taken place; one of which had resulted in the death of a patient in MH Company (January, 2005). While not all critical incidents have involved patients who were primarily receiving psychiatric treatment, the Psychiatric Continuity Service assumed a primary role for engaging and maintaining these discussions with command.

These discussions were focused on the need for, and the development of, better “risk management” practices to ensure that patients did not engage in problematic, dangerous behaviors. Although initial efforts focused on effectively managing patients who were primarily receiving psychiatric treatment, it soon became clear that ALL patients in the MH/MHO population were at risk of potentially experiencing some mild to moderate emotional/behavioral difficulties as the result of stressors associated with being stationed at Walter Reed. As a result, PCS attempted to offer a clear definition of the scope and severity of the problem. This led to a more comprehensive, well-developed understanding of the needs of the entire MH/MHO Companies, a discussion of which appears in the slide show presentation in Appendix A.

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## THE PROBLEM

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As previously stated, the problems associated with outpatient care for service members in MH/MHO go well beyond physical plant issues. A survey of over 200 soldiers in MH/MHO Companies was undertaken in March, 2006. The results (included in Appendix A) indicated that not only were services needed for the purpose of risk management, but to support patient wellness and provide for more information regarding how patients could effectively interface with “the system”. Overall there are three categories of problems/stressors faced by the MH/MHO population: (1) Physical space and conditions of the accommodations in which soldiers are housed; (2) A complicated, overwhelming and disjointed “social service” delivery system; and (3) A slow, confusing, and repetitive medical board and physical evaluation board process.

### **Physical Space and Accommodation Conditions**

As previously stated, it would be inaccurate to suggest that the problems associated with Building 18 went unnoticed by staff and command. Indeed, there were ongoing efforts to improve the living conditions, although these by no means addressed all the issues effectively. It would be more appropriate to state that the living conditions were not seen as a “priority” in terms of designating resources. The situation is a clear example of something patients in MH/MHO

Companies have complained about frequently: the attitude of the Army that as a soldier you should “Suck it up, soldier and drive on!” There is a pervasive attitude shared by many in the command structure that the service members in MH/MHO Companies are soldiers “first”. There is a strong resistance to treat them as patients, and as such, afford them the care and comfort associated with that role (including improving accommodations and providing “social services” to better manage the patient population). Soldiers and staff have experienced many encounters with command staff in which this attitude was directly stated, if not tacitly implied. It is the belief of several staff that this attitude led to the existence of the conditions in Building 18, as well as an overall mood of dissatisfaction, disenfranchisement, and resentment among the patients in the MH/MHO companies.

### **A Complicated, Overwhelming and Disjointed “Social Service” Delivery System**

The influx of such a large patient population quickly overwhelmed the Army’s ability to effectively manage the needs of the patient population. In fact, the Army’s approach has been to adopt a typical company command structure to address the issues of soldier accountability and “asset management”. Initially, there was no way in which to appropriately orient soldiers and their families to “life” at Walter Reed. Upon arriving at Walter Reed, many soldiers are routinely admitted as inpatients. While they are in the hospital, they are treated as patients. Once transferred to outpatient status, they are assigned or attached to MH/MHO. Systemically, these patients now have to be accountable to a command structure, in addition to managing their medical care and recovery, while dealing with the implications of their injuries. These competing roles often lead to role overload, resulting in the soldier not being able to meet the requirements of either role effectively.

A good example of this role overload is the “in processing” that is required of all soldiers when they transfer to a duty post. Each time a soldier transfers to a new unit or duty station, they are required to go through an “in processing”. For soldiers attached or assigned to the MH/MHO Companies, that requires the signature of up to 23 individuals located all over the post. Managing such a complicated and confusing process, in addition to getting medical care and treatment (which usually involves serious pain medication) is often overwhelming and results in resentment and anger on the part of the patient and their family. Having patients complete these tasks (sometimes in wheelchairs, with missing limbs) seems pointless and irrelevant. In addition, requiring patients to report to formation (in full uniform) on a daily basis adds more challenges for the recovering patient: adjusting medication times to be “awake” and “alert” for formation; getting less sleep in order to get up at 4:30 AM to prepare to report to formation on time; and interacting effectively with platoon sergeants and their “military” expectations.

These noncommissioned officers, who are neither medics, nor have any psychiatric training in dealing with needs associated with this population, often focus on the patient as “soldier first”. There have been reports that patients are at times threatened with administrative separations if they do not comply with expectations, which are near impossible to meet given their medical conditions and treatment. This then leads to intense resentment, anger, and certainly withdrawal from important services that are meant to engage patients and help them manage their medical care and recovery in positive and pro-active ways.

Although there is a myriad of professionals and command staff (case managers, doctors, and platoon sergeants) there is no comprehensive “net” of support services for soldiers to access

consistently reliable, relevant and helpful assistance/information. Each professional and NCO has distinct areas of responsibility and information; for the soldier, there is no guarantee that information given from any of these sources is reliable, and in fact the information from one source is usually contradictory to that of another. The inability of the military and medical communities to net resources and put in place a comprehensive system of patient management (information and resources) contributes significantly to a resentful, disenfranchised, angry patient population that is less invested in managing their health and medical care to a positive outcome.

### **A Slow, Confusing, and Repetitive Medical Board and Physical Evaluation Board Process**

Upon arriving as an outpatient at Walter Reed, soldiers have to contend not only with the issues mentioned above, but also the anxiety regarding their status within the military. Often patients are not aware of the medical board process, how it works, how long it takes, and what determines if they will get a medical discharge. This lack of information leads to frustration, anxiety, and unrealistic expectations regarding the outcome of the process. Once it is determined that a patient is receiving a medical board, the process itself can be considered quite simple. The patient is evaluated for a number of factors, with doctors writing a narrative summary regarding their assessment of the patient's condition. If more than one condition exists, there is a primary condition for which the patient is evaluated, with addendums written by other doctors addressing the co-occurring conditions. The problem associated with the process is in the execution.

There are many doctors, interns, residents with whom a patient has contact. This is in part due to the fact that Walter Reed is also a teaching hospital. Narrative summaries can get lost, take longer to complete for a number of reasons, and if the intern or resident has "rotated" to another clinic or department, "tracking" them down can be an arduous task that adds unnecessary time to the process. There are times when locating doctors results in the discovery that they have been deployed to Iraq or Afghanistan, or are no longer at Walter Reed. Furthermore, if another doctor has been designated to complete the board, it takes additional time (and more appointments) for the doctor to adequately assess the patient to competently write the narrative summary. In the meantime, if it's discovered that an addendum is more than six months old, it has to be reviewed/re-written and the entire process begins all over again. It's not unusual for a patient to followed/treated by more than one service (i.e. orthopedics, surgery, internal medicine) and each one must complete a timely addendum. Unfortunately, it can become the patient's responsibility to take on this process. In addition to making appointments, keeping appointments, and complying with requirements of the process (sometimes inaccurately or unclearly represented by professionals), patients become confused, overwhelmed, and can become ineffective in completing the necessary tasks within the appropriate time frame. If this happens, the patient must "renew" evaluations that have become outdated.

In part, this process is complicated by the "accountability gap" created by the way in which the system manages the information. Case managers in MH/MHO Companies do not take responsibility for tracking the progression of a patient's medical board. Indeed, each case manager has a caseload of up to 45 -55 soldiers. Individual doctors only write "their piece" of the report, leaving the patient to be responsible for tracking all the necessary paperwork. In many cases, the patient can be unaware of which professional hasn't completed a portion of the report, resulting in necessary steps having to be repeated. Although there are units and clinics at Walter Reed that have set up their own tracking system for patients on their service getting a medical board, there remains

the issue of accountability and who oversees the entire process. Dealing with this process is not only stress inducing, but it also has the effect of patients wishing to avoid the process altogether, or to accept a lesser percentage than perhaps they are entitled to in order to put an end to the stress.

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#### WHAT'S WORKING

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In order to effectively address the issue of change within the system, it's necessary to identify what has been working to address the concerns outlined above. There is a good foundation within the system upon which to build and implement systemic interventions that can more effectively manage the outpatient population currently assigned or attached to MH/MHO Companies. The point has been made previously, and it bears repeating here: there are good people, hardworking professionals (civilian and military) who strive to carry out the mission of providing the best medical care they can to the wounded at Walter Reed. When the question is asked "how this could be allowed to happen?" the answer must include a serious discussion about the lack of systemic flexibility in allowing individuals to create and implement solutions. The culture of the military and of the Army in particular, has never experienced a patient population (in size or complexity) such as this one. Solutions to the problems outlined above come in colors other than "Army Green", and need to be evaluated on their own merits in terms of how well they meet the needs of the patients, rather than in terms of how well they conform to the culture of the Army.

Having taken on a primary role for connecting patients in MH/MHO Companies to services, the staff within the Dept. of Psychiatry, specifically Psychiatric Continuity Service and Psychiatric Continuity Liaison Service (PCLS) undertook some ambitious initiatives, including:

1. Creating a Medical Board Oversight Committee that meets twice a month to track the status of every patient's medical board. Representatives include case managers in MH/MHO Companies; case managers from the Physical Evaluation Board Liaison Office; doctors and service providers from within the Department of Psychiatry; and social workers and staff from the unit discuss and problem solve issues associated with getting medical boards complete and filed in a timely fashion. Since its inception, the committee has reduced the number of patients waiting for medical boards by 65%.
2. Developing and maintaining collaborative relationships with other services/clinics, including the Army Substance Abuse Program, as well as with command staff in MH/MHO Companies to track patients' progress and compliance with treatment.
3. Designing and implementing an innovative and creative program (Warrior Outreach and Wellness) to address issues of risk management, patient wellness, and overall patient management by stressing prevention and early intervention strategies to address unnecessary stressors that have negatively impacted patient wellness. The program was successful in establishing collaborative partnerships with Army Community Services (ACS) and the Occupational Therapy Clinic (OT).
4. Seeking funding through the Commander's Initiative Account to continue to expand and broaden the function of the program. Although funding was approved, materials and

supplies requested have not been ordered, as funds became “unavailable” in the current fiscal year. (See Appendix B).

5. Staff within the Department of Psychiatric Continuity Liaison Services/Preventive Medical Psychiatry (PCLS) has implemented support groups for family members of soldiers to provide them with supportive connections to others, as well as to potentially helpful services. A Reunion and Reunification group conducted by Army Community Services (ACS) and PCLS has just begun meeting for the purpose of assisting patients and family members adjust to the patient’s return from Iraq and their injuries.

While these initiatives and programs have been helpful to providing services to the MH/MHO patient population, they are but discreet efforts, individually implemented, with no connection to each other, nor with the larger system. Indeed, these services are typical of the manner in which care is administered to this patient population: individuals (usually civilian) recognize and identify a need within the patient population and advocate for resources to implement services within their own department or service. There is no “centralized” mechanism to funnel these services to the larger population, and patient access to these services becomes “hit or miss”. Further, such a collection of discreet services can become overwhelming to illustrate and describe to incoming patients, and does not provide for a friendly, easy, or relevant patient interface. There is a need for these services to achieve a more integrated and connected status with the larger medical and military service systems.

Attaining such status, however, can be difficult, and has only been the case with one such program: the Warrior Outreach and Wellness Program. With concerted and consistent effort, staff members were able to convince command that the initial briefing provided by the program should be placed on the in-processing checklist, so that all patients in-processing to MH/MHO companies are required to attend. While this was a significant step towards “institutionalization” of the program, it further burdens patients with yet another stop in their long trek to complete administrative tasks associated with being a soldier. Feedback from patients and family members who have attended the program is generally positive, although they have often expressed a desire to have attended the briefing FIRST, as the information given would have been useful in helping them navigate the system.

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#### SUMMARY AND RECOMMENDATIONS

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The current issues and problems associated with the MH/MHO patient population are best defined and discussed within the context of patient care and management. It’s clear from speaking to many “frontline” social workers, as well as with patients and their family members, that the needs of this population require more than an improvement in living conditions. To think otherwise, is to waste valuable time, energy and resources in effectively developing ways to meet the needs of this increasingly diverse and complex population.

Effective and efficient outpatient services must address not only the medical needs of the patients, but their emotional, psychological, and functional needs as well. In doing so, a system must be created to manage and track patients (providing for necessary accountability) and their needs, while at the same time, giving them the tools necessary to manage their own care and recovery to positive outcomes. Such a system of care must be integrated, collaborative, and include: (1) recognition of service members as patients first; (2) sufficient and comprehensive resources devoted to ensuring patients “have what they need” to address all the administrative tasks associated with receiving medical care; (3) services to support family members and bedside caregivers in their often necessary role as liaison between the patient and the medical and military systems; (4) accessible points of entry into the system of care that provide for seamless transitions from inpatient to outpatient status; and (5) a clearly defined mission, role, and “place” within the military patient care system with appropriate scope of authority to direct resources as needed to various initiatives and programs in response to ongoing assessments of patients’ needs.

Specifically at Walter Reed, the system of care outlined above would require the following:

1. A comprehensive review of all programs, services, and initiatives currently operating in support of patients and their families in MH/MHO companies, with the goal of creating a system of care to address the previously identified needs of the patients.
2. The establishment and maintenance of collaborative partnerships and relationships between hospital staff and military command to create a system of care that addresses the need for patient accountability, as well as supporting the tracking of patients, and their progress and compliance with treatment.
3. Identifying and making improvements to the current operation of the Medical Board and Physical Evaluation Board processes such that doctors and staff more efficiently and quickly complete necessary “paperwork” to move the process to a speedy and just conclusion.
4. Completely funding the current Warrior Outreach and Wellness program to carry out its mission.
5. Establishing a “one stop” in-processing experience for soldiers and their families to ease the transition from inpatient to outpatient status.

The design and implementation of these recommendations, both qualitatively and quantitatively will require systemic change of an order greater than the renovation of buildings. Such change will require a strong commitment to viewing wounded soldiers as patients first; and to recognize the necessity for collaborative, cooperative relationships that can effectively pool resources to carry out a patient-centered mission. That mission must include more than providing the best medical care to the wounded: it must also include caring for patients while they receive that medical care.