[H.A.S.C. No. 112–19]

HEARING

ON

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2012

AND

OVERSIGHT OF PREVIOUSLY AUTHORIZED PROGRAMS

BEFORE THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON MILITARY PERSONNEL HEARING

ON

MILITARY HEALTH SYSTEM OVERVIEW AND DEFENSE HEALTH PROGRAM COST EFFICIENCIES

HEARING HELD
MARCH 15, 2011

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MILITARY HEALTH SYSTEM OVERVIEW AND DEFENSE HEALTH PROGRAM COST EFFICIENCIES

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Tuesday, March 15, 2011.

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2212, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Mr. WILSON. Ladies and gentlemen, I would like to welcome everyone to the Military Personnel Subcommittee hearing today on the Military Health System [MHS] overview and Defense Health Program cost efficiencies.

And today, the subcommittee meets to hear testimony on the Military Health System and the Defense Health Cost Program for the fiscal year 2012. I would like to begin by acknowledging the remarkable military and civilian medical professionals who provide extraordinary care to our service members and their families along with veterans, here at home and around the world, often in some of the toughest and most austere environments.

I have recently returned from Balad and Bagram where I am always appreciative of the professionals who have saved so many American, Iraqi, and Afghani lives. I have firsthand knowledge of their dedication and sacrifice from my second son, who has served in Iraq and is now an orthopedic resident in the Navy, but we are joint service. As a grateful dad, as a military family, I was reassured to the medical care available for my Army son and my Air Force nephew who also both served in Iraq.

The subcommittee remains committed to ensuring that the men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. Even in this tight fiscal environment, the Military Health Care System must continue to provide world-class health care to our beneficiaries and remain strong and viable in order to maintain that commitment to future beneficiaries.

The Department of Defense [DOD] has proposed several measures aimed at reducing the cost of providing health care to our service members and their families and military veterans. While I appreciate that your plan is a more comprehensive approach than previous cost cutting efforts, the challenge here is to find a balance

between fiscal responsibility while maintaining a viable and robust military health care system.

We must be sure to remember these proposals have complex implications that "go beyond beneficiaries." They also affect the people who support the defense health system, such as local pharmacists, as health care employees at hospitals and contractors. The subcommittee has a number of concerns about the Department's initiatives. To that end, we would expect the Department's witnesses to address our concerns, including first, the proposed TRICARE Prime fee increase for the fiscal year 2012, while appearing to be modest, is a 13 percent increase over the current rate.

DOD proposes increasing the fee in the out years based on an inflation index. You suggest 6.2 percent but it is not clear which index you are using now and in the future. Second, you plan to reduce the rate that TRICARE pays the sole community hospitals for inpatient care provided to our Active Duty, family members, and veterans.

Several of these hospitals are located very close to military bases; in fact some are right outside the front gates, especially important for 24-hour emergency care. What analysis have you done to determine whether reducing these rates will affect access to care for our beneficiaries and in particular the readiness of our Armed Forces? I would also like our witnesses to discuss the range of efficiency options that were considered but not included in the President's budget.

I would appreciate hearing your views on the recent GAO [Government Accountability Office] recommendations included in their report on Federal duplication, overlap and fragmentation. GAO made recommendations regarding establishing a unified medical command and for the DOD to finally jointly modernize their electronic health record system with the Veterans Administration.

In addition, I would like to hear from the military surgeons about efforts they are taking within the military departments to increase the efficiency of the health care systems and reduce cost. I would also like the military surgeons' views on areas where additional efficiencies can be gained across the DOD health system.

The Department of Defense, just last week, recently announced they have hired Governor John Baldacci, the former Governor of Maine, to undertake a full-scale review of the military health care and the impacts of military health care on the forces. I would appreciate hearing from Dr. Stanley the considerations for this review and what the Department hopes to gain from Governor Baldacci's efforts. I am concerned.

First of all, I have faith in Dr. Stanley. He is a graduate of South Carolina State University. So I know of his capabilities. Why is having a military health care czar not a duplication of the duties already assumed by Under Secretary Stanley and Assistant Secretary Woodson?

Finally, I would like to make it clear that in the effort to reduce the cost of military health care and find efficiencies in the military health care system, we must never lose sight of the population that the military medical system serves. The members of the Armed Forces and their families who currently serve and those who served as veterans for a full career in the past warrant the best health

care system available. Reducing cost must never result in reduced quality of the availability, or the availability of health care they earned and they deserve.

I hope that our witnesses will address these important issues as directly as possible in their oral statements and in the response to Members' questions. Before I introduce our panel, let me offer Ranking Member, who is a distinguished former chairman of this subcommittee, Congresswoman Susan Davis an opportunity to make her opening remarks.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 39.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman. And thank you for summarizing many of the issues that are before us today, I look forward to hearing from Under Secretary Stanley and Assistant Secretary Woodson on their views on the status of the military health care system, particularly the TRICARE program and their efforts to improve the care that we are providing to our service men and women, retirees, survivors, and their families.

Assistant Secretary Woodson, we welcome you. We are delighted that you are here. And I understand that it is your first testimony before this subcommittee. I am pleased that the Senate finally confirmed you as the Assistant Secretary for Health Affairs. The Department is confronting many issues and having you there is important if we are to be successful in facing those challenges.

I also look forward to hearing from our Surgeon Generals, General Schoomaker and Admiral Robinson, thank you very much for your service. And I know that both of you, I believe, are retiring this year. So we will miss you. It has been a pleasure working with both of you over the past several years.

The last 10 years of conflict have taken a toll on our forces, and in particular those who serve in our military health care system. The constant demand on the system and the successes that we have seen both on the battleground and back home here in the States have been remarkable and a testament to your leadership.

General Green, welcome back to you, sir. With the departure of General Schoomaker and Admiral Robinson, of course, you would be the most senior Surgeon General and I look forward to continuing to work with you.

While I suspect that the majority of this hearing will focus on the Department of Defense's health care proposals that were included in the budget, this hearing will probably be one of the only hearings on health care that we will have prior to the subcommittee and committee markup.

So as such, it is important that members of the subcommittee have an understanding of all the challenges that the military health care system is facing, not just the budgetary constraints. Our military personnel and their families are under constant pressure and challenges. And access to quality health care should not be on that list of concerns.

I look forward to your testimony on how we are caring for our injured, ill, and wounded and what can be done to continue to improve the military health care systems.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 42.]

Mr. WILSON. Thank you, Mrs. Davis.

We have five witnesses today. We would like to give each witness the opportunity to present his testimony and each Member an opportunity to question the witnesses. I would respectfully remind the witnesses that we desire that you summarize to the greatest extent possible the high points of your written testimony in 3 minutes. I assure you that your written comments and statements will be made part of the record.

And, of course, first we want to welcome the Honorable Dr. Clifford L. Stanley, the Under Secretary of Defense for Personnel and Readiness [P&R], Dr. John Woodson, Assistant Secretary for Defense for Health Affairs and this—Doctor, I know it is your first appearance so we are delighted to have you here. And Lieutenant General Eric Schoomaker, the Surgeon General of the Department of the Army and General, thank you for your distinguished career. And this is your last appearance and we just wish you well in your future career.

And Vice Admiral Adam Robinson, the Surgeon General of the Department of the Navy and indeed General Robinson, thank you. This, too, I can see the big smile on your face which means this is your last appearance here. And we appreciate your service and thank you for in every way, for your service. And then soon to be the senior Surgeon General amazingly enough, Lieutenant General Charles Bruce Green, the Surgeon General of the Department of the Air Force.

And at this time, Dr. Stanley, you may begin.

STATEMENT OF HON. CLIFFORD L. STANLEY, PH.D., UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

Secretary STANLEY. Good morning and thank you, Mr. Chairman and members of the committee, I really do appreciate this opportunity to appear before you today to discuss the future of the Military Health System, particularly our priorities for the coming year.

Dr. Woodson, the Surgeon Generals and I look forward to discussing our health care plans for 2011 and 2012. At the outset, I just want to acknowledge the performance and courage of our military medical professionals serving in combat theaters. For service members wounded in combat, their likelihood of survival after a medic arrives remains at historic and unmatched levels.

For those seriously wounded service members who require months, years and sometimes a lifetime of medical rehabilitation and treatment, we are committed to ensuring that they and their families receive the finest evidence-based medical services available in this country. And we are working ever more closely with our colleagues in the Department of Veterans Affairs [VA] to ensure our activities are better coordinated to include the disability evaluation process, the sharing of personnel and health information and collaboration on our future electronic health record.

In addition to the efficiencies that we will discuss today, I have asked the former Governor and former Representative John Balucci—Baldacci, excuse me, from Maine to help us work in a deep dive review of health care and wellness. Dr. Woodson and our Assistant Secretary of Defense for Health Affairs ensures that the military health care system runs smoothly every day.

But I have asked the Governor to pursue a four azimuth deep dive approach which is focusing on readiness, improve health population, patient experience and care and lastly, cost. And with that, I would turn to Dr. Woodson. Before I do that, I would like to also thank the subcommittee for the tremendous support you provide the Department for our service members and their families, particularly the Military Health System. Thank you.

[The joint prepared statement of Secretary Stanley and Dr. Woodson can be found in the Appendix on page 44.]

Mr. WILSON. Next, we have Dr. Woodson.

STATEMENT OF HON. JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. WOODSON. Mr. Chairman, Ranking Davis and members of the committee, thank you so much for this opportunity to appear before you today. I will briefly elaborate on Dr. Stanley's opening statement. I have had the privilege of serving the Military Health System both in uniform as an officer and physician and in my current role as senior medical advisor to the Secretary of Defense.

This system has shown time and again that it is a vibrant, learning organization capable of self-improvement and rapid incorporation of lessons learned into both our combat and peacetime endeavors.

In our combat theaters, Dr. Stanley has already noted the historic rates of survival among those who are injured. I would also point out the reductions in disease and injuries through improved public health and preventative medicine strategies. Thanks to the ongoing support of Congress, we are continuing to invest deeply in medical research and development on the most challenging medical issues we are confronted with from the war.

We are accelerating the delivery of our scientific findings from the laboratory to the bench—to the battlefield to include prevention, diagnosis, and treatment for both visible and invisible wounds of war. We are also making important investments in how we deliver care to all of our beneficiaries. The Patient-Centered Medical Home is a transformative effort within our system.

We have enrolled more than 655,000 beneficiaries to date, with promising results in the use of preventive services, reducing emergency room [ER] use, and provision of more timely care. In addition to our investments in readiness, improved population and improved service to our patients, we also have proposed some changes that will allow us to more responsibly manage our cost.

Our efficiency initiatives share the responsibility for cost controls among all of the participants including us internally at Health Affairs and TMA [TRICARE Management Activity], among provider communities and with our beneficiaries for whom we propose a very modest change to select out-of-pocket costs.

Throughout our proposals, we have taken steps to protect those who are enrolled in existing programs or who have special circumstances that must be considered and protected. Our proposed budget helps keep fidelity with our core principles. We will never lose our focus on our commitment to all the men and women who serve our Armed Forces, their families, those who have served in the past and present, and those will serve in the future.

We are proud to represent the men and women who comprise the Military Health System and we look forward to your questions this morning.

[The joint prepared statement of Dr. Woodson and Secretary Stanley can be found in the Appendix on page 44.]

Mr. WILSON. Thank you very much.

And General Schoomaker.

STATEMENT OF LTG ERIC B. SCHOOMAKER, USA, SURGEON GENERAL, U.S. ARMY

General SCHOOMAKER. Chairman Wilson, Ranking Member Davis, distinguished members of the committee, thanks for permitting me to talk with you today about the dedicated men and women of the Army Medical Department who bring value and inspire trust in Army Medicine.

Despite over 9 years of continuous armed conflict, for which Army Medicine bears a heavy load, every day our soldiers and their families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; and are treated in a state-of-the-art fashion when prevention fails; and are supported by an extraordinarily talented medical force including those who serve at the side of the warrior on the battlefield.

We are a member of this Military Health System team committed to partnering with soldiers and families, and veterans to achieve the highest level of fitness and health for all. And we have been leaders in innovation for trauma care and preventive medicine that have saved lives and improved the well-being of our warriors and improvements that have really changed even clinical practices in the civilian sector. We are focused on delivering the best care at the right time and place.

I would like to talk about our work through the lens of the five E's: Enduring, Early, Effective, Efficient, and an Enterprise fashion. We have an enduring commitment to care through initiatives such as the Warrior Care and Transition Plan and the Soldier Medical Readiness Campaign Plan.

We have an enduring responsibility alongside our sister services in the Department of Veteran Affairs to provide care and rehabilitation for wounded, ill and injured for many, many years to come. We have a warrior transition command in the Army Medical Department under the leadership of Brigadier General Darryl Williams, many of you have met him. He is a key in our provision of care and provides a centralized oversight for the Army's Warrior Care and Transition Program.

Our focus is on investing soldiers and families with dignity, respect, and self determination to successfully reintegrate them either back into the force or into the community. Since we stood up the first warrior transition units in June of 2007, more than 40,000

wounded, ill, and injured soldiers and their families have either progressed through or are currently in care, and we have returned over 16,000 soldiers to the force.

We have also created a Soldier Medical Readiness Campaign that has been brought about because of the rising cost of health problems in our force, especially within the Reserve Components. Among its many goals under the leadership of Major General Rich Stone, a mobilized Reserve Component physician from Michigan there to identify the medically non-ready soldier population and implement medical management programs to reduce this medically non-ready population with an ultimate end state of a deployment of healthy, resilient, and fit soldiers, and increase Army medical readiness.

Those soldiers that can no longer meet retention standards have to navigate our physical disability evaluation system. Assigning disability has long been a contentious issue. DOD and VA have jointly designed a new disability evaluation system that integrates the DOD and VA processes with a goal of expediting the delivery of VA benefits to service members. This pilot, called the Integrated Disability Evaluation System or IDES, began in late 2007 at Walter Reed. It is now in 16 of our Army Medical Treatment facilities.

And it will be the DOD and VA replacement for the legacy Disability Evaluation System. But even with this improvement, disability evaluation remains complex and adversarial. Our soldiers still undergo dual adjudication where the military rates only on fitting condition and the VA rates all service-connected conditions.

Dual adjudication is confusing to soldiers and leads to serious misperceptions about the Army's appreciation of the wounded, ill, and injured soldiers' complete medical and emotional situation. And IDES has not changed the fundamental nature of the dual adjudication process. Under the leadership of the Army Chief of Staff and the Army G–1, we continue to forge the consensus necessary for a comprehensive reform of the Physical Disability Evaluation System in which the Army and the DOD only determines fitness for duty, and the VA determines disability compensation.

Our second strategic aim is to reduce suffering, illness, and injury through early prevention. Army public health protects and improves the health of the Army community through education and promotion of healthy lifestyles, and disease and injury prevention. The health of the total Army is essential for readiness and prevention is the key to health.

The examples of this are the promotion of healthy lifestyles, of achieving the highest measures of population health measured by [inaudible], the implementation of Patient-Centered Medical Home that you have heard about already, and I hope you will hear more about, and the focus on, for example, body mass index, and childhood obesity.

The Army is leading the way also in the recognition and treatment of mild traumatic brain injury [TBI] or concussion through an "Educate, Train, Treat, Track" strategy. Vice Chief of Staff of the Army Pete Chiarelli has led personally in this and we have refined this through General Richard Thomas, my Assistant Surgeon General for Force Projection. We fielded this program, which some have called the "CPR for the brain," increasing the awareness and

screening of concussive injury and leading to a decrease of the stigma associated with seeking care.

The use of evidence-based practices are aimed at the most effective care for us, is our third strategic aim. For example, we have harvested the lessons of almost a decade of war and now strengthen our soldiers' and families' behavioral health and emotional resiliency through a campaign that aligns all of the behavioral health programs within this human dimension of the Army's Force Generation cycle. We call this the Comprehensive Behavioral Health System of Care. We have got now outcome studies that demonstrate the profound value of using multiple touchpoints in assessing and coordinating health and behavioral health for soldiers and families across this cycle.

Coupled with the major advances in battlefield care under the Joint Theater Trauma System which was birthed in the Army's Medical Research and Materiel Command and the Army's Institute of Surgical Research, we have made great strides in preventing and managing physical and emotional wounds of war.

Additionally, we have launched a comprehensive pain management strategy to address chronic pain that our soldiers are focused, it is holistic, multidisciplinary, multimodal. Utilizes art—the state-of-the-art care, and it is focusing on non-pharmacologic practices such as incorporating complementary and alternative therapies, like acupuncture, and massage therapy, movement therapy, yoga, and other mind-body medical practices.

Our fourth strategic aim is optimizing efficiencies that you have alluded to. We do that through leading business processes and partnerships with the other services and veterans organizations. Ultimately, I would like to say that the principal efficiency and cost saving step in health care is the maintenance of health, promotion of good health, and the focus on good clinical outcomes and evidence-based practices.

But we are also working with the DOD and the VA to create a single electronic health record, seamlessly transferring patient data between and among the partners to improve efficiencies and continuity of care. We share a significant amount of health information today. No two health organizations in the Nation share more non-billable health information than the DOD and the VA.

The Departments continue to standardize this sharing activity and are delivering information technology solutions that will significantly improve the sharing of appropriate electronic health information.

Our fifth aim is an enterprise approach. We have reengineered Army Medicine. We have created a Public Health Command. And we have reengineered our regional medical commands to align with the TRICARE regions so that we can more efficiently provide health care in a seamless way through our TRICARE partners.

We also have at each regional medical command, a deputy commander who is responsible for readiness and can reach out even to our Reserve Component elements within their area of responsibility to ensure that all medical and dental services are being provided and our Reserve units are optimally ready.

This is my last congressional hearing cycle as the Army Surgeon General and the Commanding General, The Army Medical Com-

mand. I would like to thank the committee for the opportunities that I have been given to highlight the accomplishments we have made, the challenges that we face, to hear your collective perspectives regarding the health of our extended military family and the health care we provide.

I have appreciated your tough questions, your valuable insights, the sage advice you have offered and the deep commitment you have all demonstrated to our soldiers and their families. On behalf of over 140,000 dedicated soldiers, civilians, contractors that make up my command in Army Medicine, I would like to thank also the Congress for your continued support in providing the resources we need for delivering leading edge health services, and build healthy and resilient communities.

Thank you.

[The prepared statement of General Schoomaker can be found in the Appendix on page 59.]

Mr. WILSON. General Schoomaker, thank you very much. And thank you for being so candid.

And Admiral Robinson, again, I am so grateful for the briefing you provided at your very historic office. And so, thank you for coming by today.

STATEMENT OF VADM ADAM M. ROBINSON, USN, SURGEON GENERAL, U.S. NAVY

Admiral ROBINSON. Thank you very much, Mr. Chairman.

Chairman Wilson.

Congresswoman Davis.

Distinguished members of the subcommittee, I am pleased to be with you today. And I want to thank the committee for the tremendous confidence and unwavering support of Navy Medicine, particularly, as we continue to care for those who go in harm's way, their families, and all beneficiaries.

Force Health Protection is the bedrock of Navy Medicine. It is what we do and why we exist. It is our duty, our obligation, and our privilege to promote, protect and restore the health of our sailors and marines. This mission spans the full spectrum of health care, from optimizing the health and fitness of the force, to maintaining robust disease surveillance and prevention programs, to saving lives on the battlefield.

I along with my fellow Surgeons General traveled to Afghanistan last month and again witnessed the stellar performance of our men and women delivering expeditionary combat casualty care. At the NATO [North Atlantic Treaty Organization] Role 3 Multinational Medical Unit, Navy Medicine is currently leading the joint and combined staff to provide the largest medical support in Kandahar with full trauma care.

This state-of-the-art facility is staffed with dedicated and compassionate Active and Reserve personnel who are truly delivering outstanding care. Receiving 70 percent of their patents directly from the point of injury on the battlefield, our doctors, nurses, and corpsmen apply the medical lessons learned from 10 years of war to achieve a remarkable 97 percent survival rate for coalition casualties.

The Navy Medicine team is working side by side with Army and Air Force medical personnel and coalition forces to support U.S. military coalition forces, contractors, Afghan nationals, police, army and civilians as well as detainees. The team is rapidly implementing best practices and employing unique skill sets such as an interventional radiologist, pediatric intensivist, hospitalist and others in support of their demanding mission.

I am proud of the manner in which our men and women are responding—leaving no doubt that the historically unprecedented survival rate from battlefield injuries is the direct result of better trained and equipped personnel, in conjunction with improved systems of treatment and casualty evacuation.

We spend a lot of time discussing what constitutes world class health care. I would like to be clear that there is no doubt in my mind that the trauma care being provided in theater today to our casualties is truly world class as are the men and women delivering it. Their morale is high and professionalism unmatched.

We also had the opportunity to visit our Concussion Restoration Care Center [CRCC] at Camp Leatherneck in Helmand Province. The center which opened in last—which opened last August, assesses and treats service members with concussion or mild TBI, mild traumatic brain injury, and musculoskeletal injuries, with the goal of safely returning to duty many service members as possible to full duty following recovery of cognitive and physical function.

The CRCC is supported by an interdisciplinary team including sports medicine, family medicine, mental health, physical therapy, and occupational therapy. The CRCC, along with other programs like OSCAR, our Operational Stress Control and Readiness program, in which we embed full-time mental health personnel with deploying marines, continues to reflect our priority of positioning our personnel and resources where they are most needed.

We have no greater responsibility than caring for our service members, wherever and whenever they go. We must understand that preserving the psychological health of service members and their families is one of the greatest challenges we face today. We recognize that service members and their families are resilient at baseline but the long conflict and repeated deployments challenge this resilience.

We also know that nearly a decade of continuous combat operations has resulted in a growing population of service members suffering with traumatic brain injury. We are forging ahead with improved screening, surveillance, treatment, education, and research. However, there is still much we do not yet know about these injuries and their long-term impact on the lives of our service members.

I would specifically point out that the issuance of the directive type memorandum in June 2010 has increased line leadership awareness of potential traumatic brain injury exposure and mandates post-blast evaluations and removal of blast-exposed warfighters from high risk situations to promote recovery.

We also recognize the important of collaboration and partnerships, and our efforts include those coordinated jointly with the other services, the Department of Veterans Affairs, the Centers of Excellence, as well as leading academic and research institutions.

Let me now turn to patient- and family-centered care. Medical Home Port is Navy Medicine's Patient-Centered Medical Home model, an important initiative that will significantly impact how we provide care to our beneficiaries. Medical Home Port emphasizes team-based comprehensive care and focuses on the relationship between the patient, their provider and the health care team.

Critical to its success is leveraging all of our providers and supporting information technology systems into a cohesive team that will not only provide primary care but integrate specialty care as well. We continue to move forward with the phased implementation of Medical Home Port and our medical centers and family-practice teaching hospitals, and the initial response from our patients is very encouraging.

Both force health protection and patient and family-centered care are supported by robust research and development capability and outstanding medical education programs. These are truly force multipliers. The work that our researchers and educators do is having a direct impact on the treatment we are able to provide our wounded warriors and helping to shape the future of military medicine.

Finally, I would like to address the proposed Defense Health Program cost efficiencies. Rising health care costs within the MHS continue to present challenges. The Secretary of Defense has articulated that the rate at which health care costs are increasing and relative proportion of the Department's resources devoted to health care cannot be sustained. He has been resolute in his commitment to implement systemic efficiencies and specific initiatives which will improve quality and satisfaction while more responsibly managing cost.

The Department of the Navy fully supports the Secretary's plan to better manage costs moving forward and ensure our beneficiaries have access to the quality care that is the hallmark of military medicine.

In summary, I am proud of the progress we are making, but not satisfied. We continue to see ground-breaking innovations in combat casualty care and remarkable heroics in saving lives, but all of us remain concerned about the cumulative effects of worry, of stress and anxiety on our service members and their families brought about by a decade of conflict. Each day resonates with the sacrifices that our sailors, marines, and their families make quietly and without bravado.

It is this commitment, this selfless service that helps inspire us in Navy Medicine. Regardless of the challenges ahead I am confident that we are well-positioned for the future. Since this is my last cycle of hearings, I too would like to extend my sincere appreciation to the committee, to the Members and the professional staffers for all of the support, the insights and the advice being given; it has been a true honor being before you and actually working with you.

I appreciate the opportunity to be here today and look forward to your questions. Thank you very much.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 82.]

Mr. WILSON. Admiral, thank you very much.

And General Green.

STATEMENT OF LT. GEN. CHARLES BRUCE GREEN, USAF, SURGEON GENERAL, U.S. AIR FORCE

General GREEN. Good morning, Mr. Chairman, Representative Davis, and distinguished members of the committee, I appreciate the opportunity to meet with you today representing the men and women of the Air Force Medical Service.

We cannot achieve our goals of better readiness, better health, better care and best value for our heroes and their families without your support, and we thank you.

Military Health System achievements have changed the face of the war. We deploy and set up hospitals within 12 hours of arrival anywhere in the world. We move wounded warriors from the battlefield to an operating room within minutes and have achieved and sustained less than 10 percent died-of-wounds rate.

We move our sickest patients in less than 24 hours of injury and get them home to loved ones within 3 days to hasten recovery. We have safely evacuated more than 85,000 patients since October, 2001, 11,300 in 2010 alone, many of them critically injured.

The Air Force Medical Service has a simple mantra: Trusted Care Anywhere. This fits what we do today and will continue to do in years ahead. It means creating a system that can be taken anywhere in the world and be equally as effective whether in war or for humanitarian assistance.

Medics at Air Combat Command have now developed an EMEDS [expeditionary medical support] deployable hospital that is capable of seeing the first patient within 1 hour of arrival and performing the first surgery within 3 to 5 hours. These systems are linked back to American quality care and refuse to compromise on patient safety.

Providing trusted care anywhere requires the Air Force Medical Service to focus on patients and populations. Patient-centered care builds new possibilities in prevention by linking the patients to provider teams that both the patient and the provider can be linked to an informatics network dedicated to improving care.

Efficient and effective health teams allow recapture of care at our medical treatment facilities to sustain currency and continually improving our readiness insures patients and warfighters always benefit from the latest medical technologies and advancements.

The Air Force supports the DOD strategy to control health care costs, and believes it is the right approach to manage the benefit while improving quality and satisfaction. By the end of 2012, Air Force Patient-Centered Medical Home will provide 1 million of our beneficiaries new continuity of care via single provider led teams at all of our Air Force facilities.

We will do all in our power to improve the health of our population while working to control the rising costs of health care.

The Air Force Medical Service treasures our partnerships with OSD [Office of the Secretary of the Defense], the Army, Navy, Veterans Administration, civilian, and academic partners. We leverage all the tools you have given us to improve retention and generate new medical knowledge. We will continue to deliver nothing less

than world-class care to military members and their families, wherever they serve around the globe.

Thank you and I look forward to answering your questions this morning.

[The prepared statement of General Green can be found in the Appendix on page 109.]

Mr. WILSON. Thank you very much, General.

And as we begin questions I want to make it clear, we are going to have a 5-minute rule and first of all it applies to me. And we have someone very impartial who is going to be observing this and monitoring it, Jeanette James.

And so, Ms. James, on the mark, get set, go.

With this in mind and to you, Dr. Stanley, knowing your background, your military background and medical, and Dr. Woodson, I have faith in both of you and I have faith in both of you as to the oversight of military health care. And so, it was a real surprise to me that out of the blue, last week, there would be a military health care czar appointed, Governor Baldacci, a former governor of Maine. And I understand he is to conduct a 1-year review.

I truly believe that is a duplication and the General Accountability Office just 2 weeks ago said that our government suffers from duplication, overlap, fragmentation; and then in light of that, a new position is created at a time where we are all concerned about efficiencies and now we are adding a new job, I believe, a $163,000 a year. That just doesn't seem right to me.

And then I am also concerned and in light of this study, why should Congress enact what you are proposing which are the defense health cost efficiencies, if this work could be overturned by another major reform by another party.

Secretary STANLEY. First of all, Congressman and Chairman, I thank you first of all for your confidence because the efficiencies that we are talking about today and specifically are de-coupled and are not directly related to what Governor Baldacci is going to be doing.

His charge, by me, because I asked him—first of all, I wanted to have an objective, outside look. I have looked at GAO reports; my charge from Secretary Gates when I first joined the Department last year was to look at P&R a little differently.

We have not really been as open as I think we should have been with VSOs [veteran service organizations], I don't think we have been as open as we should have been in terms of following some of the things that have been laid out before in terms of recommendations and I needed an outside look and I had a Member of Congress as well a former governor now who served two terms to help with not only the Guard, Reserve issues but also looking at the holistic viewpoint of readiness, of wellness, of looking at how we are going to do, you know, patient satisfaction and then cost was the last piece.

So the duplication is not what I actually see right now, actually I am asking Dr. Woodson to work very closely with him as we look at the objectives assessment of this.

Mr. WILSON. And Dr. Woodson.

Dr. WOODSON. Thank you for that question. I think in part with the delay in my confirmation and sort of the inconsistent leader-

ship within health affairs there was a need to in fact look at how business was conducted within health affairs.

I do not see the governor's mandate as interfering with my statutory authorities and the efficiencies that we need to roll out. To the extent that Governor Baldacci conducts his studies and produces products that informs me in terms of what additional reforms need to made, I look forward to his work.

Mr. WILSON. I am concerned too and I am glad you brought up about confirmation. I don't believe this position goes through confirmation; that concerns me.

General Schoomaker, real quickly with the—it is so important about the Walter Reed Bethesda what I consider to be merger, but I am very concerned about the level of support provided for the wounded warriors. Will it be equal to what we know is world class currently at Walter Reed?

General SCHOOMAKER. Sir, we have worked—I think all the services have worked very, very hard to ensure that that is going to occur. We have had some very, very tight schedules and some unexpected hurdles that we are going to have to overcome.

I feel that I should say, honestly, that there are going to be some patients and some clinical situations in a new system that is going to be, who are going to be facing unfamiliar terrain. We are going to have a new physical plant, a new organizational arrangement and a new virtual space, that is the Electronic Health Record to deliver that care. But I can say that we are working as hard as we can to meet those, both the deadlines as well as the standards of high-quality care.

Mr. WILSON. Thank you, and with the 5-minute rule, Mrs. Davis.

Mrs. DAVIS. Thank you.

Dr. Stanley, I understand that the Department analyzed a number of options before it considered what proposals to put forward to try and address the growing health care budget. So I wondered if you could share with the subcommittee what other proposals were considered and subsequently rejected by the Department?

Secretary STANLEY. Yes, Congresswoman Davis. The Department did, in fact, look at other options, everywhere from curtailing certain studies, doing curtailment on research, dealing with not only cancer research but looking at a whole range of options that I know that I am going to ask Dr. Woodson to help with some of this but the bottom line is, is that over the years, before I came, there were actually higher costs looked at which were rejected not only by this body but also internally looking at ways to be more efficient but also having minimal impact or effect on our troops and affecting our Active Duty Component.

So we looked at things that will have minimal impact on Active Duty and at the same time not really affecting even our retirement community or Reserve and Guard significantly, just looking at ways to manage costs but still deliver quality care. And that is the side, that is where we came down with these minimal efficiencies that we are looking at.

Mrs. DAVIS. Dr. Woodson.

Dr. WOODSON. Thank you very much for that question. Producing efficiencies and reduction in costs in health care is an ongoing ef-

fort, both within the Military Health System and within civilian sector as well.

Since 2007 $1.65 billion have been saved in the Military Health System by introducing mail-order pharmacy products, going after Federal price ceilings, using outpatient perspective payment systems, enhanced fraud detection, and standardizing medical supplies and equipment.

And of course I would remind the committee that the factors that are influencing the rise in health care include the fact that we have an increased number of users, new products and we have growing pharmacy use and growing utilization of health care resources.

Now we have endeavored to streamline our practices and produce efficiencies. We mentioned Patient-Centered Home as a method for particularly managing chronic disease which reduces cost but also improves quality of care. We have undergone consolidation and initial outfitting and transition of equipment efficiencies. We have centralized procurement of medical equipment and devices. We have also reduced service contracts and we continue to look at this as a source of efficiencies and as you know we are undergoing an efficiency evaluation to reduce 780 FTEs [full time equivalents] from Health Affairs and TRICARE Management Activity.

We streamlined TMA, TRICARE Management Activity operations and expanded the use of urgent care and nurse advice lines to produce better quality of care and more efficient care.

So there have been a number of initiatives that have been implemented and continue to be implemented, and again I would remind the committee that between 2001 and 2008, the rise in cost of health care was about 11.8 percent per year. We are really desperately trying to bend that curve and produce all sorts of efficiencies, and that is why we have considered for fiscal year 2012 a really balanced approach to bending that cost curve. Thank you.

Mrs. DAVIS. I appreciate, you know, your response. And one of the things I was wondering about this, Surgeons General, could you just talk a little bit about the engagement of you all and whether you felt that there was adequate opportunity for people to weigh in on these issues?

Admiral, did you want to——

Admiral ROBINSON. Yes, Congresswoman Davis. I think that the Surgeon Generals, all of us have been brought into the whole efficiency movement. I think that coming from Health Affairs, we have all been tasked to look not only at what we are doing externally with the five efficiencies that have been named, but also the internal approach.

And it has been through, in my opinion, the Medical Home where all three services leverage some of the efficiencies that are occurring in terms of access to care for primary care, integration of specialty care, having a real provider-patient relationship 24 hours, 7 days a week, decreasing urgent and emergency room visits, and having the ability to emphasize prevention rather than disease care.

So, in the Medical Home Port model, what the Navy calls, the same model that, the Medical Home is what Air Force and Army uses also—I think that it is going to be one of those major efficiency moves in terms of quality of care.

Yes, ma'am.

Mrs. DAVIS. I think my time is up. General, perhaps later we will have a chance for your response.

Mr. WILSON. And thank you very much.

Congressman Jones of North Carolina.

Mr. JONES. Mr. Chairman, thank you very much. And my question will be directed to Admiral Robinson and General Schoomaker. I want to thank you first for your service, and the many times you have testified, and the fine work you have done for our military.

I, like most Members of Congress, I have visited Walter Reed and Bethesda on a regular basis. And I make reference to this article of March 9th report reveals steep increase in war amputations the last fall.

And it seems like the last year that I have had the privilege to visit the heroes at Walter Reed and Bethesda, that the severity of the wounds are deeper or more severe than ever.

One being a kid that lost most of his lower body parts, the other being a sergeant first class who on a fourth tour in Afghanistan as he told me that day that he has always told the young marines to walk in the boot print in front. He did and it blew his leg off and other parts of his lower body were injured.

My concern for those who are still in the military who are severely wounded as well as when they leave the military, but this panel today, and that is why I have to single out the admiral and the general for this answer, are you satisfied that we are where we need to be as it relates to psychiatrists in the Army and the Navy?

Do we have an issue there that the government needs to really reach out and try to encourage those who are graduating from the schools, who are getting degrees in psychiatry, to look more at trying to come into the military? Or do you feel like the numbers are where they need to be?

My concern is—I am going to let you answer in one sec—my concern is not only the young injured, but if they have a mom and dad or if they have a wife and children. My concern is that I want to make sure that they get the mental health care as well as the physical health care.

General, I would go to you first and then the admiral second.

General SCHOOMAKER. Well, mindful of the time, sir, I am going to say two things real quickly. First of all, not to minimize or in any way to marginalize the interest that you have in this complex injury pattern that you have seen, we have recognized the same thing.

In fact, I have started up a task force a month or so ago to look in greater detail under the leadership of Brigadier General Joe Caravallo from the Southern Regional Medical Command and Brooke Army Medical Center.

He has pulled a team together to look at the data and look at the magnitude of the injuries that we are now seeing. We are seeing a larger number as you have seen of complex injuries from dismounted operations in Afghanistan with more multiple limbs lost, and higher limbs with abdominal and genital injuries as well.

We think this is the dark side of a good story. Soldiers and marines are surviving even more than they have in the past. The battlefield medicine is improving in all facets.

But what we get is a soldier, marine, sailor, airman who is very, very severely injured. And we are focusing now on what we need to do for them.

As far as psychological care, this is a moving target. We have seen as Dr. Woodson talked about it, increasing utilization especially in behavioral health across all of our units and families.

We have increased the number of behavioral health specialists, not just psychiatrists, but social workers, psychologists, our nurse psychiatric workers as well as our enlisted.

The Army has allowed us to put more of them down into battalions and brigades. We continue to chase that; we are not satisfied as you pointed out. The need is still there.

Mr. JONES. Admiral.

Admiral ROBINSON. The entire nation has a real challenge with behavioral health needs. The military certainly has an even increased challenge. I would say that what General Schoomaker said is correct. I would ditto everything that he has said.

We don't have enough psychiatrists, psychologists, social workers, or nurse practitioners in the sense that I can always use more. If we look at the retention rates particularly with psychiatry, we are probably in the Navy at 72 percent.

With that said, we have spent about $240 million in contracts. We have now about 144 more behavioral health contractors at 14 of our MTFs [military treatment facilities].

We have billeted for an increase in social workers from 35 to about 86, which is a substantial increase. We are looking at each facet of behavioral health, who we have, where they are located, and how we use them. We also put them and we embed our mental health professionals with our operational stress control, our OSCAR teams, we put them with the deploying units so that we can get care to people that they need immediately.

On the home front, we have FOCUS—or Families OverComing Under Stress. It is a focus, the program is called, in which we look at families and their behavioral health needs and the needs of the children and spouses, et cetera.

So we are putting together, I think, across the Military Health System a comprehensive look. Is it enough? It is all that we have now. We can always do better. And this is the major challenge as I said in my opening statement, a continuing major challenge. It really is a moving target.

We are trying to stay with it. And we will never leave those men and women behind.

Mr. JONES. Thank you, sir. Thank you, Mr. Chairman.

Mr. WILSON. Thank you.

And it is a good story. In January, I visited a young injured marine, Corporal Kyle Carpenter. And Kyle has had dozens of operations. He was gruesomely injured.

And he—last week it was on the front page, the newspapers across South Carolina appearing at the South Carolina Senate where he was on the floor. And all the members of the Senate welcomed him and shook his hand. And he was given a hero's deserved welcome.

Congresswoman Niki Tsongas of Massachusetts.

Ms. TSONGAS. Thank you all for being here. And I have to say I share Congressman Jones' concern. But I too have a good story.

Last week, I visited a young first lieutenant in the Army who had been injured by an IED [improvised explosive device] in Afghanistan. He had sadly lost the lower portion of his leg. But he was on a good recovery, yet another example of a very determined young man who wants to make the best of his service to our country and to the life that lies before him.

So, I thank you all for the great work that you are putting in, in challenging times. But I will also wanted to start out by commenting on the Uniformed Services Family Health Plan [USFHP]. The USFHP had its genesis 30 years ago when the direct care system needed help to meet the health care needs of our military personnel, retirees, and dependents.

And since then, as you all know, they have become the highest rated health care program in the Military Health System based on beneficiary satisfaction with a 90.4 percent satisfaction rate in 2009.

Their approach to patient care management with the focus on prevention and a continuum of care has improved clinical outcomes, decreased emergency room visits and hospital admissions.

This health plan is a model for what we have been aiming to do as we all struggle with the rising cost of health care. So, I would urge that as a body, we give careful analysis to the impact of your proposals to shift its cost to Medicare for retirees. Simply a statement of concern.

But I have a question, Secretary Stanley and Dr. Woodson. Secretary Gates has stated that, "Healthcare costs are eating the Defense Department alive." And according to the US News & World Report, "Healthcare cost as part of the Defense budget have gone from $19 billion in 2001 to about $55 billion now, about a 10th of the total."

Currently the over 2 million military retiree families enrolled in the lifetime health insurance system, TRICARE, pay $460 per family per year for health insurance. And an individual pays $230 per year. As we all know, these fees have not been raised in 15 years.

With this in mind, I do believe that Congress needs to take on the difficult task of reviewing this fee structure. It is an issue that will have to be dealt with because of the massive strain which has been placed on the defense budget by rising health care cost.

However, I believe it must be done in such a way as to minimize its impact. It would be inexcusable to deprive our retired heroes of the health benefits they have earned.

For Active Duty personnel, the Department has different annual deductible rates for TRICARE Extra and TRICARE Standard on the basis of pay grade. For example, under TRICARE Standard, the deductible is $150 per individual or $300 per family for beneficiaries at E5 and above and $50 per individual or $100 per family if the beneficiary is under E5.

Retirement benefits vary greatly depending on how long a person served and at what rank they retired.

One of the most significant changes made by the National Defense Authorization Act for Fiscal Year 2000 was a lifting of the

75 percent cap used in the calculation of retired pay for members eligible for service retirement.

Under this calculation, a retired O10 with 45 years of service could earn over $210,000 per year before taxes in retirement. But an E5 with 20 years of service would earn only around $17,000 in annual retirement pay before taxes.

Keeping this great gap in benefits in mind, I would like to ask, has the Department seriously reviewed any proposals for a stepped increase of TRICARE Prime fees determined on the basis of rank at the time of retirement and retiree benefits earned.

Secretary STANLEY. Congresswoman Tsongas, thank you very much for the question.

I am not aware of stepped increase look. The amount that was chosen was considered really a minimalist approach to addressing probably a longstanding issue of prices just not changing, or cost or charges being, you know, put onto the beneficiaries.

If Dr. Woodson, I am not sure if you have heard anything on that. I haven't.

Dr. WOODSON. Thank you, Dr. Stanley.

Thank you for the question. I agree that we haven't looked at the step-wise increases because we have introduced very modest changes. And as an administrative process, it becomes more difficult to assess income and who should have the step-wise increase because of that.

Even an enlisted person who retires after 20 years may actually enter a very good-paying job. And so what they actually make may not always relate just to their retirement pay.

And I would just remind the committee members to reflect on the fact that our proposals suggest modest increases for working-age retirees. And so, we would probably have to means-test against the issue of what their total salaries are; it is conceivable that following retirement, as talented as our men and women are who serve, they contribute greatly, get advanced degrees, and may be doing quite well.

So, administratively, it would be very tough to means-test. If we were proposing large fee increases, I would agree with you strongly.

Ms. TSONGAS. Thank you.

Mr. WILSON. Thank you, Ms. Tsongas.

And we are very grateful to have distinguished freshmen on the committee. The first is Dr. Joe Heck of Nevada. He is actually a staff alumnus of the Uniformed Services University of Health Sciences.

Dr. HECK. Thank you, Mr. Chairman.

And Dr. Stanley, Dr. Woodson, Surgeons General, thank you for being here today and thank you for your commitment to our service men and women's health and the health of their families.

I am going to refer to the joint written statement of Dr. Stanley and Dr. Woodson specifically, Reserve health readiness. You have referenced the individual medical readiness metric that has been developed. And in your statement you quote—"Within the Reserve Component, medical readiness is below our benchmarks."

And of course this is an area of great concern for me. And it raises several issues that I would like to bring up revolving pri-

marily around the LHI [Logistics Health Incorporated] contract and how that service has currently performed for the Army Reserve.

You know, as you well know, we have units in the Army Medical Reserve, MSUs, Mobilization Support Units, whose job it is to accomplish the medical aspect of soldier readiness processing when they get mobilized to their support base.

However, they are prohibited from performing that very same service for their own Reserve counterparts on a BTA [battle training assembly] weekend.

In your notes, you mentioned issues with minor dental procedures and immunizations being an issue that can be readily fixed in pre-mobilization or pre-deployment mobilization. Yet, in my unit, I have dentists that on a BTA weekend can go out and provide services to homeless people as a community service, but can't examine the reservists that are in their own unit because it is prohibited because of the LHI contract.

In immunizations, every fall, our immunization readiness plummets because a new flu vaccine comes out and everybody's compliance falls off until everybody gets their flu vaccine. You would think that in a medical unit full of doctors, nurses, and medics, we could immunize each other. But we can't even get the vaccine because we have to put in a voucher for LHI to come and do the immunizations.

The issues here are multiple. One, as you well recognize, it impacts our medical readiness. Two, it impacts our ability to perform real world training. Certainly, our doctors and nurses are doing that in their day job. But my 68 Whiskeys, my combat medics, they could be a janitor, they could be garbage man, they could be a schoolteacher, and we are taking away an opportunity for them to actually do their medical training on a drill weekend.

We send people to a PHA [periodic health assessment]. We send soldiers that are well and they come back to us broken. They go in well and they come back with a P3 profile. They are now medically non-deployable. And it takes us 6 months or more to backtrack and get that profile lifted because the folks doing these physicals don't understand what the profile process is.

I am encouraged by Major General Kasulke at AR–MEDCOM [Army Reserve Medical Command] who is starting a pilot project to review all these things and trying to find a way to take care of these mis-profiles. But the answer is not to have the person come back broken to begin with.

So my questions are: I understand that the LHI contract is up for renewal. I would like to know who has the formal approval authority for that contract? Is the Army considering any other options or modifications to the contract? What is the overall cost? And how can we document whether or not the LHI contract has provided any value-added service to our medical readiness?

Dr. WOODSON. Thank you, Congressman, for that very good question. And I would like to take that one for the record and get back to you with the substantive facts and answer you specifically. I think that probably it is time for review as we look at individual medical readiness and seeing how we can get added value out of all of the contracts that we employ.

[The information referred to can be found in the Appendix on page 131.]

Dr. HECK. I appreciate that. And I think it is critical that we also look at the opportunities to allow—I mean, back in the old days—and I guess, for the record, I should probably disclose that the Honorable Woodson used to be my rater when he was Brigadier General Woodson at AR–MEDCOM. And I thank you for all those good ratings, sir.

But, you know, we need to get back to the point where our Army Reserve medical personnel can do medical stuff on BTA weekend and maintain their skills. In the old days, we used to do all the physicals. And then all of a sudden there was an LHI contract and we were prohibited from doing those same things that we did for decades.

So, I look forward to the answers for the record, sir. Thank you.

General SCHOOMAKER. And, Congressman, if I could just make one comment. I think what you described also is why we stood up the Soldier Medical Readiness Campaign under mobilized reservist Rich Stone. And I would welcome the opportunity to have him come out and talk to you about that and what we are trying to do in partnership with both the Guard and Reserve.

Dr. HECK. Okay, thank you, General. I appreciate that.

Mr. WILSON. Thank you very much. And the issues that we are dealing with are so important for our service members, families, and veterans. In consultation with the ranking member, we will do a second round of one question each. But at this time, we immediately, of course, go to Ms. Pingree of Maine.

Ms. PINGREE. Thank you very much, Mr. Chair, Secretary Stanley, Dr. Woodson and all of the Surgeons General. I really appreciate your service to our country, your testimony this morning and so much of what you have been talking about are things that I appreciate hearing about, whether it is how you treat traumatic brain injury or using alternative methods of care to find more ways to heal our soldiers, talking about the medical home concept.

There are so many good things that you are doing. And I appreciate it, and I appreciate all the work that you have done. And I understand Chair Wilson's concern about the recent appointment of the governor from my state, Governor Baldacci, and his interest in making sure we are doing everything that is as cost effective as possible.

But I do want to say that Governor Baldacci has a great work ethic. He is very devoted to our military. He has worked very closely with the National Guard in our state to improve many of the practices in our state. So I look forward to him looking for some of the efficiencies that could be found.

But I want to reiterate some of what my colleague from Massachusetts talked about earlier. It is a deep concern for me. I represent the state of Maine, and I am proud to represent many Active Duty members and their families as well as military retirees and their families. I have over 34,000 military families and retirees that are fortunate to have access to outstanding health care provided by U.S. Family Health Plan at Martin's Point Healthcare in Maine.

I visited their facility. I have seen their use of the Medical Home model of care. The beneficiaries tell me how much they like this health care option. I mean, it has been said many times. This is exactly where we want to go with health care with our military retirees. And they are very happy, very satisfied about it.

In March, I sent a letter to you stating my unequivocal support of how this program currently works and suggesting that I would oppose any changes that would negatively impact the ability of them to provide care to beneficiaries, including those aged 65 and over who have earned their health benefits through their service to our Nation.

I am sorry to say, General Stanley, and with all due respect, I wasn't completely pleased with your response. And now the fiscal year 2012 President's budget request includes a proposed legislative provision that future enrollees would not remain on the plan upon reaching age 65. I am concerned about this proposal, that it would eliminate access for those in greatest need of care and their ability to receive what is the highest rated health care plan in the military.

Let me just shorten up some of my conversation here because I know you know exactly what my concerns are and what I am talking about. But I want to reiterate that I am sure you know by law, the government cannot pay more for the care of a U.S. Family Healthcare Plan enrollee than it would if that beneficiary were receiving care from another government program.

So I have a hard time seeing this as anything but a cost shift over to Medicare while destabilizing what is already a very successful program. So I guess I would like to hear you address that and also address my concerns that the destabilization of this program, in my opinion, isn't consistent with DOD's stated priorities of improved health management and the continuity of care.

I am just not pleased about what we are doing here in the budget. I understand the importance of cost efficiencies, but, to me—and I guess it is a little smoke and mirrors and maybe not going to be good for the long-term health care of the people of my state.

Secretary STANLEY. Thank you for the question, Congresswoman Pingree. I think, as we look at what we are proposing, that each hospital that we are working with particularly with the Family Health Plan that we are going to be working very closely with them because the changes first of all may be minimal in some cases or almost barely perceptible initially as we work, as we look at how the Medicare, you know, the funding is worked out because you really don't want to just unplug and move right into something that becomes a cost shift.

At the same time, we are trying to address something that had not been addressed for a number of years in terms of how we, you know, work with the cost and everything. So the bottom line is we are going to work with them.

And I hear your concern and I recognize your concern. And we are going to do our very best to work with them. I am going to ask Dr. Woodson to address this also.

Dr. WOODSON. Thank you very much for that very important question. I think the issues that we need to remind ourselves of is that this is not about taking a beneficiary away from their doctor.

They can continue to see their doctor. They can continue to go to the same hospitals. But we pay about $16,000 per member per year in capitated fees to the Uniformed Services Family Health Plans.

And it is important to note that their plan is not just about hospital fees, but it is about the money that is also paid to their primary care physicians, whereas, the cost to the government for, let's say, TRICARE Prime is about $4,500 and for TRICARE Standard is about $3,500. Just good business practice in this day and age would suggest that we have to get better value for the dollar.

Now, I want to say up front that we consider all of these facilities and providers that are in the Uniform Services Family Health Plan as great partners. We don't want to lose them. I just think that in these tough times of budget constraints and rising health care cost, we look at contracts everywhere and say how can we get the best of value.

The proposal actually will save the entire Federal Government about $300 million over about 10 years because right now, of course, we pay about 42 percent higher in cost than we would pay under Medicare fees. I remind you also that most of the individuals that are Medicare eligible actually have taken already on part B.

Ninety percent or so all ready have part B because if they were to move or circumstances in their life cause them to shift to other doctors, if they don't take it on at age 65, they pay severe penalties. So the impact to any individual patient is likely to be not that dramatic as well.

So it is about being good stewards of public money. It is about preserving money for the future and making sure that the Military Health System and the provisions under TRICARE remain strong in the future for those who might serve in the future and bringing equity, if you will, to the benefits for all Medicare eligible beneficiaries as well as equity in terms of how we pay all of our providers and hospitals that may serve our men and women who have served.

So there are multiple reasons to really consider this. And I think again, it is one of those modest changes that on the balance says that we have looked at a number of initiatives to produce efficiencies.

Ms. PINGREE. My time is up, but thank you. I am sure——

Mr. WILSON. And, Ms. Pingree, we will get back to another question, too. So thank you so much, very good question.

And as we conclude this first round, it is very fitting that we have another distinguished freshman, Colonel Allen West of Florida, who himself has had an extraordinary record of military service.

Colonel West.

Mr. WEST. Thank you, Mr. Chairman, also Madam Ranking Member, the Honorable Stanley, Honorable Woodson, General Schoomaker, General Green, and Admiral Robinson. Thank you so much for appearing here today.

We talked about the visible injuries that we see coming out of the combat theaters of operation in Iraq and Afghanistan, but one of my concerns is the unseen injury and, of course, that is traumatic brain injury, TBI.

I have had the opportunity to visit with a gentleman by the name of Dr. Ray Kraul down at South Florida who has been offering hyperbaric oxygen treatments to several returning veterans. I have had the chance to sit down with three of them and we have seen some noticeable improvements.

About 3 weeks or so ago, I had the opportunity to sit down and have lunch with Vice Chief of Staff General Chiarelli, and we talked about the opportunities and the options of the hyperbaric oxygen treatment. One of the things he said is that there are some obstacles out there to the implementation of this as a viable treatment for returning veterans.

And so I would like to know what are those obstacles that are out there and how can this committee help to, I guess, eradicate some of those obstacles so we can facilitate taking care of our veterans?

General SCHOOMAKER. Well, I don't think there is anything that the committee can necessarily do for this, Congressman. Thanks for that question. Hyperbaric oxygen is currently an FDA [Food and Drug Administration] regulated treatment. It is not currently approved by the FDA for treatment of either concussive brain injury or for post-traumatic stress disorder.

We have offered through your generous funding any and all investigators out there who are administering hyperbaric oxygen to design and administer protocols that would test and demonstrate the utility of this. We finally undertook those investigations ourselves. We have currently three projects. One has been completed at the LDS Hospital in Salt Lake City by an international expert in hyperbaric medicine, Dr. Lin Weaver.

Its results on a non-randomized and uncontrolled study show that hyperbaric oxygen appears safe at this point for patients with moderate and stable brain injury. We currently are awaiting the results of an Air Force School of Aerospace Medicine study that has just been concluded that is controlled and sham controlled so that we can see what the effect of the hyperbaric oxygen is against a semblance of that administration of oxygen, but without it. We have yet to see what the results of that. And we are awaiting a more definitive study that will be overseen by the Army's Medical Research and Materiel Command that will include four or five sites across the country, military and non-military.

So the summary of all of this is that despite a series of published and unpublished anecdotes, there really remains no medical evidence that hyperbaric oxygen has a therapeutic role in the relief of symptoms of—or brain dysfunction for warriors with post concussive syndrome, or mild traumatic brain injury, or posttraumatic stress disorder.

And until we have that, we just can't in good conscience provide care which is quite expensive without knowing its ultimate safety and its utility.

Mr. WEST. Well, I guess the thing is when you sit down and you do speak to some of these young men as I have that say that it has made a difference, I think that is some pretty good anecdotal evidence for myself.

But, you know, perhaps, Mr. Chairman, we ought to look at seeing if we do need to send a letter over to the FDA and ask what

impediments that they are making. But we cannot, you know, take too much time because every day some soldier, sailor, airman, marine is going through an IED blast. And these IEDs continue to cost much injury as far as TBI. So, hopefully, we can put a little bit more emphasis and a little bit more speed to this.

Thank you very much and I yield back.

Mr. WILSON. Thank you, Congressman. I look forward to working with you in a joint letter or whatever. And I appreciate your promotion of this issue.

We will now have a second round with everyone, a single question. And, for me, so often we hear the bad, but there is so much good. And military medicine really has been the best in the world providing for care of people with brain injuries and trauma injuries. And this applies to the civilian world of auto accidents and these who are people who are injured in sports injuries, additionally, prosthetics, truly the best in the world now, our American military medicine and available to the civilian population.

With this, I would like to know from each of the Surgeons General what you have done in regard to cost efficiencies. Can you give us an example of a cost efficiency on behalf of the taxpayers of our country. And we will begin with General Schoomaker, the senior person and then we will end up with the junior general.

General SCHOOMAKER. Sir, what we have focused on a lot within Army Medicine is standardization of practices, both administrative and clinical practices. It has been widely discussed both in the private sector as well as in government medicine that elimination of unwarranted variation in practices—clinical practices and administrative practices—will squeeze out a lot of waste in the system.

We have focused very hard on that. We have also used a business case model for all of our hospitals and clinics in which commanders are encouraged to target health promotion and health improvement as a way of preventing preventable hospitalizations, ER visits and the like.

And, finally, I would say that all of us here—and we commend the Air Force for their lead on this—have embraced the Patient-Centered Medical Home, which we think is going to be transformative in bringing into the primary care sector both ready access continuity, because many of our patients seek continuity where we think they are looking for access alone, and a fusion site for behavioral health, for pain management and many of the other things that we are doing that will ultimately result I think in better and healthier people, better and healthier communities and reduction and cost over all.

Mr. WILSON. Thank you.

Admiral.

Admiral ROBINSON. Thank you very much for the question. In addition to what General Schoomaker said—I am not going to repeat that—many of the Navy initiatives are along the same line. We have also taken some internal looks. And partnering with the Applied Physics Lab at Johns Hopkins and also the Center for Naval Analyses, we have come through and looked at business practices and also clinical practices in our medical treatment facilities across the enterprise.

We are taking an enterprise approach, having industrial engineers come through, look at the orthopedic departments and how we have patient flows at Balboa or Camp Pendleton, how we have access to care for the patient, how we then work them through our system, how we could do that more efficiently, not only from a patient perspective, but also from a provider perspective.

I am talking about from the corpsman, from the nurses, from the physicians, from everyone on that team. So we are trying to take an enterprise look at how we can implement that across the board and doing what Eric said in terms of the standardization of practice so that we can reduce the variation.

Additionally, in the financial world and I, not being a financial expert, am blessed to have a really excellent Navy Medicine controller who has instituted a great deal of effort at standardization of how we in fact do our financial accounting, how we do our audits and how we look at the financial program's execution. He has been sensational and there is so much more that I can't describe, but he has been sensational and has become a real best practice for not only the Department of the Navy but also the Department of Defense. So he is being utilized and a lot of his programs are being utilized there.

Those two business practices, that industrial engineering and the way we do our financials across the gamut within Navy Medicine have produced efficiencies and savings that have really made a much better enterprise approach to the way we do Navy Medicine.

Mr. WILSON. Thank you, and General.

General GREEN. We have looked at several different things. We actually decreased our headquarters manning to increase the manning back to the hospitals trying to recapture care. We have looked at standardizing our practice. Part of the Medical Home was to basically look at support staffing ratios and put some of the nursing staff back into hospitals again, based on business case analysis to bring the care back in.

We have had systems looking at our ORs [operating rooms] and at our emergency rooms basically trying to maximize the efficiency to increase access. We have seen at some of our bases as much as a 40 percent increase in the surgical cases that can go through our ORs by recapturing care. Under the Patient-Centered Medical Home, the satisfaction is up, the continuity jumps from about 40 percent to 70 percent, and we end up encouraging the providers to work at the top of their license based on changes to their practice.

I would tell you that the partnerships that we are doing are based on bringing care back into the direct care facilities, both for currency and to decrease cost in terms of what is going to the private sector. And finally, the efforts in disease management and case management across all three services are reducing care cost. In fact, in one case out at Hill Air Force Base we have saved probably $400,000 in reduced utilization by diabetics based on the output and the efforts to try to case manage.

Mr. WILSON. Thank you all very, very much, and Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman. One thing that I would like to mention is I hope that we will have an opportunity to look at mental health issues overall, whether or not we are providing the support to encourage people to go into those fields and also a

look at some of the research and development that has been done, and whether or not we are utilizing those dollars well and coordinating those efforts in a way that we really do know what has happened over the last number of years, because we have certainly put a lot of effort into that and I would like to take a look at that and see how it is really affecting our service members and their families.

But I wanted to go back to Ms. Pingree's question, I think generally because the new proposal really could have an impact on our Active Duty members and because there is in the proposal we are reducing possible payments to Sole Community Hospitals, and those hospitals may of course decide to limit TRICARE participation due to the reduced rates. And so I am wondering, and this goes really I think to General Green, whether or not the Air Force has particularly engaged with Sole Community Hospitals outside of Air Force bases to assess the impact of this proposal on the beneficiaries in those communities, and if you are confident that the proposal will not severely impact them.

In addition to the concerns that I think a lot of our Members are going to have because there are certain Members, communities that are more affected by this than others, we also know that those hospitals that have many cases of disproportionate share hospitals also even in urban communities might be affected by this. So I am wondering if you could address it, General Green and perhaps others quickly. What do we know about that and what can we anticipate could be the impact on our beneficiaries?

General GREEN. Eight of the 20 hospitals that have over 5 percent of their income based on admissions are from Air Force areas and so, when you look at those, about 4 of those facilities actually are in the 10 percent to 15 percent range for us. We are not the highest, but it is a concern.

The reality of the implementation is that we have had longstanding partnerships with these organizations. We believe that the care will still continue to go to these organizations. As you change the payment and bring it in line with payment elsewhere in the country in terms of how we receive care, we believe that the implementation is conservative enough in terms of the basically bringing online over a 4-year period that we can look at it, work with the local facilities and if necessary, work with Health Affairs in terms of any type of transitional changes in payments to make certain that this is sustainable.

Our belief is that this is a reasonable approach to try and bring this back in line with what is going on elsewhere in the Nation and obviously remains to be seen, particularly with these hospitals where it is a large portion or a larger portion of their income.

There should be no effect on our beneficiaries because their care would still go to the same areas. They just would be at the rate of payment that is provided at every other site where they might go and seek care if they were out of that area. And so the question is going to be does it end up affecting the facilities to the point where despite the long-term partnerships, they feel they have to change the mix of patients, and so we will be watching that very closely.

General SCHOOMAKER. Yes, I would echo those comments. Two of the 20 are Army-centric including a hospital in the community that our Secretary of the Army represented at one point, and I think everything that General Green said applies to the Army as well and we have been reassured by Dr. Woodson that the financials of this will be looked at very carefully and that we won't erode the relationship that we have with these hospital systems.

Dr. WOODSON. Thank you for that question. I think I want to emphasize that we are willing to reach out proactively to these hospitals to look at their revenue streams and how they will be impacted. We do have the ability as the law is allowed to pay Medicare rates when practicable and if it turns out in a situation that there is hospital that is providing needed services and there are no other hospitals, adjustments can be made. So I want to emphasize that in fact we are going to be proactive about this. We want to be fair about this. But again, we need to in this day and age, make sure that all of our contracts are really looked at carefully and add value and—as well as quality in terms of the care that is provided.

Mr. WILSON. Thank you very much. We now go the Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman. And my question in just a moment would be for you Admiral Robinson. I appreciate the question by Congressman West. I remember 10 years ago I think I was briefed by Dr. Harch from LSU about hyperbaric oxygen as a treatment for head wounds. And I know I had a conversation a couple of years ago, I cannot remember the Air Force officer, about where the research is going and I appreciate your statement, General Schoomaker, that my concern or interest is this—Admiral Robinson, I know that—and I want to thank Admiral Mullen.

Quite frankly, I brought this up at a full hearing about a year ago about hyperbaric chamber down at Camp Lejeune. We do have one at Camp Lejeune. And I believe that they are in the process now preparing to be part of a pilot program to treat marines down at Camp Lejeune which I am grateful for.

Help me understand when—I understand the need for studies, please understand I do realize they are very, very important. But when would the military get to a point after the study by the Air Force, maybe the Army, I don't know that. Maybe the Navy as well. When did you get to a point that the studies say and I will tell you why, then I am going to let you answer, I have called numerous moms and dads whose sons and a couple of daughters had been in the hyperbaric chamber for treatment. What really sticks with me and I want to use this before and then you answer please, sir.

I called Colonel Bud Day who won the medal of honor in Vietnam, and he told me that his grandson had a severe brain injury from Iraq I believe at that time, and he was just not satisfied with the treatment, and at his own expense, he sent his grandson to LSU to Dr. Harch and I know I will never forget what Colonel Day said to me. He said that, "I will go anywhere I need to go to testify that this treatment has given my grandson a quality of life that he would never have had if he had not had the hyperbaric treatment."

So now this—was the question—I just remember. When do we get to the point that we say, meaning Department of Defense, that this protocol does help, it does work?

Admiral ROBINSON. Congressman Jones, thanks for the question. This has been for me as a Surgeon General of the Navy a 4-year question. We have looked at hyperbaric oxygen and Dr. Harch who has been at several meetings and I have met him many times and looked at his results.

We have invited him to come through and participate firsthand in our double-blinded studies so that we can get away from the anecdotal results of individual patients, families, and other anecdotal lessons, and we can get down to what we have to have from an objective and a definitive way so that we can base clinical practice guidelines both for the Military Health System and also for the private sector. We need to base those therapies on objective clinical data that cannot be influenced by opinions of people who have benefited, but we can't prove that benefit in a scientific way. So we need to employ a scientific method.

What we have done, and I can say that after in my fourth year as Surgeon General, we now have studies—we are now beginning to produce data from competent studies that look at, number one, hyperbaric oxygen seems to be safe, so I think that that is a clear improvement in terms of our knowledge. And now we need to go and look more deeply at the Air Force study and that study has been completed, but the analysis has not been done. So I think we are very, very close to getting more data.

I think when we can get some studies on the record that actually look at the efficacy of hyperbaric oxygen therapy, I think at that point we can simply say, that is an effective treatment, it is not an effective treatment, but it is a treatment that can be utilized in complementary medical ways so that people who may benefit from it can use it, it certainly not going to harm them. We will have an array of answers.

I think we are literally months away from getting there, but it normally takes—and this is one of the issues with medicine—it normally takes time to get to where we need to be and we have to base it on a scientific method unless, in order to keep from having everything become a clinical practice guideline, things that are not proven. So the scientific method is being utilized in this way.

Mr. JONES. Thank you, Admiral. Thank you, Mr. Chairman.

Mr. WILSON. Thank you and next we go to Ms. Pingree of the great state of Maine.

Ms. PINGREE. Thank you, Mr. Chair. Thanks for the opportunity to discuss these issues with you again in a second round. And I just want to say again, I understand how well you are all doing your job and the importance of all of you looking for cost efficiencies in what you do as we face a difficult time with the budget deficit. And also where there is a lot of examination of the military budget and looking for places where we can cut.

And maybe my first comment really is more to my fellow committee members than to all of you, but I might see more places to cut the fat in the military budget than others of my colleagues, but I am deeply concerned that we are going after medical care for both our Active Duty personnel and our retirees when I think there are other places to make more effective cuts. So I know you have to do your job and look for those cuts, but almost everything that is before us today, either myself or one of my colleagues has mentioned

a concern about, whether it is the changes to TRICARE, how we are going to deal with some of our Sole Community Hospitals. I have two in my district, there are four in our state of only 1.2 million people in a state where we have almost a fifth of our citizens are either Active Duty or retired military.

So there is a very big dependence on this system in our state and I am worried about that particular program. So for me, many of the efficiencies that you are talking about are going to reduce the level of medical care to the people who have served us, to whom we have made a huge promise. And there is going to be, I think, a reduction in the services that they receive, so I just—I know you have to do your job, but I don't like it and I don't think it is all necessarily good.

And the only other program that hasn't been brought up today but I might ask you to comment on is the pharmacy co-pay. I have seen a little bit about that and know that some of the co-pays will be reduced through using mail order pharmacies. I have concerns about that as well because I do believe that people get better care when they go directly to a pharmacist in their community, that is where we catch a lot of redundancies or problems with the medications that people are taking, particularly with retirees.

So, in my opinion, having to go to mail order to get your pharmaceutical products is not necessarily always good treatment or good service. And one of the things I might ask is how much the Department is doing to negotiate for better prices with the pharmaceutical companies and bringing costs down in that way as opposed to this other option? That was my question, if you have got any comments about that.

Dr. WOODSON. We continue to have efforts to negotiate with pharmaceutical companies. I think in fact that the mail order advances care because there is a large percentage of retail prescriptions that are never picked up and there are breaks in terms of the supply of medications.

Our proposal not only reduces the cost, but it ensures timely supply of medicines and, of course, linked with our concept of the Patient-Centered Home, they have a team of health care providers that can counsel, coach, monitor their medicines. We have new electronic databases that highlight medication to medication interactions and notify practitioners of medications that may be unsafe.

So, I think there are a number of things that we are doing that are going to enhance the quality of care while reduce the costs and provide a better service for the beneficiaries.

Ms. PINGREE. I appreciate your perspective on that. That is useful information in thinking about the program. Back to the question of negotiating, is that an active activity that goes on today, to negotiate for cost-cutting? We still continue to pay some of the highest prices in the world in this country for prescription drugs and I know the military has done a better job of bringing down the costs, but I just—I wonder how engaged we are in the process and how much resistance there is to it?

General SCHOOMAKER. Ma'am, I am told that is a commodity that is managed through the Defense Logistics Agency and the center in Philadelphia. And I am told that the Department of Defense

has some of the most favorable cost profiles of any organization in the United States because of our—because of leveraging volume.

Ms. PINGREE. Great. I will take up that issue with them. Thank you again for your answers today.

Mr. WILSON. Thank you and I share your appreciation of local pharmacists too. We will conclude with Dr. Joe Heck.

Dr. HECK. Thank you, Mr. Chairman. And not to belabor the issue, but I am going to go back to TBI. First, I appreciate the Surgeons General and the academic rigor with which their reviewing the HBOT [hyperbolic oxygen therapy] issue and please, I encourage you and implore you to keep that academic rigorous approach before we make a determination on its application.

No matter how that turns out and no matter what treatment process we have in place for TBI, my biggest concern is identifying the soldier, sailor, airman, marine who has TBI. Based on my deployment to Iraq, when young guys were getting their bells run so many times that they had the MACE [Military Acute Concussion Evaluation] card memorized, it no longer became a valid screening tool because they knew the answers before I asked them.

When I came back, it spurred me to write my joint forces staff college paper on TBI entitled "Re-thinking the Treatment Paradigm" and that was 3 years ago last month. I don't think we have come that far in 3 years, as far as we should have, in being able to recognize folks suffering from MTBI [mild traumatic brain injury].

I know there was an initiative underway that everyone pre-deployment was supposed to get cognitive assessment, the ANAM [Automated Neuropsychological Assessment Metric] or equivalent. Where are we in that process in making sure that everybody before they deploy has a baseline cognitive assessment done so that we can find the small changes when they come back.

And then specifically going back to my heart of hearts in the Reserve side of the house, it seems it is the reservists that are getting lost to the follow-up. They get home, get irritable. The spouse or family member saying, "Well, he is just reintegrating. We got to, you know, this is his re-acclimation process." Three months later, he is still irritable and then somebody starts to think, "Well, maybe it is something more than just he has been gone for a year." But by that time, we have lost 3 months of intervention.

So again, the status of the cognitive assessment pre-deployment and what are we doing to make sure we don't lose reservists to follow-up or it just gets brushed aside as they are just getting reintegrated or re-acclimated.

General SCHOOMAKER. Let me take a stab at this if I might, Congressman. First of all, I think we have come a long way in the last few years especially with the publication as was referred to earlier of the decision type memorandum.

Early in the war as you may recall, we had clinical practice guidelines in the battlefield, but they were not mandatory in their application and we failed to recognize that the soldier, the marine, the sailor, the airman who was actively engaged in battle and was part of the team was very reluctant to leave formation, and would celebrate their survival of an IED but then would go right back in the fight.

We now have a mandatory screening tool down range. In our recent trip to Afghanistan, we looked at its application and how well we are complying with it. We are seeing very good acceptance by combatants, by their small unit leaders, all the way up to General Petraeus himself. And with resiliency centers such as the one that Admiral Robinson mentioned, and we have seven in eastern Afghanistan and southern Afghanistan, we are seeing rapid turnaround.

So, we have mandatory screening of a clinical diagnosis only, as you know, at this point and then we apply tools like the ANAM, the Automated Neurocognitive Assessment Module, to do longitudinal tracking of whether they are recovering. We have done studies now with the ANAM down range with fresh casualties to be able to know that as a screening tool, it is insensitive and nonspecific. It misses about a quarter to a third of those who are concussed and it includes about 50 percent of people who aren't concussed.

We are doing a head to head evaluation between the ANAM and the impact tool that the National Football League uses and so many high schools use right now. But you are absolutely right. Right now, we have no single definitive test for the diagnosis other than the clinical diagnosis of concussion. But we are being very much more aggressive. And right over the horizon we see biomarkers and other tools that we think will be useful.

Dr. HECK. Thank you very much. Admiral, did you want to answer that?

Admiral ROBINSON. I think that General Schoomaker was very comprehensive. I will add one piece. We also have the NICOE [National Intrepid Center of Excellence] and the Defense Center of Excellence that is devoting a great deal of research efforts both in the basic science areas and in the areas of trying to understand how we can diagnose and then how we can assess and treat traumatic brain injury.

Now, I am not going to mix the two, but PTS is also there and it is on the continuum. But I am going to stay with the TBI. So I think that we are not only doing the in-theater assessments, we are reporting the data, we are actually compiling data, reporting it. I think that General Schoomaker has emphasized the concussion part because concussion as a clinical diagnosis is at least something we can diagnose and follow as opposed to just TBI which becomes a little bit more difficult to define and understand.

But with the ANAM and with the MACE, with our professionals trained, with the Uniformed Services University deployment psychology group training our professionals, just in time training as they go over into theater, and with adequate data, having the concussion restoration centers, multicomprehensive teams, I think we are going to get at least a look at who has been involved, how we can do a longitudinal look at them and make sure that we can at least follow them even if we can't do a lot in terms of understanding how it works now. We don't understand this completely, but we are not going to let it go.

Mr. WILSON. Thank you and I would like to again point out how much we appreciate all of you being here today, particularly General Schoomaker, Admiral Robinson. We want to wish you God-

speed in your future endeavors and again, I think it has been so illuminating and we want the best for our military, military families and veterans.

At this time, we are adjourned.

[Whereupon, at 11:48 a.m., the subcommittee was adjourned.]

A P P E N D I X

MARCH 15, 2011

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 15, 2011

Statement of Chairman Joe Wilson (R-South Carolina)

House Subcommittee on Military Personnel

Hearing on

Military Health System Overview and Defense Health Program Cost Efficiencies

March 15, 2011

Today the Subcommittee meets to hear testimony on the Military Health System and the Defense Health Program for Fiscal Year 2012. I would like to begin by acknowledging the remarkable military and civilian medical professionals who provide extraordinary care to our servicemembers and their families along with veterans, here at home and around the world, often in some of the toughest and most austere environments. I have recently returned from Balad and Bagram where I am always appreciative of the professionals who have saved so many American, Iraqi, and Afghani lives. I have firsthand knowledge of their dedication and sacrifice from my second son, who has served in Iraq and is now an orthopedic resident in the Navy. As a grateful dad, in a military family, I was reassured as to the medical care available for my Army son and Air Force nephew who both served in Iraq.

The subcommittee remains committed to ensuring that the men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. Even in this tight fiscal environment, the Military Health System must continue to provide world-class health care to our beneficiaries and remain strong and viable in order to maintain that commitment to future beneficiaries.

The Department of Defense has proposed several measures aimed at reducing the cost of providing health care to our servicemembers and their families and military veterans. While I appreciate that your plan is a more comprehensive approach than previous cost-cutting efforts, the challenge here is finding the balance between fiscal responsibility while maintaining a viable and robust military health system. We must be sure to remember these proposals have complex implications that go "beyond beneficiaries." They will also

affect the people who support the defense health system, such as pharmacists, hospital employees, and contractors.

The subcommittee has a number of concerns about the Department's initiatives. To that end, we would expect the Department's witnesses to address our concerns, including that:

The proposed TRICARE Prime fee increase for Fiscal Year 2012, while appearing to be modest, is a 13-percent increase over the current rate. The Department of Defense (DOD) proposes increasing the fee in the out-years based on an inflation index. You suggest 6.2 percent, but it is unclear exactly which index you are using:

- You plan to reduce the rate that TRICARE pays Sole Community Hospitals for inpatient care provided to our active duty, family members and retirees. Several of these hospitals are located very close to military bases; in fact some are right outside the front gates, especially important for 24-hour emergency care. What analysis have you done to determine whether reducing these rates will affect access to care for our beneficiaries and in particular the readiness of our armed forces?

I would also like our witnesses to discuss the range of efficiency options that were considered but not included in the President's budget. I would appreciate hearing your views on the recent GAO (Government Accountability Office) recommendations included in their report on Federal duplication, overlap and fragmentation. GAO made recommendations regarding establishing a unified medical command and for DOD to finally jointly modernize their electronic health records system with the VA (Veterans Administration).

In addition, I would like to hear from the military surgeons about efforts they are taking within the military departments to increase the efficiency of the military health system and reduce costs. I would also like the military surgeons' views on areas where additional efficiencies can be gained across the DOD health system.

The Department of Defense recently announced that they have hired Governor John Baldacci, former Governor of

Maine, to undertake a full-scale review of military health care and the impacts of military health care on the force. I would appreciate hearing from Dr. Stanley the considerations for this review and what the Department hopes to gain from Governor Baldacci's efforts. Why is having a "Military Health Care Czar" not a duplication of the duties already assumed by Under Secretary Stanley and Assistant Secretary Woodson?

Finally, I would like to make it clear that in an effort to reduce the cost of military health care and find efficiencies in the military health system we must never lose sight of the population that the military medical system serves. The members of the Armed Forces and their families who currently serve and those who served as veterans for a full career in the past warrant the best health care available. Reducing cost must never result in reduced quality or the availability to the health care they earned and they deserve.

I hope that our witnesses will address these important issues as directly as possible in their oral statements and in response to Member questions.

Statement of Susan A. Davis, Ranking Member,
Subcommittee on Military Personnel

Hearing on
Military Health System Overview and Defense Health Program Cost Efficiencies

March 15, 2011

Thank you, Mr. Chairman. I look forward to hearing from Under Secretary Stanley and Assistant Secretary Woodson on their views on the status of the military health care system, particularly the TRICARE program, and their efforts to improve the care that we are providing to our service men and women, retirees, survivors and their families.

Assistant Secretary Woodson, welcome, I understand that this is your first testimony before the subcommittee. I am pleased that the Senate finally confirmed you as the Assistant Secretary for Health Affairs. The Department is confronting many issues, and having you there is important if we are to be successful in facing those challenges.

I also look forward to hearing from our Surgeon Generals—General Schoomaker and Admiral Robinson—thank you for your service. I understand that both of you will be retiring this year. It has been a pleasure working with both of you over the past several years. The last ten years of conflict have taken a toll on our forces and in particular, those who serve in our military health care system. The constant demand on the system and the successes that we have seen both on the battle and back home here in the States have been remarkable and

a testament to your leadership. General Green, welcome back, with the departure of General Schoomaker and Admiral Robinson, you will become the most senior Surgeon General, and I look forward to continuing to work with you.

While I suspect that the majority of this hearing will focus on the Department of Defense's health care proposals that were included in the budget, this hearing will probably be one of the only hearings on health care that we will have prior to the subcommittee and committee markup. As such, it is important that members of this subcommittee have an understanding of all the challenges that the military health care system is facing, not just the budgetary constraints.

Our military personnel and their families are under constant pressure and challenges, and access to quality health care should not be on that list of concerns. I look forward to your testimony on how we are caring for our injured, ill and wounded, and what can be done to continue to improve the military health care system.

Thank you, Mr. Chairman.

JOINT STATEMENT
BY

THE HONORABLE CLIFFORD STANLEY, Ph.D
UNDER SECRETARY OF DEFENSE (PERSONNEL & READINESS)

AND

THE HONORABLE JONATHAN WOODSON, M.D.
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

REGARDING

THE MILITARY HEALTH SYSTEM OVERVIEW

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
MILITARY PERSONNEL SUBCOMMITTEE

MARCH 15, 2011

Mr. Chairman, Members of the Committee, thank you for the opportunity to appear before you today and discuss the future of the Military Health System (MHS), particularly our priorities for the coming year.

This is Dr. Jonathan Woodson's first public appearance before this subcommittee in his role as the Assistant Secretary of Defense for Health Affairs, and we want to first express our deep gratitude for the warm and helpful guidance both you and your staffs have offered in his first two months in this position.

We are committed to full transparency, and a straightforward accounting of our performance as a system, and our performance as leaders. We want to begin by acknowledging the people who comprise the MHS. They have a well-deserved reputation for exceptional professional performance and personal courage. We believe deeply that military medicine has proven itself time and again as a learning organization, capable of self-critical analysis and substantive improvement in those areas where it falls short of its own and others' expectations.

We begin 2011 on a strong foundation. Our medical achievements on the battlefield, in combat hospitals, and in the air continue to set new standards for medical outcomes in combat...anywhere in the world.

We are fortunate to have the continued, substantive support of both the Congress and the White House. This support has been greatly enhanced by the very public effort led by the First Lady and Dr. Biden to highlight the contributions of military families to our national security, and to focus on how the broader American community can acknowledge this and support military families on the home front. Within the MHS, we are engaged in this effort as well, and we will illustrate some of our efforts in this testimony.

Even with our successes, challenges remain. First, we continue to provide medical treatment to Service members in combat in some of the most austere environments on the planet. There is nothing routine about this, regardless of how long we have been or remain at war. We will not waver from our primary focus to ensure the medical readiness of all of our Armed Forces, and the readiness of the MHS to deliver highly trained medical professionals to support them.

International events and ongoing humanitarian crises also remind us that we must be prepared to respond to additional events on a moment's notice at the direction of national command authorities. Readiness is more than the center of our strategic plan; it is our fundamental obligation and reason for being.

A key component of our readiness obligation is to ensure we sustain the confidence of the Service members we support here at home, and who have borne the greatest burden of war – the Service members with serious wounds, visible and invisible, along with their

families who sacrifice, who grieve, and who carry their own wounds from this conflict. We will continue to dedicate our time and resources to our care for wounded warriors and their families.

Finally, we must also operate in an environment that recognizes financial resources are limited. We must prioritize what is most important, and make difficult decisions about programs and services that are worthy, but not necessarily vital to our core mission. Today, we will explain the actions we are taking to address this real challenge.

The MHS has adopted a strategic construct – the Quadruple Aim – that captures the core mission requirements of this unique system of ours: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

This construct has been in place for over a year and it has value in capturing our leading strategic imperatives. We are committed to a plan that has relevance and consequences for our medical personnel at the tip of the spear – delivering care around the world, and to the people we serve. We will use it to drive our investments, our priorities, and our measures for determining successful patient care.

Within the MHS, we have established an Individual Medical Readiness (IMR) metric to determine the medical preparedness of each Service member to deploy. For several years, our IMR measures have shown that, on average, our active duty Service members are prepared. Within the Reserve Component, medical readiness is below our benchmarks. We find that, in general, the individual reservists can quickly be elevated to a prepared status during the pre-deployment period (e.g., complete health assessments and ensure minor dental procedures and immunizations, etc. are quickly performed). We are in the process of engaging with commanders, particularly in the Reserve Component, to focus attention and corrective action on these matters within their unit. Overall, the medical readiness of our forces remains sound, and for the last two years we have seen continuous improved readiness each quarter, across both the Active and Reserve Components.

Congress has expressed much interest in the Department of Defense's (DoD's) ability to accurately identify deployed environmental health threats, characterize any risks, and reduce hazardous exposures. More than 19,000 air, water, and soil samples have been taken within the Central Command area of responsibility since 2003 to identify environmental hazards that may affect either the short-term or long-term health of our Service members and deployed civilian employees. We are pleased to report that the level of hazardous exposures appears to be minimal. In addition, our disease and non-battle injury rates remain very low, a testament to the efforts of our medical professionals in preventive medicine and environmental health. While we have been unable to identify any long-term health risks, on a population-wide basis, associated with the high levels of

airborne particulate matter and with burn pit smoke, we do not rule out that a small number of individuals may be adversely affected. All burn pits in Iraq, serving more than 100 individuals, have now been closed, and programs are in place in Afghanistan to replace as many of the burn pits as is feasible. We will continue to apply the best possible science to identify any long-term health effects that may be associated with these exposures. VA has contracted with the Institute of Medicine (IOM) of the National Academies to study the long-term health effects of exposure to burn pits in Iraq and Afghanistan. IOM's report is due in the fall 2011.

We also continue to work closely with the Department of Veterans Affairs (VA) on the implementation of a special medical surveillance program for approximately 1,000 veterans and DoD civilian employees who may have been briefly exposed to a carcinogen at the Qarmat Ali Industrial Water Treatment Plant in 2003.

In addition to our focus on the medical readiness of our current force, we are also looking to more rapidly implement proven technologies and clinical approaches, as well as to sustain our medical research and development programs that are essential to our future readiness posture. We are advancing our understanding – and the understanding of the broader American and global health community – of how to prevent, diagnose, and treat scores of illnesses and injuries. We are transferring our knowledge from the research bench to the battlefield, and lives are being saved.

The MHS medical research and development investment strategy for Fiscal Year (FY) 2011 is focused on early Diagnosis and Treatment of Brain Injury; Polytrauma and Blast Injury; Military-Operational Health and Performance; Rehabilitation; Psychological Health and Well-Being for Military Personnel and Families; and Military Medical Training Systems and Health Information Technology Applications.

Recognizing that important, early-stage medical research is also being conducted outside of the Defense Health Program (DHP), particularly within the Defense Advanced Projects Research Agency (DARPA), our staff and DARPA staff are directly coordinating to ensure full awareness of our respective programs and funding priorities. We also invite representatives from the VA and National Institutes of Health (NIH) to participate in our research planning and to review activities to assure that we leverage programs and knowledge across federal agencies.

It is not possible to reflect on every research project or program initiative in our portfolio, but we would like to highlight just a few high-interest areas and point out where we are seeing particularly promising results or proven outcomes.

Our Service members continue to incur more than 20,000 cases of traumatic brain injury (TBI) every year. Although the vast majority of TBI incidents is diagnosed as "mild" and resolve with rest, the DoD has implemented numerous programs within the last three

years to ensure early detection and state of the science treatment in those who sustain a TBI.

Mandatory concussion screening occurs at multiple levels to maximize treatment opportunities for Service members who may have sustained a concussion: 1) in-theater at the point-of-injury; 2) at Landstuhl Regional Medical Center (for all medically evacuated personnel); 3) during Post-Deployment Health Assessments and Post-Deployment Health Reassessments; 4) and upon initial entry into VA facilities for all OEF/OIF/OND veterans. Our policies mandate medical screening for concussion similar to the "automatic grounding" that occurs after an aviation incident. These policies also address management of recurrent concussion to help protect Service members from repeated exposures to concussive events, and strengthen medical tracking of these injuries.

Clinical care instructions for all levels of TBI severity have been developed and cover both the deployed and the non-deployed environments. Educational materials include a pocket guide for TBI care, web-based case studies in TBI diagnosis and treatment and education modules on TBI care for the line commanders, providers, Service members and their families.

TBI research continues to be fast-tracked to assist our Service members with close collaboration among the line, medical, and research communities. Key areas of promise include understanding blast dynamics, rapid field assessment of mild TBI, to include identification of objective biomarkers to be used in the diagnosis of concussion, and TBI innovative treatment modalities such as the ongoing clinical trials for neuroprotectants.

A specific example of a successful federal partnership that is advancing our understanding of TBI is the Center for Neuroscience and Regenerative Medicine (CNRM). This is a collaborative intramural federal program between the DoD and the NIH to enhance the expertise of clinicians and scientists to catalyze innovative approaches to TBI research. The CNRM research programs emphasize those of high relevance to the military populations, with a primary focus on patients at Walter Reed and National Naval Medical Centers.

The National Intrepid Center of Excellence (NICoE), which opened its doors in 2010, is another vital new resource in the MHS. The NICoE is bringing novel technology and interdisciplinary care to patients with TBI, along with emphasizing the family dynamic and pathways of care for patients who suffer from simultaneous post-traumatic stress (PTS) and TBI.

As with any research efforts, the science regarding some treatments is not yet settled. There have been a number of inquiries by members of Congress and the media regarding cognitive rehabilitation therapy (CRT). This is a particularly complex medical issue, and we have delved deeply into our policies in this area in recent months.

Cognitive rehabilitation therapy, despite its name, is not one therapy. Just as the term "heart surgery" really refers to several different types of surgery on the heart, CRT refers to a number of individual types of treatments designed to improve problems with memory, attention, perception, learning, planning and judgment brought about by a traumatic injury to the brain. These treatments are delivered by a wide array of health professionals including psychologists, occupational, speech and physical therapists and physicians. And, just like the individual heart surgeries would be separately studied to determine if they were safe and proven to work, TRICARE has investigated, and will continue to investigate as required by law, whether and which cognitive rehabilitation treatments will truly work for our injured Soldiers, Sailors, Airmen, Marines and their family members. That urgent investigation is current and ongoing.

Let us get to the most important point. Every wounded warrior who requires cognitive rehabilitation for their injuries can receive that treatment in the Military Health System. Once again, any Soldier, Sailor, Airman or Marine with a traumatic brain injury that requires treatment for impaired memory, attention, perception, learning, planning and judgment can receive that treatment in our Military Treatment Facilities, through VA hospitals and clinics, or by providers in the private sector. In addition, special computer technologies that assist Service members in remembering appointments, medication schedules, and personal contact information are provided free to our injured service members. Through these programs and the DoD's TRICARE health benefit, our Service members are able to receive occupational, physical, speech and cognitive rehabilitative services essential to their recovery. Since 2009, the Department has directly provided over 71,000 hours of cognitive rehabilitation for thousands of Active Duty, Guard and retired Service members with traumatic brain injury.

To protect our Service members and their families, the Department insists and the law requires that any medical treatment, including cognitive rehabilitation, is proven safe and effective. To do this, the Department is continuing to investigate which CRTs will make a measurable difference in clinical outcomes for our patients. Yet, there are times when treatments that are under ongoing evaluation are considered so promising and so important to the health and mission readiness of our Service members that the Department finds every means possible to provide that treatment. Under these circumstances, we have authority to provide the treatment for our Service members, while still considering the medical evidence that is required to make the intervention fully available to dependents under the TRICARE program.

This is the case with CRT. The Department is making these treatments available to our Service members now, because they offer the best hope of recovery for our injured warriors. We do this while we urgently perform research and intensively study the work of others. During this interval, a bundled or inclusive payment for a CRT package of services will not be available under TRICARE, but family members who require rehabilitation may access medically necessary physical, occupational, and speech

therapy, as well as psychological and behavioral therapy when delivered by a certified TRICARE provider and billed separately. In fact, we have funded more than 6,000 family members and retirees for such services since 2009.
We are pleased that the Institute of Medicine has convened a panel to assist us with reviewing the available medical evidence on the safety and effectiveness of the many cognitive rehabilitation strategies that are currently being offered. We promise to expedite decisions that derive from their recommendations. We have also directed urgent evaluation of our options to develop a bundled payment mechanism for certain cognitive rehabilitation day programs under TRICARE.

We want to be very clear, however, about one element of our decision-making process regarding health care coverage that has, at times, been misrepresented. We do not make our coverage decisions based on cost. TRICARE employs well-recognized scientific processes to search for and review reliable evidence, as well as to review policies of the Centers for Medicare and Medicaid Services (CMS) and other carriers. These processes utilize transparent and broadly accepted criteria for evaluating the quality and strength of the scientific literature on a topic. Utilizing the information available from these various sources results in a balance between ensuring the safety and efficacy of the care delivered to TRICARE beneficiaries and their access to evolving methods of clinical practice.

Along with TBI, we continue to confront the serious concern of mental health conditions, particularly post-traumatic stress disorder (PTSD) and depression. The Department continues to seek ways to mitigate the development of mental health disorders, and to reduce the number of suicides in our Armed Forces. We engage in a number of preventive, diagnostic and treatment approaches to reduce the incidence of these disorders, if possible, and to identify and treat those impacted. We assess Service members regarding their mental health before they deploy, when they return from deployment, and again three to six months later. We have added a new mental health assessment, to be done in a private setting to foster trust and to include a person-to-person dialogue, at the one- and two-year points after return from deployment

In Afghanistan and Iraq, mental health support is distributed across the theaters in order to: 1) manage those with stable mental health disorders; 2) provide support after traumatic experiences; 3) identify those needing increased support, consult with leadership; 4) and make recommendations regarding sustained deployment, or the need for medical evacuation.

Back at home, Service members receive and their family members are invited to participate in post-deployment programs, such as the Yellow Ribbon and Resiliency Training Programs. These programs help to identify signs of difficulty readjusting to home life and to help them take appropriate steps to overcome such problems.

Together with the line community, both officer and enlisted, we have undertaken a Department-wide effort to reduce and eliminate the stigma associated with seeking mental health care. Our leadership programs specifically train leaders to think about

mental health symptoms as they might think of physical injuries and to see treatment for those symptoms as essential to readiness as the treatment of any medical problem. These programs also advise leaders when to make appropriate and timely referrals before any problems can worsen. There are indications that this effort is working, as important measures are heading in the right direction. Specifically, we are seeing that significantly more Service members who are referred for mental health care seek it out, and stay in treatment. We are encouraged by this trend and believe it will continue in the right direction.

We know that mental health conditions, like most medical conditions, are treatable. Most patients with post-traumatic stress symptoms recover without treatment in a few months, and many recover with medication and/or psychotherapy. With your help, we have made a tremendous investment in behavioral health care, increasing from $500 million in 2005 to over $1 billion in 2010. That translates to the addition of nearly 2,000 behavioral health providers to our military hospitals and clinics, and 10,000 more to the networks. Together, they deliver 231,000 behavioral health visits per week to Service members and their families. By embedding mental health providers in our primary care clinics, we have improved access to mental health services for all of our beneficiaries.

The White House Interagency Policy Committee on Military Families has established "Enhancing psychological and behavioral health and ensuring the overall well-being of the military family" as one of its four priorities. This initiative will increase collaboration among federal, state, and local agencies in support of military family mental health needs.

Psychological support to military families spans the care continuum, from universal prevention to intensive mental health treatment. There are ongoing efforts by clinicians to share information about resources and programs that are available from DoD (such as Military OneSource, Military Pathways, the Joint Family Support Assistance Program, and the inTransition Program). The Services also provide programs such as the Army's Strong Bonds program and the Navy's Project FOCUS. These programs strive to provide families with access to the level of psychological care they need.

We continue to recruit and retain qualified mental health providers, directly benefiting families. As we mentioned earlier, our efforts with both direct care system hiring and expansion of TRICARE network providers have added more than 10,000 mental health providers nationwide to meet the needs of military families. To enhance services available to National Guard, Reserve, and Active Duty families who live in remote areas without easy access to installation-based psychological support, military and civilian providers are collaborating to educate local health care providers on military culture and treatment of psychological problems that military families encounter. We have also introduced the TRICARE Assistance Program, which offers 24/7 web chat with a licensed counselor, recognizing that family stress can often occur outside of normal provider hours, or in locations that do not have readily accessible counseling services. And we continue to fund an initiative with Health and Human Services to place 200

Public Health Service officers, who are credentialed mental health clinicians, in our MTFs.

Finally, the DoD/VA Integrated Mental Health Strategy is a new effort launched in 2010 to better align and coordinate the two Departments' mental health services. Included in the strategy are two action items directly focused on family members: 1) building family resilience; and 2) educating and coaching families to recognize mental health problems in Veterans and Service members.

Many of you have asked pertinent questions about our policies regarding the process by which health care providers assess whether Service members with psychiatric disorders or those who are prescribed psychotropic medication should be deployed. A Service member who suffered symptoms of PTS as a result of a previous deployment is not automatically disqualified from a future deployment. It is our policy to evaluate each case individually based on the unique considerations, circumstances, motivation, and actual condition of each member.

We recently updated pre-deployment policies, and our new policy mandates that a health care provider will perform a person-to-person mental health assessment to determine a Service member's readiness for deployment. This new policy ensures a thorough pre-deployment screening by mandating that the provider conduct a detailed review of self-reported mental health conditions, along with a thorough inquiry about current psychotropic medications (both prescription and over-the-counter), and a careful review of the medical record.

Service members requiring the use of psychotropic medications are evaluated for potential limitations to deployment or continued military service during every mental health assessment event during routine clinical care both in-garrison or in a deployed settings. Healthcare providers make recommendations, which may include requests for waivers and/or accommodations, to operational and Combatant Commanders, who may then make the final decision regarding waivers for deployment.

A key element in our efforts to improve care to Service members, enhance patient experience and responsibly manage the taxpayers' contributions to military and Veteran health care is our growing interoperability with the VA.

We continue to increase the number of sharing agreements between DoD and VA medical facilities. We are sharing more clinical data every day in a secure manner and are regularly adding new features and new forms of clinical data; and our early efforts to bring the Virtual Lifetime Electronic Record to reality are promising. In October 2010, we opened the Captain James A. Lovell Federal Health Care Center at North Chicago to serve both DoD and VA populations – the first integrated facility of its kind.

We are putting real money and manpower behind these efforts. The VA/DoD Health Executive Council has approved 116 Joint Incentive Fund projects valued at $394 million

over the last eight years, and we appreciate that the National Defense Authorization Act (NDAA) for FY 2010 extended this very valuable program until September 30, 2015.

The Departments continue to identify opportunities to enhance DoD/VA electronic health data sharing. After a December 2010 review by the Vice Chairman of the Joint Chiefs of Staff (VCJCS), DoD and VA formed six teams to create a collaborative approach to the EHR Way Ahead. The teams—Enterprise Architecture, Data Interoperability, Business Process, Systems Capabilities, Presentation Layer, and Missions Requirements/ Functions—cover high-level activities needed to plan, develop and deploy final recommended solutions. In-progress reviews of the joint EHR modernization collaboration effort have been held with the Deputy Secretaries of the two departments and team findings are being elevated to the DoD and VA Department Secretaries for discussion and consideration.

We believe this careful, collaborative approach will, in fact, enhance our decision-making process and lead to a solution that can be implemented in a more timely and coordinated manner. The EHR Way Ahead addresses specific challenges with the current EHR, including outdated legacy technologies; ongoing performance and data availability problems; and difficulty in using healthcare industry standards.

The MHS is fully engaged in implementing a new approach to primary care in our MTFs. Known as the Patient-Centered Medical Home (PCMH), the principles focus on developing a cohesive relationship between the patient and the provider team. This relationship focuses on prevention, attainment of health goals, and partnering for the control of chronic conditions.

We view the PCMH as a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus—readiness, population health, patient experience and per member cost. With 655,000 patients enrolled to date, the results have been very promising – improved preventive service compliance, reduced use of the emergency room, and more timely care.

We are introducing processes and tools that are improving access to care – and deepening the patient's engagement in managing their own health. TRICARE Online already allows patients to make appointments, refill prescriptions and download a basic personal health history. Secure patient-physician email, online laboratory results, nurse advice lines, and other technological tools will serve to greatly enhance our ability to communicate with our patients, redirect them away from inappropriate use of emergency rooms, and improve their overall health.

The Department is moving forward with a number of initiatives to improve population health. We closely monitor our performance in delivering necessary preventive services and compare ourselves to our civilian counterparts on important measures of prevention

and patient safety. And we are making a focused effort on anti-smoking and anti-obesity initiatives. We continue to perform well against most national benchmarks.

Yet, we are not satisfied with the status quo. In 2011, we will announce several demonstration projects that conform with NDAA for FY 2009 and 2010 direction to evaluate new approaches and help us determine whether incentives to beneficiaries will lead to improved health status and compliance with clinical preventive services.

One major new program that emerged from the NDAA for FY 2011is a new and important benefit in TRICARE – allowing the Department to extend TRICARE coverage to adult dependents up to age 26. This provision ensures that TRICARE will be able to provide this benefit as included in the Patient Protection and Affordable Care Act, or the National Health Care Reform law. We are pleased we will be able to extend coverage to this population.

Health Affairs staff is working closely with the Comptroller, Office of Management and Budget, and other partners to complete the regulatory and contracting actions to put this law into effect, with benefits that will be retroactive to January 1, 2011. This premium-based coverage will provide eligible dependents with access to the TRICARE Standard benefit, including access to military medical treatment facilities. We anticipate a TRICARE Prime option will become available later in 2011.

We are also nearing resolution of the protests that delayed implementation of the third round of TRICARE contracts, or T-3. As the Committee is well aware, the awards that were first announced in the summer of 2009 were delayed when contract protests were upheld by the Government Accountability Office. Transition in the North region is almost complete and we will begin health care delivery on April 1st. The TRICARE acquisition team is working diligently to address issues in the remaining regions and recently announced the award of the South region contract to Humana.

We are now planning for the next series of TRICARE contracts, or T4. We have engaged outside health care experts who are helping us shape a contracting strategy that reflects the needs and imperatives of our unique system, and adopts best practices in health service delivery and health plan management. As the strategy evolves, we will include provisions to ensure continued access to high quality primary care as the demand for primary care services well exceeds the supply in some states.

The MHS is making tremendous progress in improving health care in our National Capital community, and serving as a leader for the civilian health community. In addition to our groundbreaking work in battlefield medicine and medical research, for the last several years, we have been building a model for 21st century medicine in the National Capital Region (NCR). The vision of many is about to be realized. Our new community hospital at Fort Belvoir and the new Walter Reed National Military Medical Center will

both open their doors in 2011. These facilities will serve as showcases for leadership in patient-centered care, in patient safety standards, in environmental responsibility and sustainability, and in medical quality and outcomes. This achievement could not have occurred without the sustained interest and investments by the Congress, and we are grateful for your unwavering support through the last several years.

Today, however, we are cognizant that the federal budget cannot continue to expand. As Secretary Gates has repeatedly declared, we in this Department must tighten our belts just as so many Americans have done over the last several years. We share the Secretary's concerns that the exponential growth in DoD health care costs can pose a long-term threat to our defense capabilities.

In the budget proposed by the Department, we have included a number of specific initiatives that, viewed as a whole, can set us on a path to proper financial stewardship of the taxpayers' dollar. Secretary Gates, Chairman Mullen, and the Joint Chiefs have all spoken on this issue consistently and with clarity – we will continue to provide the finest health benefit in the country for our active and retired Service members and their families.

We have benefited from lessons learned in previous efforts to control rising military health care costs. First, the Department has looked internally as our number one priority to find and implement efficiencies. In the coming year, we will reduce TRICARE Management Activity contractor overhead by a substantial amount. Our actions will be carefully considered, and will not detract from any activities that directly support patient care, although some management programs will either be eliminated or significantly reduced.

This is just a first step, and together with the Surgeons General, we will continue to identify and rapidly implement other initiatives that take advantage of joint purchasing and greater optimization of our medical supply chain.

Second, we are pursuing a more equitable management of benefits across all health care programs. Congress has long directed us to align our reimbursement policies with those of Medicare. We will continue to make the necessary regulatory changes to follow the law. In 2011, we will adjust our payments for care provided by facilities designated as Sole Community Hospitals to also align with Medicare reimbursement levels. We also seek to ensure all health care providers are reimbursed in the same manner regardless of their geographic location. We propose to amend our Uniformed Services Family Health Plan (USFHP) enrollment policies so that they align with all other TRICARE providers. All current enrollees will be grandfathered into the current program. In our budget, we propose that all future USFHP enrollees will convert to TRICARE For Life benefits upon reaching Medicare eligibility.

Finally, for working age retirees, we are proposing minor changes to out-of-pocket costs that are exceptionally modest, manageable and remain well below the inflation-adjusted out-of-pocket costs enjoyed in 1995, when TRICARE Prime was first introduced. We also propose minor adjustments in prescription drug copayments that include both reductions and increases in co-pays, the increase or decrease dependent upon the outlet selected by beneficiaries. We want to offer incentives to use the most appropriate and cost-effective outlet for their needs, and believe the minor changes to this copayment will be accepted and assist us in this goal. We are heartened by support expressed by leading beneficiary organizations for this change. We have made progress in the last few years in encouraging beneficiaries to elect prescription drug home delivery, and we believe this proposal will accelerate the adoption of this option as it has demonstrated greater medication compliance while saving on overall costs for the beneficiary.

Our proposals have been carefully considered. We have incorporated numerous safeguards – grandfathering in all current enrollees to unique programs; phasing-in new reimbursement methodologies for providers; and exempting certain beneficiaries (survivors and medically retired Service members) from enrollment fee changes – in order to protect our most vulnerable beneficiaries and providers. None of these proposals affect the free health care we deliver to our Active Duty Service members.

As the Congress assesses these proposals, we will continue to wisely invest in items of vital interest – improved research, diagnosis and treatment of Service members with mental health disorders or TBI; enhanced access to health services; and better service delivery for military families.

We would be remiss if we did not mention the critical importance placed on our Nation's outstanding university – the Uniformed Services University of the Health Sciences (USU), located in Bethesda, Maryland. This critical resource provides top quality military physicians, nurses, scientists and other health professionals to the DoD at a time when these key resources are gravely needed. Besides USU's key role as an educational platform for our military health professionals, it also plays a significant role in biomedical research and consultation, both within the military community and to many sources external to the military.

What makes USU so special is that the university ensures that the health care providers educated there are equipped to deal with the unique challenges of military medicine and the wide scope of public health issues. Many of the faculty that teach our military students at USU have extensive military experiences themselves and that experience readily extends the student's educational experiences even further.

Since the first class graduated in 1980, USU alumni have become an integral part of our MHS and many of USU's graduates are assigned in key leadership positions throughout each of our Service medical departments.

The value of a USU education was never more evident than following the recent tragic shooting that occurred in Tucson. In the aftermath of this tragedy, it was the medical education received at USU that set in motion the training that the University of Arizona Health Science Center's Chief Trauma Surgeon, Dr. Peter Rhee, called upon as he provided the initial care and treatment to Representative Gabrielle Giffords. His extensive military experiences, coupled with his strong educational foundation, proved extremely beneficial in providing the best care possible to the Congresswoman. And, when he needed to consult on her care plan to ensure his approach was optimal for her condition, he called upon his USU classmate, neurosurgeon Dr. James Ecklund and USU's Interim Chief of Neurology, Dr. Geoffrey Ling.

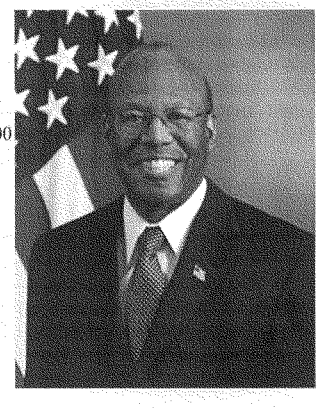
USU is a national treasure and its value to our Nation is seen every day in the battlefields of Iraq and Afghanistan, in the care we provide worldwide to our very deserving Service men and women, in the research being carried on in the fields of TBI and PTS, and in the many laboratories conducting research on emerging infectious disease and many other public health issues.

In conclusion, we will never lose our focus on those members of our Armed Forces in combat. We will honor the sacrifices of so many Service members and families. We have always been personally inspired by the commitment and dedication of our soldiers, sailors, airmen, marines, and coast guardsmen. These talented young men and women, who have been asked to shoulder the responsibilities for defending this Nation and have suffered the consequences of nearly a decade of war, deserve the best medical care both at home and abroad.

We are both pleased and proud to be here with you today to represent the men and women who compromise the MHS, and we look forward to answering your questions.

Dr. Clifford L. Stanley

Under Secretary of Defense (Personnel and Readiness)



Dr. Clifford L. Stanley was sworn in as the Under Secretary of Defense for Personnel and Readiness on February 16, 2010. He is the senior policy advisor to the Secretary of Defense on recruitment, career development, pay and benefits for 1.4 million active duty military personnel, 1.3 million Guard and Reserve personnel, 680,000 DoD civilians, and is responsible for overseeing the overall state of military readiness.

Before assuming his current position, Dr. Stanley was President of Scholarship America, the nation's largest nonprofit, private-sector scholarship organization. Prior to assuming this position at Scholarship America, he served on the senior leadership team of the University of Pennsylvania as the Executive Vice President. In that capacity, he was responsible to the president for the non-academic functions of the university, such as business, finance, facilities maintenance, and campus security.

Secretary Stanley, a retired United States Marine Corps infantry officer, served 33 years in uniform, retiring as a Major General. His last position was as the Deputy Commanding General, Marine Corps Combat Development Command, Quantico, Virginia. Additionally, he served as the Marine Corps Principal Representative to the Joint Requirements Board which supported the Chairman of the Joint Chiefs of Staff in carrying out his responsibilities.

Other leadership positions included: Commanding General, Marine Corps Air Ground Combat Center, Twentynine Palms, CA; Director of Public Affairs, Headquarters Marine Corps, Washington DC; Assistant Deputy Chief of Staff for Manpower and Reserve Affairs, (Manpower Plans & Policy); Commanding Officer, 1st Marine Regiment, Desk Officer in the Office of the Assistant Secretary Of Defense, East Asia and Pacific Region; Advisor to the Secretary of Defense on POW/MIA Affairs; Special Assistant and Marine Corps Aide for the Assistant Secretary of the Navy; and instructor at the US Naval Academy. Secretary Stanley was also a White House Fellow where he served as Special Assistant to the Director of the Federal Bureau of Investigation.

Throughout his career, both in and out of the military, Dr. Stanley has helped men and women exceed their expectations while building cohesive teams dedicated to high achievement and selfless service. Dr. Stanley has a proven track record of being a visionary and inspirational leader dedicated to diversity, families, and a true sense of taking care of others.

Dr. Stanley is a graduate of South Carolina State University. He received his Master of Science degree from Johns Hopkins University, graduating with honors. His formal military education includes Amphibious Warfare School, the Naval War College, Honor Graduate of Marine Corps Command and Staff College, and National War College. Dr. Stanley earned his Doctorate Degree from the University of Pennsylvania, and holds Doctor of Laws degrees from South Carolina State University and Spalding University.

LIEUTENANT GENERAL ERIC B. SCHOOMAKER

THE SURGEON GENERAL OF THE UNITED STATES ARMY

AND COMMANDER, US ARMY MEDICAL COMMAND

TESTIMONY FOR

COMMITTEE ON ARMED SERVICES

UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 112TH CONGRESS

15 MARCH 2011

Chairman Wilson, Ranking Member Davis and distinguished members of the committee. Thank you for providing me this opportunity to talk with you today about some of the other very important work being performed by the dedicated men and women—military and civilian—of the U.S. Army Medical Department (AMEDD) who bring value and inspire trust in Army Medicine.

Now in my last Congressional hearing cycle as the Army Surgeon General and Commanding General, US Army Medical Command (MEDCOM), I would like to thank the committee for the opportunities provided over the past four years that have allowed me to share what Army Medicine is, to highlight the accomplishments we have made, to detail the challenges we have faced, and to hear your collective perspectives regarding the health of our extended Military Family and the military healthcare we provide. On behalf of the over 70,000 dedicated Soldiers, civilians, and contractors that make up Army Medicine, I also thank Congress for your continued support of Army Medicine and the Military Health System, providing the resources we need to deliver leading edge health services to our Warriors, Families and Retirees.

Despite over nine years of continuous armed conflict for which Army Medicine bears a heavy load, every day our Soldiers and their Families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in state-of-the-art fashion when prevention fails; and are supported by an extraordinarily talented medical force including those who serve at the side of the Warrior on the battlefield.

Army Medicine is a dedicated member of the Military Health System and is equally committed to partnering with our Soldiers, their Families, and our Veterans to achieve the highest level of fitness and health for each of our beneficiaries. Army Medicine historically is a leader in developing innovations for trauma care and preventive medicine that save lives and improve well-being for our uniformed personnel, improvements which have also favorably influenced civilian care. We are focused on delivering the best care at the right time and place. Army Medicine operates using the following strategic aims—The Five E's: Enduring, Early, Effective, Efficient, and Enterprise to reflect our commitment to selfless service.

- To provide ***Enduring care*** through initiatives such as the Warrior Care and Transition Program and the Soldier Medical Readiness Campaign Plan
- To reduce the need for subsequent care through ***Early prevention***; for example, Army Medicine identifies medical issues early with its concussive protocols and behavioral health practices, and promotes healthy lifestyles with the patient-centered medical home model of primary care delivery.
- To use evidence-based practices which provide the most ***Effective treatment*** for medical issues such as pain management and post-traumatic stress (PTS).
- To ***optimize Efficiencies*** through leading edge business processes and partnerships with other services and veterans organizations.
- To be an integral part of the Army ***Enterprise approach*** through re-engineering Army Medicine such as the provisional Public Health Command (PHC) to keep the Army strong and with other Army commands and agencies to optimally serve the Soldier and Family.

We must continue to provide the very best ongoing care for wounded, ill, or injured Soldiers. We have an enduring responsibility – alongside our sister services and the Department of Veterans Affairs (VA) – to provide care and rehabilitation of our wounded, ill, and injured for many years to come. The US Army Warrior Transition Command (WTC) is a Major Subordinate Command under the MEDCOM and a key part of the enduring provision of care. The WTC Commander, Brigadier General Darryl Williams is also the Assistant Surgeon General for Warrior Care and Transition. The WTC's mission is to provide centralized oversight of the Army's Warrior Care and Transition Program. This includes providing the necessary guidance and advocacy to empower wounded, ill, and injured Soldiers and Families with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. The WTC supports Army Force Generation (ARFORGEN) by supporting those who have returned from combat and require coordinated, complex care management to help them cope with and overcome the cumulative effects of war and multiple deployments.

At the heart of the Warrior Care and Transition Program are 29 Warrior Transition Units (WTUs) located at major Army installations worldwide, and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the United States and Puerto Rico. Today, 4,280 highly trained cadre and staff oversee a current population of 10,011 wounded, ill and injured Soldiers. Since their inception in June 2007, more than 40,000 wounded, ill, or injured Soldiers and their Families have either progressed through or are being currently cared for by these dedicated caregivers and support personnel. Over 16,000 of those Soldiers have been returned to the force.

The Army, with great support of Congress, has spent or obligated more than $1.2 billion in military construction projects to improve the accessibility and quality of Wounded Warrior barracks, including the development of Warrior Transition complexes that will serve both Warriors in Transition and their Families. Construction of complexes continues through FY12 at which time 20 state-of-the-art complexes will be in operation.

Since 2004, the Army Wounded Warrior Program (AW2) has supported the most severely wounded, ill, and injured Soldiers. Soldiers are assigned an AW2 Advocate who provides personalized assistance with day-to-day issues that confront healing Warriors and their Families, including benefits counseling, educational opportunities, and financial and career counseling. AW2 Advocates serve as life coaches to help these wounded Warriors and their Families regain their independence. Since its inception, AW2 has provided support to nearly 8,000 Soldiers and Veterans.

The WTC is refining a policy change to enhance the Army's ability to ensure Reserve Component Soldiers recovering at home from wounds, illnesses, or injuries incurred while on Active Duty benefit from the same system of care management and command and control experienced by Soldiers who are recovering in WTUs. The revised policy makes it easier for Reserve Component Soldiers who do not require complex medical care management to heal and transition closer to home.

To support each wounded, ill, or injured Soldier in their efforts to either return to the force or transition to Veteran status, the Army has created a systematic approach called the Comprehensive Transition Plan (CTP). The CTP is a six-part multidisciplinary and automated process which enables every Warrior in Transition to develop an individualized plan that will enable them to set and reach their personal

goals. These end goals shape the Warrior in Transition's day-to-day work plan while healing.

Additionally to help Warriors in Transition achieve their physical fitness goals, WTUs offer several adaptive sports options to supplement the Warrior in Transition's therapy, often in coordination with the U.S. Olympic Committee's Paralympic Military Program. The WTC is also coordinating the Army's participation in the 2011 Warrior Games to be held at the U.S. Olympic Training Center in Colorado Springs, Colorado 16-21 May 2011.

We created a Soldier Medical Readiness Campaign to ensure we maintain a healthy and resilient force. Major General Richard Stone, Deputy Surgeon General, Mobilization, Readiness, and Reserve Affairs, is the campaign lead. The deployment of healthy, resilient, and fit Soldiers and increasing the medical readiness of the Army is the desired end state of this campaign.

The campaign's key tasks are to provide Commanders the tools to manage their Soldiers' medical requirements; coordinate, synchronize and integrate wellness, injury prevention and human performance optimization programs across the Army; identify the medically not ready (MNR) Soldier population; implement medical management programs to reduce the MNR Soldier population, assess the performance of the campaign; and educate the force.

Those Soldiers who no longer meet retention standards must navigate the Physical Disability Evaluation System (PDES). Assigning disability has long been a contentious issue. The present disability system dates back to the Career Compensation Act of 1949. Since its creation problems have been identified include long delays, duplication in DOD and VA processes, confusion among Service members, and distrust of systems regarded as overly complex and adversarial. In response to these concerns, DOD and VA jointly designed a new disability evaluation system to streamline DOD processes, with the goal of also expediting the delivery of VA benefits to service members following discharge from service. The Army began pilot testing the Disability Evaluation System (DES) in November 2007 at Walter Reed Army Medical Center and has since expanded the program, now known as the Integrated Disability

Evaluation System (IDES), to 16 military treatment facilities. DOD is now planning on replacing the military's legacy disability evaluation system with the IDES.

The key features of the of the IDES are a single physical disability examination conducted according to VA examination protocols, a single disability rating evaluation prepared by the VA for use by both Departments for their respective decisions, and delivery of compensation and benefits upon transition to veteran status for members of the Armed Forces being separated for medical reasons. The DoD PDES working group continues to reform this process by identifying steps that can be reduced or eliminated, ensuring the service members receive all benefits and entitlements throughout the process.

The WTC is also working with U.S. Army Medical Command staff to develop the concept of "Medical Management Centers." Medical Management Centers utilize the case management approaches developed for the WTUs to assist Soldiers who remain in their units but require a PDES determination. The WTC is also working closely with Army Reserve and Army National Guard leadership to develop and provide necessary support to the Reserve Component Soldier Medical Support Center (RCSMSC) being established in Pinellas Park, Florida. The RCSMSC is intended to ensure the PDES process also runs smoothly and efficiently for Reserve Component Soldiers not on Active Duty or in WTUs.

Army Medicine strives to reduce the need for subsequent care through ***early prevention*** and the emphasis on health promotion. Over the past year Army medicine has initiated multiple programs in support of this aim and I would like to highlight a few of those starting with the new US Army Public Health Command (Provisional) (PHC).

As part of the overall US Army Medical Command reorganization initiative, all major public health functions within the Army, especially those of the former Veterinary Command and the Center for Health Promotion and Preventive Medicine have been combined into a new PHC, located at Aberdeen Proving Ground in Maryland, under the command of Brigadier General Timothy K. Adams. The consolidation has already resulted in an increased focus on health promotion and has created a single accountable agent for public health and veterinary issues that is proactive and focused

on prevention, health promotion and wellness. The PHC reached initial operational capability in October 2010 and full operational capability is targeted for October 2011.

Army public health protects and improves the health of Army communities through education, promotion of healthy lifestyles, and disease and injury prevention. Public health efforts include controlling infectious diseases, reducing injury rates, identifying risk factors and interventions for behavioral health issues, and ensuring safe food and drinking water on Army installations and in deployed environments. The long-term value of public health efforts cannot be overstated: public health advances in the past century have been largely responsible for increasing human life spans by 25 years, and the PHC will play a central role in the health of our Soldiers, deployed or at home.

The health of the total Army is essential for readiness, and prevention is the best way to health. Protecting Soldiers, retirees, Family members and Department of Army civilians from conditions that threaten their health is operationally sound, cost effective and better for individual well-being. Though primary care of our sick and injured will always be necessary, the demands will be reduced. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is crucial to military success. Army Medicine is on the pathway to realizing this proactive, preventive vision.

While the PHC itself is relatively new, a number of significant public health accomplishments already have been achieved. Some examples:

- Partnering with Army installations to standardize existing Army Wellness Centers to preserve or improve health in our beneficiary population. The centers focus on health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. They partner with providers in our Military Treatment Facilities (MTFs) through a referral system. I hold each MTF Commander responsible for the health of the extended military community as the installation Director of Health Services (DHS).
- Hiring installation Health Promotion Coordinators (HPCs) to assist the MTF Commander/DHS and to facilitate health promotion efforts on Army installations. HPCs are the "air traffic controllers" or coordinators of services and identifiers of

service needs; they work with senior mission commanders and installation Community Health Promotion Councils to synchronize all of the installation health and wellness resources.

- Providing behavioral health epidemiological consultations to advise Army leaders and program developers on the factors that contribute to behavioral health issues including high-risk behaviors, domestic violence and suicide.
- Identifying Soldier physical training programs that optimize fitness while minimizing injuries and resultant lost-duty days and improve Soldier medical readiness.
- Decreasing the rate of overweight and obese Family members and retirees by adopting the Healthy Population 2010 goals for weight and obesity and implementing a standardized weight-management program developed by the VA.
- Integrating human and animal disease surveillance to better assess health risks.

The Army recognizes that traumatic brain injury or TBI is a serious concern, and we will continue to dedicate resources to research, diagnose, treat and prevent mild, moderate, severe, and penetrating TBI. The Army is leading the way in early recognition and treatment of mild TBI or concussive injuries with our "Educate, Train, Treat, and Track" strategy. Under the personal leadership of the Vice Chief of Staff of the Army, General Peter Chiarelli and refined by Brigadier General Richard Thomas, Assistant Surgeon General for Force Projection, we are fielding a program which some have called "CPR for the brain". Our education and training efforts have led to increased awareness and screening for TBI and have contributed to decreasing the stigma associated with seeking diagnosis or treatment for TBI. TBI training has been integrated into education and training initiatives of all deploying units to increase awareness and education regarding recognition of symptoms as well as emphasize commanders and leaders' responsibilities for ensuring their Soldiers receive prompt medical attention as soon as possible after an injury.

DoD policy changes in June 2010 implemented mandatory event-driven protocols following exposure to potentially concussive events in deployed environments. Events mandating an evaluation include any Service Member in a vehicle associated with a blast event, collision, or rollover; all personnel within close proximity to a blast; or anyone who sustains a direct blow to the head. Additionally, the command may direct a

medical evaluation for any suspected concussion under other conditions. All new medics and Physician Assistants at the Army Medical Department Center and School are being trained on their roles in supporting this policy. During my recent visit to Afghanistan with my fellow Surgeons General in February 2011, discussions with Warriors and medical personnel at a number of sites lead me to conclude that these protocols are aggressively endorsed by commanders and are being complied with.

The Army along with the DoD is implementing computerized tracking of these events for the purposes of providing healthcare providers with awareness of an individuals' history of proximity to blast events, allowing for greater visibility of at risk Soldiers during post-deployment health assessment, informing Commanders, and to provide documentation to support Line of Duty investigations for Reserve and Guard members. The program from August to December 2010 has documented 1,472 Soldiers. We are working hard to overcome the technical barriers for complete data input. My fellow Surgeons General and I saw this first hand in our trip to Afghanistan last month. We saw, as well, the complete commitment of all field commanders, small unit leaders, and medical professionals to the implementation of these protocols.

To further the science of brain injury recovery, the Army relies on the US Army Medical Research and Materiel Command's TBI Research Program. The overwhelming generosity of Congress and the DoD's commitment to brain injury research has significantly improved our knowledge of TBI in a rigorous scientific fashion. Currently, there are almost 350 studies funded by DoD to look at all aspects of TBI. The purpose of this program is to coordinate and manage relevant DoD research efforts and programs for the prevention, detection, mitigation and treatment of TBI. Some examples of the current research include medical standards for protective equipment, measures of head impact/blast exposure, a portable diagnostic tool for TBI that can be used in the field, blood tests to detect TBI, medications for TBI treatment, and the evaluation of rehabilitation outcomes. The TBI Research Program leverages both DoD and civilian expertise by encouraging partnerships to solve problems related to TBI. The DoD partners with key organizations and national/international leaders, including the VA, the Defense Centers of Excellence for Psychological Health and TBI, the Defense and Veterans Brain Injury Center, academia, civilian hospitals and the National

Football League, to improve our ability to diagnose, treat and care for those affected by TBI.

Similar to our approach to concussive injuries, Army Medicine harvested the lessons of almost a decade of war and has approached the strengthening of our Soldiers and Families' behavioral health and emotional resiliency through a campaign plan to align the various Behavioral Health programs with the human dimension of the ARFORGEN cycle, a process we call the Comprehensive Behavioral Health System of Care (CBHSOC). This program is based on outcome studies that demonstrate the profound value of using the system of multiple touchpoints in assessing and coordinating health and behavioral health for a Soldier and Family. The CBHSOC creates an integrated, coordinated, and synchronized behavioral health service delivery system that will support the total force through all ARFORGEN phases by providing full spectrum behavioral health care. We leveraged experiences and outcome studies on deploying, caring for Soldiers in combat, and redeploying these Soldiers in large unit movements to build the CBHSOC. Some have been published, such as the landmark studies on concussive brain injury and PTSD by Charles Hoge, Carl Castro and colleagues or the recent publication of a forerunner program to the CBHSOC in the 3rd Infantry Division by Chris Warner, Ned Appenzeller and their co-workers. These studies will be discussed further later.

The CBHSOC is a system of systems built around the need to support an Army engaged in repeated deployments - often into intense combat – which then returns to home station to restore, reset the formation, and re-establish family and community bonds. The intent is to optimize care and maximize limited behavioral health resources to ensure the highest quality of care to Soldiers and Families, through a multi-year campaign plan.

Under the leadership of Major General Patricia Horoho, the Deputy Surgeon General, the CBHSOC campaign plan has five lines of effort: Standardize Behavioral Health Support Requirements; Synchronize Behavioral Health Programs; Standardize & Resource AMEDD Behavioral Health Support; Access the Effectiveness of the CBHSOC; and Strategic Communications. The CBHSOC campaign plan was published

in September 2010, marking the official beginning of incremental expansion across Army installations and the Medical Command. Expansion will be phased, based on the redeployment of Army units, evaluation of programs, and determining the most appropriate programs for our Soldiers and their Families.

Near-term goals of the CBHSOC are implementation of routine behavioral health screening points across ARFORGEN and standardization of screening instruments. Goals also include increased coordination with both internal Army programs like Comprehensive Soldier Fitness, Army Substance Abuse Program, and Military Family Life Consultants. External resources include VA, local and state agencies, and the Defense Centers of Excellence for Psychological Health.

Long-term goals of the CBHSOC are the protection and restoration of the psychological health of our Soldiers and Families and the prevention of adverse psychological and social outcomes like Family violence, DUIs, drug and alcohol addiction, and suicide. This is through the development of a common behavioral health data system; development and implementation of surveillance and data tracking capabilities to coordinate behavioral health clinical efforts; full synchronization of Tele-behavioral health activities; complete integration of the Reserve Components; and the inclusion of other Army Medicine efforts including TBI, patient centered medical home, and pain management. Integral to the success of the CBHSOC is the continuous evaluation of programs, to be conducted by the PHC.

For those who do suffer from PTSD, Army Medicine has made significant gains in the treatment and management of PTSD as well. The DoD and VA jointly developed the three evidenced based Clinical Practice Guidelines for the treatment of PTSD, on which nearly 2,000 behavioral health providers have received training. This training is synchronized with the re-deployment cycles of US Army Brigade Combat Teams, ensuring that providers operating from MTFs that support the Brigade Combat Teams are trained and certified to deliver quality behavioral healthcare to Soldiers exposed to the most intense combat levels. In addition, the US Army Medical Department Center & School, under the leadership of Major General David Rubenstein, collaborates closely with civilian experts in PTSD treatment to validate the content of these training products

to ensure the information incorporates emerging scientific discoveries about PTSD and the most effective treatments.

Work by the Army Medical Department and the Military Health System over the past 8 years has taught us to link information gathering and care coordination for any one Soldier or Family across the continuum of this cycle. Our Behavioral Health specialists tell us that the best predictor of future behavior is past behavior, and through the CBHSOC we strive to link the management of issues which Soldiers carry into their deployment with care providers and a plan down-range and the same in reverse.

As mentioned previously, the results of a recent Army study published in January in the *American Journal of Psychiatry* by Major Chris Warner, Colonel Ned Appenzeller and colleagues report on the success of pre-deployment mental health support and coordination of care that dramatically reduced adverse behavioral health outcomes for over 10,000 Soldiers who received pre-deployment support prior to deployment compared to a like group of over 10,000 Soldiers who were deployed to the same battle space but were unable to receive the pre-deployment behavioral health assessment and care coordination. These results show the Army, as part of its Comprehensive Behavioral Health System of Care Campaign Plan, is moving in the right direction implementing new policies and programs to enhance pre- and post-deployment care coordination for Soldiers. This study demonstrates the ability to bridge the gap between identification through pre-deployment screening, as required by the National Defense Authorization Act for FY 2010, Sec. 708 and actively managing and coordinating care for Soldiers with existing behavior health concerns to insure a successful deployment that benefits the Army and continued support to Soldiers and Families.

The results are significant and provide the first direct evidence that a program that combines pre-deployment support and coordination of care that includes primary care managers, unit surgeons and behavioral health providers is effective in preventing adverse behavioral health outcomes for Soldiers. The study results move away from a perception of use of mental health screenings by Army and DoD as a tool to "weed out" Soldiers and service members deemed mentally unfit, to one of use and integration of behavioral health screenings as a routine part of Soldiers' and service members primary

care during deployment. Coupled with insights provided by Walter Reed Army Institute of Research (WRAIR) researchers, such as Dr. Charles Hoge and COL Carl Castro about the relationship between concussive injury and PTSD as well as seven years of annual surveys of BH problems and care in the deployed force through the WRAIR Mental Health Advisory Teams, we are making giants steps forward in prevention, early recognition, and mitigation of the neuropsychological effects of prolonged war on our Soldiers and Families.

Much of the future of Army Medicine will be practiced at the Patient-Centered Medical Home (PCMH). The PCMH is a model of primary care-based health improvement and healthcare services being adopted throughout the Military Health System and in many venues in civilian practice. I commend the Air Force for taking the lead on some PCMH practices. The PCMH will be the principal enabler to improve readiness of the force and continuity of access to tailored patient services. It is a design that the Army will apply to all primary care settings.

Dr. Paul Grundy, Director of Healthcare Transformation at IBM, pointed out that "a smarter health system forges partnerships in order to deliver better care, predict and prevent disease and empower individuals to make smarter choices." In his estimation, the PCMH is "advanced primary care." According to Dr. Grundy the PCMH can build trust between patient and physician, improve the patient experience of care, reduce staff burnout, and hold the line on expenditures.

The Medical Home philosophy concentrates on what a patient requires to remain healthy, to restore optimal health, and when needed, to receive tailored healthcare services. It relies upon building enduring relationships between patient and their provider-doctor, nurse practitioner, physician assistant and others-and a comprehensive and coordinated approach to care between providers and community services. This means much greater continuity of care, with patients seeing the same physician or professional partner 95% of the time. The result is more effective healthcare for both the provider and the patient that is based on trust and rapport.

The PCMH integrates the patient into the healthcare team, offering aggressive prevention and personalized intervention. Physicians will not just evaluate their patients

for disease to provide treatment, but also to identify risk of disease, including genetic, behavioral, environmental, or occupational risk. The healthcare team encourages healthy lifestyle behaviors, and success will be measured by how healthy they keep their patients, rather than by how many treatments they provide. The goal is that people will live longer lives with less morbidity, disability and suffering.

Community Based Medical Homes (CBMHs) are part of the Army's implementation of the Patient Centered Medical Home. CBMHs are Army operated primary care clinics located in leased space in the off-post communities in which many of our active duty Families live. These clinics are extensions of the Army Hospital and staffed by government civilians. Active duty Family members receive enrollment priority. This initiative was undertaken to improve access and continuity to healthcare services, including behavioral health, for active duty Family members by expanding capacity and extending MTF services off-post. The Army has grown and consumption of healthcare services is on the rise as a result of the war. These clinics will help Army Medicine improve quality of care and the patient experience; improve value through standardization and optimization of resources enabling operations at an economic advantage to the DoD; and improve the readiness of our Army and our Army Families. Clinics are placed where Families lacked access to Army primary care services and currently 17 clinics are being developed in 13 markets. Recently clinics supporting Fort Campbell, Fort Sill, Fort Stewart and Fort Bragg have opened and initial feedback has been outstanding.

The CBMHs build upon and are in many ways the culmination of a MEDCOM–wide campaign to closely monitor and reduce barriers to access and continuity; improve clinic productivity through standardization of administrative operations and support; to leverage improved health information management tools like AHLTA; and to incentivize commanders and providers to provide the right kind of care so as to improve individual and community health and outcomes of healthcare delivery in accordance with evidenced-based practices for chronic illness.

We are adopting other methods as well to ensure better outcomes for patient care. At the MEDCOM, we have implemented a performance-based adjustment model

(PBAM) to increase hospital and department responsibilities for how our funding is spent in health improvement and the delivery of health care services. PBAM creates a justifiable budget by a business planning process that links to outputs, such as volume or complexity of procedures. With the need for greater accountability and transparency, the MEDCOM has used PBAM to create performance measures that are consistent and can be compared across our facilities. We have experienced gains in total output, gains in provider efficiency, and increases in coding accuracy all aimed at improved outcomes of care – a more effective system for our beneficiaries and the Army. Incentives which are built into the program have measurably improved health and compliance with science – or – evidence-based care for chronic disease like diabetes and asthma.

Army Medicine is committed to using evidence-based practices which provide the most effective treatment for the variety of medical issues confronting our patient population and especially those issues caused by the almost 10 years of war such as pain management. An Army at war for almost a decade recognizes it has accumulated significant issues with acute and chronic pain amongst its Soldiers. In August 2009, I chartered the Army Pain Management Task Force to make recommendations for a MEDCOM comprehensive pain management strategy. I appointed Brigadier General Richard Thomasas the Task Force Chairperson. Task Force membership included a variety of medical specialties and disciplines from the Army, as well as representatives from the Navy, Air Force, TRICARE Management Activity, and VA.

The Pain Management Task Force developed 109 recommendations that lead to a comprehensive pain management strategy that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain. The Army Medical Command is operationalizing recommendations through the Pain Management Campaign Plan. I am proud to say that Army Medicine was recognized by the American Academy of Pain Medicine with the Presidential Commendation for its impact on pain medicine in the United States.

An important objective of the Pain Management Task Force calls for building a full spectrum of best practices for the continuum of pain care, from acute to chronic, which is based on a foundation of the best available evidence based medicine. This

can be accomplished through the adoption of an integrative and interdisciplinary approach to managing pain. Pain management should be handled by integrated care teams that use a biopsychosocial model of care. The standard of care should decrease overreliance on medication driven solutions and create an interdisciplinary approach that encourages collaboration among providers from differing specialties.

The DoD should continue to responsibly explore safe and effective use of advanced and non-traditional approaches to pain management and support efforts to make these modalities covered benefits once they prove safe, effective and cost efficient. One way to achieve an interdisciplinary, multimodal and holistic approach to pain management is by incorporating complementary and alternative therapies - integrative approaches - into an individualized pain management plan of care to include acupuncture, massage therapy, movement therapy, yoga, and other tools in mind-body medicine. To best address the goal of patient-centered care, providers must work in partnership with patients and Families in providing health promotion options while maintaining efficacy and safety standards. This integration needs to be methodical, appropriate, and evaluated throughout the process to ensure the best potential outcomes.

While the Pain Management Task Force has worked to expand the use of non-medication pain management modalities, as combat operations continue, more Soldiers are presenting with physical or psychological conditions, or both, which require clinical care, including medication therapy. Consequently, some of them may be treated for multiple conditions with a variety of medications prescribed by several health care providers. While the resulting "polypharmacy" - the use of multiple prescription or other medications - can be therapeutic in the treatment of some conditions, in other cases it can unwittingly lead to increased risk to patients. New Army policies and procedures to identify and mitigate polypharmacy have reduced the risk of these factors in garrison and deployed environments.

Polypharmacy is not unique to military medical practice and is also a patient safety issue in the civilian medical community. The risks of polypharmacy include overdose (intentional or accidental); toxic interactions with other medications or alcohol; increased risk of adverse effects of medications; unintended impairment of alertness or

functioning that may result in accident and injury; and the development of tolerance, withdrawal, and addiction to potentially habit-forming medications.

US Army Medical Command has issued guidance for enhancing patient safety and reducing risk via the prevention and management of polypharmacy. For example, Soldiers and Commanders are educated to take responsibility for, and active roles in, ensuring effective communication between patients and primary care managers to formulate treatment plans and address potential issues of polypharmacy. Annual training on managing polypharmacy patients is required for clinicians who prescribe psychotropic agents or central nervous system depressants. And through the electronic health record, patient health information, including prescriptions, is shared among providers to increase awareness of those patients with multiple medications.

Evidence-based science makes strong Soldiers and we rely heavily on the US Army Medical Research and Material Command (MRMC). Under the leadership of Major General James Gilman, MRMC manages and executes a robust, ongoing medical research program for the MEDCOM to support the development of new health care strategies. I would like to highlight a few research programs that are impacting health and care of our Soldiers today.

The Combat Casualty Care Research Program (CCCRP) reduces the mortality and morbidity resulting from injuries on the battlefield through the development of new life-saving strategies, new surgical techniques, biological and mechanical products, and the timely use of remote physiological monitoring. The CCCRP focuses on leveraging cutting-edge research and knowledge from government and civilian research programs to fill existing and emerging gaps in combat casualty care. This focus provides requirements-driven combat casualty care medical solutions and products for injured Soldiers from self-aid through definitive care, across the full spectrum of military operations.

The mission of the Military Operational Medicine Research Program (MOMRP) is to develop effective countermeasures against stressors and to maximize health, performance, and fitness, protecting the Soldier at home and on the battlefield. MOMRP research helps prevent physical injuries through development of injury

prediction models, equipment design specifications and guidelines, health hazard assessment criteria, and strategies to reduce musculoskeletal injuries.

MOMRP researchers develop strategies and advise policy makers to enhance and sustain mental fitness throughout a service member's career. Psychological health problems are the second leading cause of evacuation during prolonged or repeated deployments. MOMRP psychological health and resilience research focuses on prevention, treatment, and recovery of Soldiers and Families behavioral health problems, which are critical to force health and readiness. Current psychological health research topic areas include behavioral health, resiliency building, substance use and related problems, and risk-taking behaviors.

The Clinical and Rehabilitative Medicine Research Program (CRMRP) focuses on definitive and rehabilitative care innovations required to reset our wounded warriors, both in terms of duty performance and quality of life. The Armed Forces Institute of Regenerative Medicine (AFIRM) is an integral part of this program. The AFIRM was designed to speed the delivery of regenerative medicine therapies to treat the most severely injured US service members from around the world but in particular those coming from the theaters of operation in Iraq and Afghanistan. The AFIRM is expected to make major advances in the ability to understand and control cellular responses in wound repair and organ/tissue regeneration and has major research programs in Limb Repair and Salvage, Craniofacial Reconstruction, Burn Repair, Scarless Wound Healing, and Compartment Syndrome.

The AFIRM's success to date is at least in part the result of the program's emphasis on establishing partnerships and collaborations. The AFIRM is a partnership among the US Army, Navy, and Air Force, the Department of Defense, the VA, and the National Institutes of Health. The AFIRM is composed of two independent research consortia working with the US Army Institute of Surgical Research. One consortium is led by the Wake Forest Institute for Regenerative Medicine and the McGowan Institute for Regenerative Medicine in Pittsburgh while the other is led by Rutgers – the State University of New Jersey and the Cleveland Clinic. Each consortium contains approximately 15 member organizations, which are mostly academic institutions.

MRMC is also the coordinating office for the DoD Blast Injury Research Program. The Blast Injury Research Program is addressing critical medical research gaps for blast-related injuries and is developing partnerships with other DoD and external medical research laboratories to achieve a cutting-edge approach to solving blast injury problems. One of the program's major areas of focus is the improvement of battlefield medical treatment capabilities to mitigate neurotrauma and hemorrhage. Additionally, the program is modernizing military medical research by bringing technology advances and new research concepts into DoD programs.

We created a systematic and integrated approach to better organize and coordinate battlefield care to minimize morbidity and mortality, and optimize the ability to provide essential care required for casualty injuries – the Joint Theater Trauma System (JTTS). JTTS focuses on improving battlefield trauma care through enabling the right patient, at the right place, at the right time, to receive the right care. The components of the JTTS include prevention, pre-hospital integration, education, leadership and communication, quality improvement/performance improvement, research and information systems. The JTTS was modeled after the civilian trauma system principles outlined in the American College of Surgeons Committee on Trauma *Resources for Optimal Care.*

Effectiveness and efficiency are also enhanced by electronic tools. To support DoD and VA collaboration on treating PTSD, pain, and other health care issues, the Electronic Health Record (EHR) should seamlessly transfer patient data between and among partners to improve efficiencies and continuity of care. The DoD and the VA share a significant amount of health information today and no two health organizations in the nation share more non-billable health information than the DoD and VA. The Departments continue to standardize sharing activities and are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health information. We need to include electronic health information exchange with our civilian partners as well – a health information systems which brings together three intersecting domains – DoD, VA, civilian – for optimal sharing of beneficiary health information and to provide a common operating picture of health care delivery. These initiatives enhance healthcare delivery to beneficiaries and improve the

continuity of care for those who have served our country. Previously, the burden was on service members to facilitate information sharing; today, we are making the transition between DOD and VA easier for our service members.

The Office of the Surgeon General (OTSG) works closely with Defense Health Information Management System of Health Affairs/TRICARE Management Activity in pursuing additional enhancements and fixes to AHLTA. The OTSG Information Management Division also continues to implement the MEDCOM AHLTA Provider Satisfaction Program, which now provides dictation and data entry software applications, tablet computing hardware, business process management, clinical business intelligence, and clinical systems training and integration to the providers and users of AHLTA. OTSG is taking the EHR lead in designing and pursuing the next generation of the EHR by participating in DoD and Inter-agency projects such as the EHR Way Ahead, the Virtual Lifetime Electronic Record Pilot Project, Nationwide Health Information Network, In-Depth EHR Training, and VA/DoD Sharing Initiatives. We are aligned with the Air Force's COMPASS program in ensuring that our providers and our clinics have the best and most user-friendly EHR.

The Medical Command was reorganized in October 2010, to align regional medical commands (RMCs) with TRICARE regions with the resulting effect of improved readiness and support for the Army's iterative process of providing expeditionary, modular fighting units under the ARFORGEN cycle. We are well on the way to standardizing structure and staffing for RMC headquarters to provide efficiencies and ensure standardized best practices across Army Medicine. Three CONUS-based regional medical commands, down from four, are now aligned with the TRICARE regions to provide health care in a seamless way with our TRICARE partners.

In addition to TRICARE alignment, each region will contain an Army Corps headquarters, and health-care assets will be better aligned with beneficiary population of the regions. Each RMC has a deputy commander who is responsible for a readiness cell to coordinate and collaborate with the ARFORGEN cycle. This regional readiness cell will reach out to Reserve Component elements within their areas of responsibility to

ensure that all medical and dental services required during the ARFORGEN cycle of the Reserve units are also identified and provided.

In recent years, the Army has transformed how it provides health care to its Soldiers, with improvements impacting every aspect of the continuum of care. The Patient Centered Medical Home and the Warrior Transition Command are examples of the Army's strong commitment to adapt and improve its ability to provide the best care possible for our Soldiers and their Families. We have a duty and responsibility to our Soldiers, Families, and retirees. The level of care required does not end when the deployed Soldier returns home; there will be considerable ongoing health care costs for many years to support for our wounded, ill, or injured Service members. They need to trust we will be there to manage the health related consequences of over nine years of war, including behavioral health care, post-traumatic stress, burn or disfiguring injuries, chronic pain or loss of limb. We will require ongoing research to establish more effective methodologies for treatment. Army Medicine remains focused on developing partnerships to achieve the aims of the MHS as we work together to provide cost effective care to improve the health of our Soldiers. The goal is to provide the best care and access possible for Army Families and retirees and to ensure optimal readiness for America's fighting forces and their Families.

Lastly, I would like to join General Casey in expressing support for the military health care program changes included in the FY 2012 Budget. The changes include modest enrollment fee increases for working-age retirees, pharmacy co-pay adjustments, aligning Defense reimbursements to sole community hospitals to Medicare consistent with current statute, and shifting future Uniformed Services Family Health Plan enrollees into the TRICARE-for-Life/Medicare program established by Congress in the FY 2001 National Defense Authorization Act,

In closing, over the past 40 months as the Army Surgeon General I have had numerous occasions to appear before this subcommittee, meet individually with you and your fellow members and interact with your staff. I have appreciated your tough questions, valuable insight, sage advice and deep commitment to your Army's Soldiers and their Families. Thank you for this opportunity to share Army Medicine with you. I am proud to serve with the Officers, Non-commissioned Officers, the enlisted Soldiers

and civilian workforce of Army Medicine. Their dedication makes our Nation strong and our Soldiers and Families healthy and resilient.

Thank you for your continued support of Army Medicine and to our Nation's men and women in uniform.

Army Medicine: Building Value ... Inspiring Trust

Lieutenant General Eric B. Schoomaker, M.D., Ph.D.

The Surgeon General/Commander, U.S. Army Medical Command

LTG Eric B. Schoomaker was sworn in as the 42nd Army Surgeon General on Dec. 11, 2007 and assumed command of the U.S. Army Medical Command on Dec. 13, 2007. Before this selection, LTG Schoomaker served as the Commanding General, Walter Reed Army Medical Center and the North Atlantic Regional Medical Command.

In 1970 he graduated from the University of Michigan in Ann Arbor, was commissioned a Second Lieutenant as a Distinguished Military Graduate, and was awarded a Bachelor of Science degree. He received his medical degree from the University of Michigan Medical School in 1975 and completed his Ph.D. in Human Genetics in 1979.

LTG Schoomaker completed his internship and residency in Internal Medicine at Duke University Medical Center in Durham, N.C., from 1976 to 1978, followed by a fellowship in Hematology at Duke University Medical Center in 1979. He is certified by the American Board of Internal Medicine in both Internal Medicine and Hematology. His military education includes completion of the Combat Casualty Care Course, Medical Management of Chemical Casualty Care Course, AMEDD Officer Advanced Course, Command and General Staff College, and the U.S. Army War College.

LTG Schoomaker has held a wide variety of assignments. From 1979 until 1982, he was a research hematologist at Walter Reed Army Institute of Research. He served as Assistant Chief and Program Director, Department of Medicine, Walter Reed Army Medical Center, 1982 - 1988; Medical Consultant to Headquarters, 7th Medical Command, Heidelberg, Germany, 1988 - 1990; Deputy Commander for Clinical Services, Landstuhl Army Regional Medical Center, Landstuhl, Germany, 1990 - 1992; Chief and Program Director, Department of Medicine and Director of Primary Care, Madigan Army Medical Center, Tacoma, Wash., 1992 - 1995; Director of Medical Education for the Office of The Surgeon General/Headquarters USAMEDCOM conducting a split operation between Washington, D.C., and Fort Sam Houston, Texas, 1995 - 1997; and Director of Clinical Operations at the HQ USAMEDCOM, February to July 1997. From July 1997 to July 1999, he commanded the USA MEDDAC (Evans Army Community Hospital) at Fort Carson, Colo. He attended the U.S. Army War College in Carlisle Barracks, Pa., from 1999 to 2000 followed by assignments as the Command Surgeon for the U.S. Army Forces Command (FORSCOM) from July 2000 to March 2001, and Commander of the 30th Medical Brigade headquartered in Heidelberg, Germany, from April 2001 to June 2002.

LTG Schoomaker was appointed Chief of the Army Medical Corps when he assumed command of the Southeast Regional Medical Command/Dwight David Eisenhower Army Medical Center in June 2002. He served as Corps Chief until Sept. 2006. Prior to commanding the North Atlantic Regional Medical Command, he was the Commanding General of the U.S. Army Medical Research and Materiel Command and Fort Detrick, Md., from July 2005 - March 2007.

His awards and decorations include the Distinguished Service Medal (with oak leaf cluster), the Legion of Merit (with four oak leaf clusters), the Meritorious Service Medal (with two oak leaf clusters), the Joint Service Commendation Medal, the Army Commendation Medal, the Army Achievement Medal and the Humanitarian Service Medal. He has been honored with the Order of Military Medical Merit and the "A" Proficiency Designator and holds the Expert Field Medical Badge.

STATEMENT OF

VICE ADMIRAL ADAM M. ROBINSON, JR., MC, USN

SURGEON GENERAL OF THE NAVY

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

SUBJECT:

MILITARY HEALTH SYSTEM OVERVIEW AND DEFENSE HEALTH PROGRAM COST EFFICIENCIES

15 MARCH 2011

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Introduction

Chairman Wilson, Congresswoman Davis, distinguished Members of the Subcommittee, I am pleased to be with you today to provide an update on Navy Medicine, including some of our accomplishments, challenges and strategic priorities. I want to thank the Committee Members for the tremendous confidence and unwavering support of Navy Medicine, particularly as we continue to care for those who go in harm's way, their families and all beneficiaries.

Navy Medicine delivers world class care, anytime, anywhere. We are forward-deployed and engaged around the world every day, no matter what the environment and regardless of the challenge. The operational tempo of this past year continues to demonstrate that we must be flexible, adaptable and ready to respond globally. We will be tested in our ability to meet our operational and humanitarian assistance requirements, as well as maintain our commitment to provide patient and family-centered care to a growing number of beneficiaries. However, I am proud to say that Navy Medicine is responding to these challenges with skill, commitment and compassion.

Strategic Alignment, Integration and Efficiencies

Strategic alignment with the priorities of the Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps is critical to our ability to meet our mission. As a world-wide health care system, Navy Medicine is fully engaged in carrying out the core capabilities of the Maritime Strategy and the *Cooperative Strategy for the 21st Century Seapower* around the globe. Our ongoing efforts, including maintaining warfighter health readiness, conducting humanitarian assistance and disaster relief missions, protecting the health of our beneficiaries, as well as training our future force are critical to our future success.

We also recognize the importance of alignment within the Military Health System (MHS) as evidenced by the adoption of the Quadruple Aim initiative as a primary focus of the MHS Strategic Plan. The Quadruple Aim applies the framework from the Institute for Healthcare Improvement (IHI) and customizes it for the unique demands of military medicine. It targets the MHS and Services' efforts on integral outcomes in the areas of readiness, population health and quality, patient experience and cost. The goal is to develop better outcomes and implement balanced incentives across the MHS.

Within Navy Medicine, we continue to maintain a rigorous strategic planning process. Deliberative planning, constructive self-assessment and alignment at all levels of our organization, have helped create momentum and establish a solid foundation of measurable progress that drives change. It's paying dividends as we are seeing improved and sustained performance in our strategic objectives.

This approach is particularly evident in our approach to managing resources. We are leveraging analytics to target resource decisions. An integral component of our Strategic Plan is providing performance incentives that promote quality and directly link back to workload, readiness and resources. We continue to evolve to a system which integrates requirements, resources and performance goals and promotes patient and family-centered care. This transformation properly aligns authority, accountability and financial responsibility with the delivery of quality, cost-effective health care that remains patient and family-centered.

Aligning incentives helps foster process improvement particularly in the area of quality. Our Lean Six Sigma (LSS) program continues to be highly successful in identifying projects that synchronize with our strategic goals and have system-wide implications for improvement. Examples include reduced cycle time for credentialing providers and decreased waiting times for

diagnostic mammography and ultrasound. I am also encouraged by our collaboration with the Johns Hopkins' Applied Physics Laboratory to employ industrial engineering practices to improve clinical processes and help recapture private sector workload.

Navy Medicine continues to work within the MHS to realize cost savings through several other initiatives. We believe that robust promotion of TRICARE Home Delivery Pharmacy Program, implementation of supply chain management standardization for medical/surgical supplies and the full implementation of Patient-Centered Medical Home (PCMH) will be key initiatives that are expected to successfully reduce costs without compromising access and quality of care.

Rising health care costs within the MHS continue to present challenges. The Secretary of Defense has articulated that the rate at which health care costs are increasing and relative proportion of the Department's resources devoted to health care, cannot be sustained. He has been resolute in his commitment to implement systemic efficiencies and specific initiatives which will improve quality and satisfaction while more responsibly managing cost.

The Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps recognize that the MHS is not immune to the pressure of inflation and market forces evident in the health care sector. In conjunction with a growing number of eligible beneficiaries, expanded benefits and increased utilization throughout our system, it is incumbent upon us to ensure that we streamline our operations in order to get the best value for our expenditures. We have made progress, but there is more to do. We support the efforts to incentivize TRICARE Home Delivery Pharmacy Program and also to implement modest fee increases, where appropriate, to ensure equity in benefits for our retirees.

The Department of the Navy (DON) fully supports the Secretary's plan to better manage costs moving forward and ensure our beneficiaries have access to the quality care that is the hallmark of military medicine. As the Navy Surgeon General, I appreciate the tremendous commitment of our senior leaders in this critical area and share the imperative in developing a more affordable and sustainable health care benefit.

Navy Medicine has worked hard to get best value of every dollar Congress has provided and we will continue to do so. The President's Budget for FY12 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. We are, however, facing challenges associated with operating under a potential continuing resolution for the remainder of the year, particularly in the areas of provider contracts and funding for facility special projects.

Force Health Protection

Force Health Protection is the bedrock of Navy Medicine. It is what we do and why we exist. It is our duty – our obligation and our privilege – to promote, protect and restore the health of our Sailors and Marines. This mission spans the full spectrum of health care, from optimizing the health and fitness of the force, to maintaining robust disease surveillance and prevention programs, to saving lives on the battlefield. When Marines and Sailors go into harm's way, Navy Medicine is with them. On any given day, Navy Medicine is underway and forward deployed with the Fleet and Marine Forces, as well as serving as Individual Augmentees (IAs) in support of our global health care mission.

Clearly, our focus continues to be combat casualty care in support of Operation ENDURING FREEDOM (OEF). I, along with my fellow Surgeons General, recently returned from the Central Command (CENTCOM) Area of Responsibility (AOR) and again witnessed the stellar performance of our men and women delivering expeditionary combat casualty care. At

the NATO Role 3 Multinational Medical Unit, Navy Medicine is currently leading the joint and combined staff to provide the largest medical support in Kandahar with full trauma care to include 3 operating rooms, 12 intensive care beds and 35 ward beds. This state-of-the art facility is staffed with dedicated and compassionate active and reserve personnel who are truly delivering world-class care. Receiving 70 percent of their patients directly from the point of injury on the battlefield, our doctors, nurses and corpsmen apply the medical lessons learned from ten years of war to achieve a remarkable 97 percent survival rate for coalition casualties. The Navy Medicine team is working side-by-side with Army and Air Force medical personnel and coalition forces to deliver outstanding health care to US military, coalition forces, contractors, Afghan national army, police and civilians, as well as detainees. The team is rapidly implementing best practices and employing unique skill sets with specialists such as an interventional radiologist, pediatric intensivist, hospitalist and others in support of their demanding mission. I am proud of the manner in which our men and women are responding – leaving no doubt that the historically unprecedented survival rate from battlefield injuries is the direct result of better trained and equipped personnel, in conjunction with improved systems of treatment and casualty evacuation.

Combat casualty care is a continuum which begins with corpsmen in the field with the Marines. We are learning much about battlefield medicine and continue to quickly put practices in place that will save lives. All deploying corpsmen must now complete the Tactical Combat Casualty Care (TCCC) training. TCCC guidelines for burns, hypothermia and fluid resuscitation for first responders have also been updated. This training is based on performing those interventions on the battlefield that address preventable causes of death. In addition, we have expanded the use of Combat Application Tourniquets (CATs) and hemostatic impregnated

bandages as well as improving both intravenous therapy and individual first aid kits (IFAKs) and vehicle medical kits (VMKs).

We continue to see success with our Forward Resuscitative Surgical System (FRSS) which allows for stabilization within the "golden hour". The FRSS can perform 18 major operations over the course of 72 hours without being re-supplied. Our ability to send medical teams further forward has improved survivability rates. To this end, we are clearly making tremendous gains in battlefield medicine throughout the continuum of care. Work being conducted by the Joint Theatre Trauma Registry and Joint Combat Casualty Research Teams are enabling us to capture, evaluate and implement clinical practice guidelines and best practices quickly.

Humanitarian Assistance and Disaster Relief

Navy Medicine continues its commitment to providing responsive and comprehensive support for Humanitarian Assistance/Disaster Relief (HA/DR) missions around the world. We are often the first responder for HA/DR missions due to the presence of organic medical capabilities with forward deployed Navy assets. Our hospital ships, USNS MERCY (T-AH 19) and USNS COMFORT (T-AH 20) are optimally configured to deploy in support of HCA activities in South America, the Pacific Rim and East Asia.

Navy Medicine not only responds to disasters around the world and at home, we also conduct proactive humanitarian missions in places as far reaching as Africa through *Africa Partnership Station* to the Pacific Rim through *Pacific Partnership* and South America through *Continuing Promise*. MERCY's recent deployment in support of *Pacific Partnership 2010*, the fifth annual Pacific Fleet proactive humanitarian mission, is strengthening ongoing relationships with host and partner nations in Southeast Asia and Oceania. During the 144-day, six nation

mission, we treated 109,754 patients, performed 859 surgeries and engaged in thousands of hours of medical subject matter expert exchanges.

Our hospital ships are executing our Global Maritime Strategy by building the trust and cooperation we need to strengthen our regional alliances and empower partners around the world. With each successful deployment, we increase our interoperability with host and partner nations, non-governmental organizations and the interagency partners. Today's security missions must include humanitarian assistance and disaster response,

Enduring HA missions such as *Pacific Partnership* and *Continuing Promise*, as well other Medical Readiness Education Training Exercises (MEDRETEs) provide valuable training of personnel to conduct future humanitarian support and foreign disaster relief missions. Our readiness was clearly evident by the success of Operation UNIFIED RESPONSE (OUR) following the devastating earthquake in Haiti last year. Our personnel were trained and prepared to accomplish this challenging mission.

Concept of Care

Patient and family-centered care is our core philosophy -- the epicenter of everything we do. We are providing comprehensive, compassionate health care for all our beneficiaries wherever they may be and whenever they may need it. Patient and family-centered care helps ensure patient satisfaction, increased access, coordination of services and quality of care, while recognizing the vital importance of the family. Navy Medicine serves personnel throughout their treatment cycle, and for our Wounded Warriors, we manage every aspect of medicine in their continuum of care to provide a seamless transition from battlefield to bedside to leading productive lives.

Medical Home Port is Navy Medicine's Patient-Centered Medical Home (PCMH) model, an important initiative that will significantly impact how we provide care to our beneficiaries. In alignment with my strategic goal for patient and family-centered care, Medical Home Port emphasizes team-based, comprehensive care and focuses on the relationship between the patient, their provider and the healthcare team. The Medical Home Port team is responsible for managing all health care for empanelled patients, including specialist referrals when needed. Patients see familiar faces with every visit, assuring continuity of care. Appointments and tests get scheduled promptly and care is delivered face-to-face or when appropriate, using secure electronic communication. PCMH is being implemented by all Services and it is expected to improve population health, patient satisfaction, readiness, and is likely to impact cost in very meaningful ways.

It is important to realize that Medical Home Port is not brick and mortar; but rather a philosophy and commitment as to how you deliver the highest quality care. A critical success factor is leveraging all our providers, and supporting information technology systems, into a cohesive team that will not only provide primary care, but integrate specialty care as well. We continue to move forward with the phased implementation of Medical Home Port at our medical centers and family medicine teaching hospitals, and initial response from our patients is very encouraging.

Caring for Our Heroes, Their Families and Caregivers

We have no greater responsibility than caring for our service members, wherever and whenever they need us. This responsibility spans from the deckplates and battlefield to our clinics, hospitals and beyond. This commitment to provide healing in body, mind and spirit has

never been more important. Our case management programs, both medical and non-medical, play a vital role in the development of Comprehensive Recovery Plans to provide our war-injured service members' optimal outcomes. Case management is the link that connects resources and services for our Wounded Warriors and their families.

Associated with this commitment, we must understand that preserving the psychological health of service members and their families is one of the greatest challenges we face today. We recognize that service members and their families are resilient at baseline, but the long conflict and related deployments challenge this resilience. DON is committed to providing programs that support service members and their families.

The Navy Operational Stress Control program and Marine Corps Combat Operational Stress Control programs are the cornerstones of our approach to early detection of stress injuries in Sailors and Marines and are comprised of line-led programs which focus on leadership's role in monitoring the health of their people; tools leaders may employ when Sailors and Marines are experiencing mild to moderate symptoms; and multidisciplinary expertise (medical, chaplains and other support services) for more affected members.

Navy Medicine's Psychological Health (PH) program supports the prevention, diagnosis, mitigation, treatment and rehabilitation of post-traumatic stress disorder (PTSD) and other mental health conditions, including planning for the seamless transition of service members throughout the recovery and reintegration process. We have increased the size of the mental health work force to support the readiness and health needs of the Fleet and Marine Corps throughout the deployment cycle and, during FY10, funded 221 clinical and support staff positions at 14 Navy military treatment facilities (MTFs) to help ensure timely access to care.

Stigma remains a barrier; however, Navy and Marine Corps' efforts to decrease stigma have had preliminary success—with increased active leadership support and Operational Stress Control (OSC) training established throughout the Fleet and Marine Forces.

Within the Marine Corps, we continue to see success with the Operational Stress Control and Readiness (OSCAR) program as well as the OSCAR Extender program. OSCAR embeds full-time mental health personnel with deploying Marines and uses existing medical and chaplain personnel as OSCAR Extenders and trained senior and junior Marines as mentors to provide support at all levels to reduce stigma and break down barriers to seeking help. Our priority remains ensuring we have the service and support capabilities for prevention and early intervention available where and when it is needed. OSCAR is allowing us to move forward in this important area.

We recently deployed our third Navy Mobile Mental Health Care Team for a six-month mission in Afghanistan. The team consists of three mental health clinicians, a research psychologist and an enlisted psychiatry technician. Their primary tool is the Behavioral Health Needs Assessment Survey (BHNAS). The results give an overall assessment of real time force mental health and well-being every six months, and can identify potential areas or sub-groups of concern for leaders. It assesses a wide variety of content areas, including mental health outcomes, as well as the risk and protective factors for those outcomes such as combat exposures, deployment-related stressors, positive effects of deployment, morale and unit cohesion. The Mobile Care Team also has a mental health education role and provides training in Psychological First Aid to Sailors in groups and individually. Ultimately, Psychological First Aid gives Sailors a framework to promote resilience in one another.

Our Naval Center for Combat & Operational Stress Control (NCCOSC) is one way we are developing an environment that supports psychologically fit, ready and resilient Navy and Marine Corps forces. The goal is to demystify stress and help Sailors and Marines take care of themselves and their shipmates. NCCOSC continues to make progress in advancing research for the prevention, diagnosis and treatment of combat and operational stress injuries to include PTSD. They are involved in over 64 on-going scientific projects with 3,525 participants enrolled. NCCOSC has recently developed a pilot program, Psychological Health Pathways, which is designed to ensure that clinical practice guidelines are followed and evidence-based care is practiced and tracked. To date, 1,554 patients have been enrolled into the program with 600,062 points of clinical data gathered. The program involves intensive mental health case management, use of standardized measures, provider training and comprehensive data tracking.

In November 2010, we launched a pilot program, Overcoming Adversity and Stress Injury Support (OASIS) at the Naval Medical Center, San Diego. Developed by Navy Medicine personnel and located onboard the Naval Base Point Loma, California, OASIS is a 10-week residential program designed to provide intensive mental health care for service members with combat related mental health symptoms from post-traumatic stress disorder, as well as major depressive disorders, anxiety disorders and substance abuse problems. The program offers a comprehensive approach, focusing on mind and body through various methods including yoga, meditation, spirituality classes, recreation therapy, art therapy, intensive sleep training, daily group therapy, individual psychotherapy, family skills training, medication management and vocational rehabilitation. We will be carefully assessing the efficacy of this pilot program throughout this year.

Associated with our Operational Stress Control efforts, suicide prevention remains a key component. Suicide destroys families and impacts our commands. We are working hard at all levels to build the resilience of our Sailors and Marines and their families, as well as foster a culture of awareness and intervention by the command and shipmates. Our programs are focused on leadership engagement, intervention skills, community building and access to quality treatment. All of us in uniform have a responsibility to care for our shipmates and remain vigilant for signs of stress. A-C-T (Ask – Care – Treat) remains an important framework of response. In 2010, both the Navy and Marine Corps saw reductions in the number of suicides from the prior year, with the Navy seeing a reduction of 17 percent while the Marine Corps realized a 29 percent drop.

We are also committed to improving the psychological health, resiliency and well-being of our family members. When our Sailors and Marines deploy, our families are their foothold. Family readiness is force readiness and the physical, mental, emotional, spiritual health and fitness of each individual is critical to maintaining an effective fighting force. A vital aspect of caring for our Warriors is also caring for their families and we continue to look for innovative ways to do so.

To meet this growing challenge, Navy Medicine began an unparalleled approach in 2007 called Project FOCUS (Families OverComing Under Stress) to help our families. FOCUS is a family-centered resiliency training program based on evidenced-based interventions that enhances understanding, psychological health and developmental outcomes for highly stressed children and families. FOCUS has been adapted for military families facing multiple deployments, combat operational stress, and physical injuries in a family member. It is an 8-week, skill-based, trainer-led intervention that addresses difficulties that families may have when

facing the challenges of multiple deployments and parental combat related psychological and physical health problems. It has demonstrated that a strength-based approach to building child and family resiliency skills is well received by service members and their family members. Notably, program participation has resulted in statistically significant increases in family and child positive coping and significant reductions in parent and child distress over time, suggesting longer-term benefits for military family wellness.

Project FOCUS has been highlighted by the Interagency Policy Committee on Military Families Report to the President (October 2010) and has been recognized by the Department of Defense (DoD) as a best practice. Given the success FOCUS has demonstrated thus far, we will continue to devote our efforts to ensuring our service members and their families have access to this program. To date, over 160,000 Service members, families and community support providers have received FOCUS services, across twenty-three locations CONUS and OCONUS.

Our programs must address the needs of all of our Sailors, Marines and families, including those specifically targeted to the unique needs of reservists and our caregivers. The Reserve Psychological Health Outreach Program (RPHOP) identifies Navy and Marine Corps Reservists and their families who may be at risk for stress injuries and provides outreach, support and resources to assist with issue resolution and psychological resilience. An effective tool at the RPHOP Coordinator's disposal is the Returning Warrior Workshop (RWW), a two-day weekend program designed specifically to support the reintegration of returning Reservists and their families following mobilization. Some 54 RWWs have been held since 2008 with over 6,000 military personnel, family members and guests attending.

Navy Medicine is also working to enhance the resilience of caregivers to the psychological demands of exposure to trauma, wear and tear, loss, and inner conflict associated

with providing clinical care and counseling through the Caregiver Occupational Stress Control (CgOSC) Program. The core objectives are early recognition of distress, breaking the code of silence related to stress reactions and injuries, and engaging caregivers in early help as needed to maintain both mission and personal readiness.

In addition, the Naval Health Research Center (NHRC) produced "The Docs", a 200-page graphic novel, as a communication tool to help our corpsmen with the stresses of combat deployments. "The Docs" is the story of four corpsmen deployed to Iraq. While some events in the novel are specific to Operation IRAQI FREEDOM (OIF), it is not intended to depict any specific time period or conflict but rather highlight general challenges faced by corpsmen who serve as the "Docs" in a combat zone. It was developed with the intent to instill realistic expectations of possible deployment stressors and to provide examples for corpsmen on helpful techniques for in-theater care of stress injuries. This format was chosen for its value in providing thought-provoking content for discussion in training scenarios and to appeal to the targeted age group.

Nearly a decade of continuous combat operations has resulted in a growing population of service members suffering with Traumatic Brain Injury (TBI), the very common injury of OEF and OIF. The majority of TBI injuries are categorized as mild, or in other words, a concussion. We know more about TBI and are forging ahead with improved surveillance, treatment and research. However, we must recognize that there is still much we do not yet know about these injuries and their long-term impacts on the lives of our service members.

Navy Medicine is committed to ensuring thorough screening for all Sailors and Marines prior to expeditionary deployment, enhancing the delivery of care in theater, and the identification and testing of all at-risk individuals returning from deployment. We are committed

to enhancing training initiatives, developing better tools to detect changes related to TBI and sustaining research into better treatment options.

Pre-deployment screening is prescribed using the Automated Neuropsychological Assessment Metrics (ANAM). Testing has expanded to Navy and Marine Corps worldwide, enhancing the ability to establish baseline neurocognitive testing for expeditionary deployers. This baseline test has provided useful comparative data for medical providers in their evaluation, treatment and counseling of individuals who have been concussed in theater.

In-theater screening and treatment has also improved over time. The issuance of the Directive-Type Memorandum (DTM) 09-033 in June 2010 has increased leaders' awareness of potential TBI exposure and mandates post-blast evaluations and removal of blast-exposed warfighters from high risk situations to promote recovery. Deploying medical personnel are trained in administering the Military Acute Concussion Evaluation (MACE), a rapid field assessment to help corpsmen identify possible concussions. Additionally, deploying medical providers receive training on the DTM requirements and in-theater Clinical Practice Guidelines (CPGs) for managing concussions.

In August 2010, the Marine Corps, supported by Navy Medicine, opened the Concussion Restoration Care Center (CRCC) at Camp Leatherneck in Helmand Province to assess and treat service members with concussion or musculoskeletal injuries, with the goal of safely returning as many service members as possible to full duty following recovery of cognitive and physical functioning. The CRCC is supported by an interdisciplinary team including sports medicine, family medicine, mental health, physical therapy and occupational therapy. I am encouraged by the early impact the CRCC is having in theatre by providing treatment to our service members

close to the point of injury and returning them to duty upon recovery. We will continue to focus our attention on positioning our personnel and resources where they are most needed.

Post-deployment surveillance for TBI is accomplished through the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA), which are required for returning deplorers. Further evaluation, treatment and referrals are provided based on responses to certain TBI-specific questions on the assessments.

TBI research efforts are focused on continuing to refine tools for medical staff to use to detect and treat TBI. Two specific examples are a study of cognitive and physical symptoms in USMC Breacher instructors (who have a high lifetime exposure rate to explosive blasts) and an ongoing surveillance effort with USMC units with the highest identified concussion numbers to determine the best method for identifying service members requiring clinical care. These efforts are coupled with post-deployment ANAM testing for those who were identified as sustaining at least one concussion in theater. Other efforts are underway to identify physical indicators and biomarkers for TBI, such as blood tests, to help in diagnosis and detection. We are also conducting evaluations of various neurocognitive assessment tools to determine if there is a "best" tool for detecting concussion effects in the deployed environment. Our efforts also include those coordinated jointly with the other Services, the Defense and Veterans Brain Injury Center (DVBIC), and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).

I am committed to ensuring that we build on the vision advanced by the Members of Congress and the hard work of the dedicated professionals at all the Centers of Excellence, MTFs, research centers and our partners in both the public and private sectors. These Centers of Excellence have become important components of the Military Health System and their work in

support of clinical best practices, research, outreach and treatment must continue with unity of effort and our strong support.

Our service members must have access to the best treatment, research and education available for PH and TBI. We continue to see progress as evidenced by the opening of the National Intrepid Center of Excellence (NICoE) onboard the National Naval Medical Center campus. As a leader in advancing state-of-the-art treatment, research, education and training, NICoE serves as an important referral center primarily for service members and their families with complex care needs, as well as a hub for best practices and consultation. NICoE also conducts research, tests new protocols and provides comprehensive training and education to patients, providers and families – all vital to advancing medical science in PH and TBI.

Navy Medicine is also working with the DCoE, its component centers including DVBIC, the Department of Veterans Affairs, research centers, and our partners in both the public and private sectors to support best clinical practices, research and outreach. We continue to see gains in the both the treatment and development of support systems for our Wounded Warriors suffering with these injuries; however, we must recognize the challenging and extensive work that remains. Our commitment will be measured in decades and generations and must be undertaken with urgency and compassion.

The Navy Medicine Team

Our people are our most important assets, and their dignity and worth are maintained through an atmosphere of service, professionalism, trust and respect. Navy Medicine is fortunate to have over 63,000 dedicated professionals working to improve and protect the health of Sailors, Marines and their families. Our team includes officers, enlisted personnel, government civilians and contractors working together in support of our demanding mission. I have been privileged to

meet many of them in all environments – forward-deployed with the operating forces, in our labs and training facilities, at the bedside in our medical centers and hospitals – and I'm always inspired by their commitment.

We are working diligently to attract, recruit and retain our Navy Medicine personnel. Overall, I remain encouraged with the progress we are making in recruiting and overall manning and we are seeing the successes associated with our incentive programs. In FY 10, we met our Active Medical Department recruiting goal and attained 90 percent of Reserve Medical Department goal, but there was a notable shortfall in Reserve Medical Corps recruiting at 70 percent. Given the relatively long training pipeline for many of our specialties, we clearly recognize the impact that recruiting shortfalls in prior years, particularly in the Health Professions Scholarship Program (HPSP), can have in meeting specialty requirements today and moving forward. Recruiting direct accession physicians and dentists remains challenging, requiring our scholarship programs to continue recent recruiting successes to meet inventory needs. Retention has improved for most critical wartime specialties, supported by special pay initiatives; however, some remain below our requirements and continue to be closely monitored.

Within the active component Medical Corps, general surgery, family medicine and psychiatry have shortfalls, as does the Dental Corps with general dentistry and oral maxillofacial surgery specialties. We are also experiencing shortfalls for nurse anesthetists, perioperative and critical care nurses, family nurse practitioners, clinical psychologists, social workers and physician assistants.

The reserve component shortages also exist within anesthesiology, neurosurgery, orthopedic surgery, internal medicine, psychiatry, diagnostic radiology, comprehensive dentistry

and oral maxillofacial surgery as well as perioperative nursing, anesthesia and mental health nurse practitioners.

We appreciate your outstanding support for special pays and bonus programs to address these shortages. These incentives will continue to be needed for future success in both recruiting and retention. We are working closely with the Chief of Naval Personnel and Commander, Naval Recruiting Command to assess recruiting incentive initiatives and explore opportunities for improvement.

For our civilian personnel within Navy Medicine, we are also coordinating the National Security Personnel System (NSPS) replacement for 32 healthcare occupations to ensure pay parity among healthcare professions. We have been successful in hiring required civilians to support our Sailors and Marines and their families - many of whom directly support our Wounded Warriors. Our success in hiring is in large part due to the hiring and compensation flexibilities that have been granted to the DoD's civilian healthcare community over the past several years.

Our priority remains to maintain the right workforce to deliver the required medical capabilities across the enterprise, while using the appropriate mix of accession, retention, education and training incentives.

I want to also reemphasize the priority we place on diversity. Navy Medicine has continued to emerge as a role model of diversity as we focus on inclusiveness while aligning ethnic and gender representation throughout the ranks to reflect our Nation's population. Not only are we setting examples of a diverse, robust and dedicated health care force, but this diversity also reflects the people for whom we provide care. We take great pride in promoting our message that we are the employer of choice for individuals committed to a culturally

competent work-life environment; one where our members proudly see themselves represented at all levels of leadership.

For all of us in Navy Medicine, an excerpt from the Navy Ethos articulates well what we do: "We are a team, disciplined and well-prepared, committed to mission accomplishment. We do not waiver in our dedication and accountability to our Shipmates and families."

Excellence in Research and Development and Health Education

World-class research and development capabilities, in conjunction with outstanding medical education programs, represent the future of our system. Each is a force-multiplier and, along with clinical care, is vital to supporting our health protection mission. The work that our researchers and educators do is having a direct impact on the treatment we are able to provide our Wounded Warriors, from the battlefield to the bedside. We will shape the future of military medicine through research, education and training.

The overarching mission of our Research and Development program is to conduct health and medical research, development, testing, and evaluation (RDT&E), and surveillance to enhance the operational readiness and performance of DoD personnel worldwide. In parallel, our Clinical Investigation Program activity, located at our teaching MTFs is, to an increasing degree, participating in the translation of appropriate knowledge and products from our RDT&E activity into proof of concept and cutting edge interventions to benefit our Wounded Warriors and our beneficiaries. We are also committed to connecting our Wounded Warriors to approved emerging and advanced diagnostic and therapeutic options within and outside of military medicine while ensuring full compliance with applicable patient safety policies and practices.

Towards this end, we have developed our top five strategic research goals and needs to meet the Chief of Naval Operations and Commandant of the Marine Corps war fighting requirements. These include:

- Traumatic brain injury (TBI) and psychological health treatment and fitness for both operational forces and home-based families.
- Medical systems support for maritime and expeditionary operations to include patient medical support and movement through care levels I and II with emphasis on the United States Marine Corps (USMC) casualty evacuation (CASEVAC) and En Route Care systems to include modeling and simulation for casualty prediction, patient handling, medical logistics, readiness, and command, control, communications and intelligence (C3I).
- Wound management throughout the continuum of care, to include chemical, molecular, and cellular indicators of optimum time for surgical wound closure, comprehensive rehabilitation; and reset to operational fitness.
- Hearing restoration and protection for operational maritime surface and air support personnel.
- Undersea medicine, diving and submarine medicine, including catastrophe intervention, rescue and survival as well as monitoring and evaluation of environmental challenges and opportunities.

During my travel overseas this past year, including Vietnam, current partnerships and future partnerships possibilities between Navy Medicine and host nation countries were evident. Increasing military medical partnerships are strengthening overall military to military relationships which are the cornerstone of overarching bi-lateral relations between allies. These engagements are mutually beneficial -- not only for the armed forces of both countries, but for world health efforts with emerging allies in support of global health diplomacy.

Graduate Medical Education (GME) is vital to our ability to train our physicians and meet our force health protection mission. Vibrant and successful GME programs continue to be the hallmark of Navy Medicine and I am pleased that despite the challenges presented by a very high operational tempo and past year recruiting shortfalls, our programs remain strong. All of our GME programs eligible for accreditation are accredited and most have the maximum or near maximum accreditation cycle lengths. In addition, our graduates perform very well on their

Specialty Boards - significantly exceeding the national pass rate in almost every specialty year after year. The overall pass rate for 2009 was 97 percent. Most importantly, our Navy-trained physicians continue to prove themselves to be exceptionally well prepared to provide care in austere settings from the battlefield to disaster relief missions.

In addition to GME, we are leveraging our inter-service education and training capabilities with the new state-of-the-art Medical Education and Training Campus (METC) in San Antonio, Texas. Now operational, METC represents the largest consolidation of Service training in the history of DoD, and is the world's largest medical training campus. Offering 30 programs and producing 24,000 graduates annually, METC will enable us to train our Sailors, Soldiers and Airmen to meet both unique Service-specific and joint missions. Our corpsmen are vital to saving lives on the battlefield and the training they receive must prepare them for the rigors of this commitment. I am committed to an inter-service education and training system that optimizes the assets and capabilities of all DoD health care practitioners yet maintains the unique skills and capabilities that our corpsmen bring to the Navy and Marine Corps – in hospitals, at sea and on the battlefield.

Collaboration Engagement

Navy Medicine recognizes the importance of leveraging collaborative relationships with the Army and Air Force, as well as the Department of Veterans Affairs (VA), and other federal and civilian partners. These engagements are essential to improving operational efficiencies, education and training, research and sharing of technology. Our partnerships also help create a culture in which the sharing of best practices is fundamental to how we do business and ultimately helps us provide better care and seamless services and support to our beneficiaries.

The progress we are making with the VA was clearly evident as we officially activated

the Captain James A. Lovell Federal Health Care Center in Great Lakes, Illinois – a first-of-its-kind fully integrated partnership that links Naval Health Clinic Great Lakes and the North Chicago VA Medical Center into one healthcare system. We are grateful for all your support in helping us achieve this partnership between the Department of Veterans Affairs, DoD and DON. We are proud to able to provide a full spectrum of health care services to recruits, active duty, family members, retirees and veterans in the Nation's first fully integrated VA/Navy facility. We look forward to continuing to work with you as we improve efficiencies, realize successes and implement lessons learned.

Navy Medicine has 52 DoD/VA sharing agreements in place for medical and ancillary services throughout the enterprise as well as 10 Joint Incentive Fund (JIF) projects. When earlier JIF projects ended, they were superseded by sharing agreements. Naval Health Clinic Charleston and the Ralph H. Johnson VA Medical Center celebrated the opening of the new Captain John G. Feder Joint Ambulatory Care Clinic. This newly constructed outpatient clinic located on Joint Base Charleston Weapons Station is a state-of-the-art 188,000 square foot facility that is shared by the VA and the Navy Health Clinic Charleston. This project is another joint initiative such as the Joint Ambulatory Care Center in Pensacola that replaced the former Corry Station Clinic; and another in Key West where the VA's Community Based Outpatient Clinic (CBOC) and the Navy Clinic are co-located, continuing collaboration and providing service at the site of our first VA/DoD Joint Venture.

We are also continuing to work to implement the Integrated Disability Evaluation System (IDES) at our facilities in conjunction with VA. To date, this program has been implemented at 15 of our MTFs. This world-wide expansion, to be completed in FY11, follows the DES Pilot program and the decision of the Wounded, Ill and Injured Senior Oversight Council (SOC) Co-

chairs (Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs) to move forward to streamline the DoD DES process.

One of our most important projects continues to be the successful transition of the new Walter Reed National Military Medical Center (WRNMMC) onboard the campus of the National Naval Medical Center, Bethesda. This realignment is significant and the Services are working diligently with DoD's lead activity, Joint Task Force Medical – National Capital Region to ensure we remain on track to meet the Base Realignment and Closure (BRAC) deadline of 15 September 2011. Our priority continues to be properly executing this project on schedule without any disruption of services. We also understand the importance of providing a smooth transition for our dedicated personnel - both military and civilian - to the success of WRNMMC. We recognize that these dedicated men and women are critical to our ability to deliver world class care to our Sailors, Marines, their families and all our beneficiaries for whom we are privileged to serve.

The Way Forward

I am proud of the progress we are making, but not satisfied. We continue to see ground-breaking innovations in combat casualty care and remarkable heroics in saving lives. But all of us remain concerned about the cumulative effects of worry, stress and anxiety on our service members and their families brought about by a decade of conflict. Each day during my tenure as the Navy Surgeon General, we have been a Nation at war. Each day resonates with the sacrifices that our Sailors, Marines and their families make, quietly and without bravado. They go about their business with professionalism, skill, and frankly, ask very little in return. It is this commitment, this selfless service, that helps inspire us in Navy Medicine. Regardless of the challenges ahead, I am confident that we are well-positioned for the future.

I will be retiring from Naval Service later this year and I want to express my thanks for all the support you provide to Navy Medicine and to me throughout my tenure as the Navy Surgeon General.

Vice Admiral Adam M. Robinson, Jr.
Surgeon General of the Navy
and Chief of the Navy's Bureau of Medicine and Surgery

Vice Admiral Robinson is the 36th surgeon general of the Navy and chief of the Navy's Bureau of Medicine and Surgery.

Robinson, is a native of Louisville, Ky. He entered the naval service in 1977 and holds a Doctor of Medicine degree from the Indiana University School of Medicine, Indianapolis, through the Armed Forces Health Professions Scholarship Program. Following completion of his surgical internship at Southern Illinois University School of Medicine, Springfield, he was commissioned.

Robinson's first assignment was as a general medical officer, Branch Medical Clinic, Fort Allen, Puerto Rico, before reporting to the National Naval Medical Center, Bethesda, Md., in 1978 to complete a residency in general surgery. His subsequent duty assignments included: staff surgeon, U.S. Naval Hospital, Yokosuka, Japan, and ship's surgeon, USS *Midway* (CV 41).

After completing a fellowship in colon and rectal surgery at Carle Foundation Hospital, University of Illinois School of Medicine Affiliated, Champaign-Urbana (1984-85), Robinson reported to the National Naval Medical Center, Bethesda, as the head of the Colon and Rectal Surgery Division. While there, he was called to temporary duty in 1987 as ship's surgeon in USS *John F. Kennedy* (CV 67) and in 1988 as ship's surgeon in USS *Coral Sea* (CV 43).

Robinson reported to Naval Medical Center Portsmouth, Va., in 1990 as the head of the General Surgery Department and director of General Surgery Residency Program. He was appointed acting medical director for the facility in 1994. While at Naval Medical Center Portsmouth, Robinson earned a Master's degree in Business Administration from the University of South Florida. In 1995, Robinson reported to the commander, Naval Surface Force, U.S. Atlantic Fleet, as the force medical officer serving in that capacity for two years. Following that assignment, he reported to Naval Hospital Jacksonville in 1997 as the executive officer. In January 1999, as Fleet Hospital Jacksonville commanding officer, Robinson commanded a detachment of the fleet hospital as a medical contingent to Joint Task Force Haiti (Operation *New Horizon/Uphold Democracy*).

In August 1999, Robinson reported to the Bureau of Medicine and Surgery (BUMED) as the director of Readiness and was selected as the principal director, Clinical and Program Policy in the Office of the Assistant Secretary of Defense for Health Affairs in September 2000, where he also served as the acting deputy assistant secretary of Defense for Health Affairs, Clinical and Program Policy. Robinson was assigned as commanding officer U.S. Naval Hospital Yokosuka from September 2001 to January 2004, after which he received assignment back to BUMED as deputy chief of BUMED for Medical Support Operations with additional duty as acting chief of the Medical Corps. In July 2004, Robinson reported as commander, National Naval Medical Center, Bethesda, Md. He assumed the duties as commander, Navy Medicine National Capital Area Region in October 2005.

The author of numerous presentations and publications, Robinson holds fellowships in the American College of Surgeons and the American Society of Colon and Rectal Surgery. He is a member of the Le Societe Internationale de Chirurgie, the Society of Black Academic Surgeons, and the National Business School Scholastic Society, Beta Gamma Sigma. He holds certification as a certified physician executive from the American College of Physician Executives.

Robinson's personal decorations include the Distinguished Service Medal (two awards), Legion of Merit (two awards), Defense Meritorious Service Medal (two awards), Meritorious Service Medal (three awards), Navy Commendation Medal, Joint Service Achievement Medal, Navy Achievement Medal and various service and campaign awards.

United States Air Force

Testimony

Before the House Armed Services Committee, Subcommittee on Military Personnel

Military Health System Overview and Defense Health Program Cost Efficiencies

Statement of
Lieutenant General (Dr.) Charles B. Green
The Surgeon General of the Air Force

March 15, 2011

Mister Chairman and distinguished members of the Committee, thank you for this opportunity to appear before you today, representing the Air Force Medical Service and our nearly 59,000 Total Force medics. I look forward to working with you again this year to achieve mutual goals in support of our military members and their families. We appreciate your immeasurable contributions to the success of our mission.

Military Health System achievements have changed the face of war. We deploy and set up hospitals in 12 hours of arrival almost anywhere in the world. We move wounded warriors from the battlefield to an operating room within minutes and have achieved and sustained less than 10 percent died-of-wounds rate. We move our sickest patients in less than 24 hours of injury and get them home to loved ones within 3 days to hasten recovery. We have safely evacuated more than 86,000 patients since Oct. 2001, 11,300 in 2010 alone, many of them critically injured. This is all pretty amazing.

The Air Force Medical Service (AFMS) has a simple mantra: "Trusted Care Anywhere." This fits what we do today and will continue to do in the years ahead. It means creating a system that can be taken anywhere in the world and be equally as effective whether in war or for humanitarian assistance. This system is linked back to American quality care and refuses to compromise on patient safety. These are formidable challenges, but we have the foundation we need and the best creative minds working with us to achieve this end.

Providing Trusted Care Anywhere requires the AFMS to focus on patients and populations. Patient-centered care builds new possibilities in prevention by linking the patient to a provider team and both patient and provider team to an informatics network dedicated to improving care. Efficient and effective health teams allow recapture of care in our medical

treatment facilities (MTFs) to sustain currency. Continually improving our readiness ensures patients and warfighters always benefit from the latest medical technologies and advancements.

Patient-Centered Medical Home

To improve Air Force primary care and achieve better health outcomes for our patients, we implemented our Family Health Initiative (FHI) in 2009, which is a team-based, patient-centered approach building on the Patient-Centered Medical Home (PCMH) concept established by the American Academy of Family Physicians. We aligned existing resources and now have PCMH at 32 of our MTFs caring for 340,000 enrolled patients. By the end of 2012, 1 million of our beneficiaries will have a single provider and small team of professionals providing their care at all AFMS facilities. This means much greater continuity of care, with our patients seeing the same physician or their professional partner 95 percent of the time. The result is more effective health care based on trust and rapport for both the patient and the provider.

Air Force Medical Home integrates the patient into the health care team, offering aggressive prevention and personalized intervention. Physicians will not just evaluate their patients for disease to provide treatment, but also to identify risk of disease, including genetic, behavioral, environmental and occupational risks. The health care team will encourage healthy lifestyle behavior, and success will be measured by how healthy they keep their patients, rather than by how many treatments they provide. Our goal is that people will live longer lives with less morbidity. We are already seeing how PCMH is bringing that goal to fruition. For example, diabetes management at Hill AFB, Utah, showed an improvement in glycemic control in 77 percent of the diabetic population, slowing progression of the disease and saving over $300 thousand per year.

Patient feedback through our Service Delivery Assessment survey shows an overall improvement in patient satisfaction for patients enrolled in PCMH, with the greatest improvement noted in the ability to see a personal provider when needed. As relationships develop, our providers will increase their availability to patients after hours and through secure patient messaging. This will further enhance patient satisfaction and reduce costs by minimizing emergency department visits.

Our next step is to embark on an innovative personalized medicine project called Patient Centered Precision Care, or PC2, that will draw and build on technological and genetic based advances in academia and industry. Effective, customized care will be guided by patient-specific actionable information and risk estimation derived from robust Health Information Technology applications. We're excited about our collaboration opportunities with renowned partners, such as the Duke Institute for Genome Sciences and Policy, IBM, and others.

Patient-centered care includes caring for Air Force special needs families, and we are working closely with our personnel community to ensure these families receive the specialized medical or educational support they require. The Air Force Exceptional Family Member Program (EFMP) is a collaborative and integrated program that involves medical, family support, and assignment functions to provide seamless care to these families. Enhanced communication of the program will be facilitated by an annual Caring for People Forum at each installation, giving families an opportunity to discuss concerns and receive advice. Starting in FY 2012, the Air Force will begin adding 36 full-time Special Needs Coordinators at 35 medical treatment facilities (MTFs) to address medical concerns and assignment clearance processes.

An important aspect of patient-centered preventive care includes safeguarding the mental health and well-being of our people and improving their resilience, because no one is immune to the stresses and strains of life. While Air Force suicide rates have trended upward since 2007, our rate remains below what we experienced before the inception of our suicide prevention program in 1997. The most common identified stressors and risk factors have remained the same over the last 10 years: relationship, financial and legal problems. Although deployment can stress Airmen and their families, it does not seem to be an individual risk factor for Airmen, and most Airmen who complete suicide have never deployed. We are redoubling our efforts to prevent suicide and specifically target those identified at greatest risk.

We use the Air Force Post-deployment Health Assessment (PDHA) and Post-deployment Health Reassessment (PDHRA) to identify higher risk career groups for post-traumatic stress disorder (PTSD). While most Air Force career fields have a very low rate of PTSD, others such as EOD, security forces, medical, and transportation have higher rates of post traumatic stress symptoms.

Advances in treatment, such as the Virtual Reality Exposure Therapy (VRET) system we call "Virtual Iraq," have been fielded to treat service members returning from theater with PTSD, Traumatic Brain Injury (TBI), and other related mental health disorders. This system is founded on two well established forms of psychotherapy: Cognitive-Behavioral Therapy and Prolonged Exposure Therapy. VRET is now deployed at 10 Air Force mental health clinics and is lauded by patients.

The Air Force provides additional support to our most at-risk Airmen with frontline supervisor's suicide prevention training given to all supervisors in career fields with elevated

suicide rates. Mental health providers are seeing patients in our primary care clinics across the Air Force. They see patients who may not otherwise seek care in a mental health clinic because of perceived stigma. We have significantly expanded counseling services beyond those available through the chaplains and mental health clinic. Other helping programs include Military Family Life Consultants, who see individuals or couples; and Military OneSource, which provides counseling to active duty members off-base for up to 12 sessions.

A recent example of how suicide prevention skills saved a life is the story of how Senior Airman Jourdan Gunterman helped save a friend from halfway around the world in Afghanistan. His training first helped him recognize the warning signs of a friend in trouble: drinking heavily, violent outbursts, disciplinary actions, and recent discharge from the Air Force following a challenging deployment. A cryptic emotional message on Facebook from the friend led Airman Gunterman to question his friend's disturbing behavior. He discovered his friend had ingested a bottle of pills.

When his troubled friend no longer responded, Airman Gunterman obtained the friend's phone number on-line from another friend, Senior Airman Phillip Sneed, in Japan. Airman Sneed promised to keep calling the friend until he picked up. Meanwhile Airman Gunterman enlisted the help of his chaplain to locate the suicidal friend. Finally, locating a hometown news release about his friend, Airman Gunterman was able to learn his friend's parents' names and then used a search engine to find their address. He contacted the local police, who rushed to the friend's house and saved him. Airman Gunterman is an expert with social media -- but more important -- he is an incredible Wingman who saved his buddy's life.

Resiliency is a broad term that describes the set of skills and qualities that enable Airmen to overcome adversity and to learn and grow from experiences. It requires a preventive focus based on what we have learned from individuals who've been through adversity and developed skills to succeed. Distilling those skills and teaching them will lead to a healthier force.

The Air Force uses a targeted resiliency training approach, recognizing different Airmen will be in different risk groups. For those who have higher exposure to battle, we have developed initiatives such as the Deployment Transition Center (DTC) at Ramstein AB, Germany, which opened in July. The DTC provides a two-day reintegration program en route from the war zone, involving chaplain, mental health, and peer facilitators. The DTC provides training, not treatment – the focus is on reintegration into work and family. Feedback from deployers has been overwhelmingly positive.

We teach our Airmen that seeking help is not a sign of weakness, but a sign of strength. Lieutenant Colonel Mary Carlisle is an Air Force nurse who struggled with PTSD following her deployment. She shares her story of how she was able to overcome PTSD by seeking help and treatment. She realized that she would be affected forever, but is now more resilient from her experience and treatment. She shared her story with over 700 of my senior medics at a recent leadership conference. Lt Col Carlisle's openness and leadership are an invitation to others to tell their stories, and in so doing change our culture and shatter the stigma associated with mental health care.

In addition to the Air Force-wide approach, some Air Force communities are pursuing other targeted initiatives. The highly structured program used by Mortuary Affairs at Dover AFB, Delaware, where casualties from OIF and OEF are readied for burial, is now being used as

a model for medics at our hospitals in Bagram, Afghanistan, and Balad, Iraq, where the level of mortality and morbidity are much higher than most medics see at home station MTFs. The Air Force continually seeks to leverage existing "best practice" programs such as Dover's for Air Force-wide use. If we can help our Airmen develop greater resiliency, they will recover more quickly from stresses associated with exposure to traumatic events.

Recapturing Care and Maintaining Currency

Trusted Care means good stewardship of our resources. In an era of competing fiscal demands and highly sought efficiencies, recapturing patients back into our MTFs is critical. Where we have capability, we can provide their care more cost-effectively by managing care in our facilities. Equally important is building the case load and complexity needed to keep our providers' skills current to provide care wherever the Air Force needs them. We have expanded our hospitals and formed partnerships with local universities and hospital systems to best utilize our skilled professionals.

We value our strong academic partnerships with St. Louis University; Wright State University (Ohio); the Universities of Maryland, Mississippi, Nebraska, Nevada, California and Texas, among others. They greatly enrich our knowledge base and training opportunities as well as provide excellent venues for potential resource sharing.

Since the early 1970s, many Air Force Graduate Medical Education (GME) programs have been affiliated with civilian universities. Our affiliations for physician and dental education at partnership sites have evolved to include partnership sponsoring institutions for residencies. In addition, our stand-alone residency programs have agreements for rotations at civilian sites. Our Nurse Education Transition Program (NETP) and Nurse Enlisted Commissioning Program

(NECP) have greatly benefited from academic partnerships. The NETP is available at 11 sites with enrollment steadily increasing, while the NECP enrolls a total of 50 nursing students per year at the nursing school of their choice. A nursing program partnering with Wright State University and Miami Valley College of Nursing in Ohio, and the National Center for Medical Readiness Tactical Laboratory has produced a master's degree in Flight Nursing with Adult Clinical Nurse Specialist in disaster preparedness, a first of its kind in the country.

Our GME programs are second to none. Our first-time pass rates on specialty board exams exceed national rates in 26 of 31 specialty areas. Over the past four years, we've had a 92 percent overall first time board pass rate. I am very proud of this level of quality in our medics and grateful to our civilian partners who help make Air Force GME a success.

Partnerships leveraging our skilled work force prepare us for the future. Our Centers for the Sustainment of Trauma and Readiness (C-STARS) in Baltimore, Cincinnati and St. Louis continue to provide our medics the state-of-the-art training required to treat combat casualties. In 2009 we complemented C-STARS with our Sustainment of Trauma and Resuscitation Program (STARS-P) program, rotating our providers through Level 1 trauma centers to hone their war readiness skills. Partnerships between Travis AFB and University of California at Davis; Nellis AFB and University Medical Center, Nevada; Wright-Patterson AFB and Miami Valley Hospital; Luke AFB and the Scottsdale Health System; MacDill AFB and Tampa General Hospital; and others, are vital to sustaining currency.

Our hospitals, C-STARS and STARS-P locations are enhanced by the Air Force medical modeling and simulation Distributed High-Fidelity Human Patient Simulator (DHPS) program. There are currently 80 programs worldwide and the AFMS is the DoD lead for medical

simulation in healthcare education and training. Over the next year, we will link the entire AFMS using Defense Connect Online and our new Web tele-simulation tool. This will enable all Air Force MTFs to play real time medical war games that simulate patient management and movement from point of injury to a Level 3 facility and back to the States.

Our partnership with the Department of Veterans Affairs (VA) has provided multiple avenues for acquiring service, case mix, and staffing required for enhancing provider currency. Direct sharing agreements, joint ventures and the Joint Incentive Fund (JIF) have all proved to be outstanding venues for currency and collaboration.

A great example is the JIF project between Wright-Patterson Medical Center and the Dayton VA. The expansion of their radiation-oncology program includes a new and promising treatment called stereotactic radio surgery. This surgery, really a specialized technique, allows a very precise delivery of a single high dose of radiation to the tumor without potentially destructive effects to the surrounding tissues. Without a single drop of blood, the tumor and its surrounding blood supply are destroyed, offering the patient the hope of a cure and treatment that has fewer side effects.

In another Air Force/VA success story, Keesler AFB and VA Gulf Coast Veterans Health Care System Centers of Excellence Joint Venture is receiving acclaim. Ongoing clinical integration efforts have shown an increase in specialty clinic referrals. Plans for continued integration are on track, with many departments sharing space and staff by FY 12 and the joint clinic Centers of Excellence in place by FY 13.

Providing a more seamless transition for Airmen from active duty to the VA system remains a priority. This process has been greatly enhanced with the Integrated Disability

Evaluation System (IDES). Expansion of the initial pilot program is occurring by region in four stages, moving west to east, and centered around the VA's Veteran Integrated Service Networks (VISN). Phase 3 of the expansion has added an additional 18 Air Force MTFs for a total of 24. The Services and the VA continue to conduct IDES redesign workshops to further streamline the process to be more timely and efficient for all transitioning Service members. The goal is to provide coverage for all Service members in the IDES by September 2011.

We continue to look for innovative ways and new partnerships to meet our currency needs and provide cutting-edge care to our military family. We will expand partnerships with academic institutions and the VA wherever feasible to build new capabilities in health care and prevent disease.

Continuously Improving Readiness Assets

We have made incredible inroads in our efforts to be light, lean and mobile. Not only have we vastly decreased the time needed to move our wounded patients, we have expanded our capabilities. Based on lessons learned from our humanitarian operations in Indonesia, Haiti and Chile, we developed obstetrics, pediatrics and geriatrics modules that can be added to our Expeditionary Medical System (EMEDS). We simply insert any of these modules without necessarily changing the weight or cube for planning purposes. Medics at Air Combat Command are striving to develop an EMEDS Health Response Team (HRT) capable of seeing the first patient within one hour of arrival and performing the first surgery within 3-5 hours. We will conduct functional tests on the new EMEDS in early 2011.

On the battlefield, Air Force vascular surgeons pioneered new methods of hemorrhage control and blood vessel reconstruction based on years of combat casualty experience at the Air

Force Theater Hospitals in Iraq and Afghanistan. The new techniques include less invasive endovascular methods to control and treat vascular injury as well as refinement of the use of temporary shunts. Their progress has saved limbs and lives and has set new standards, not only for military surgeons, but also for civilian trauma.

A team of medical researchers from the 59th Medical Wing Clinical Research division has developed a subject model that simulates leg injuries seen in Iraq and Afghanistan to enable them to try interventions that save limbs. The team is also studying how severe blood loss affects the ability to save limbs. Their findings show blood flow should be restored within the first hour to avoid muscle and nerve damage vs. traditional protocol that allowed for six hours. Team member and general surgery resident Captain (Dr.) Heather Hancock, stated, "You cannot participate in research designed to help our wounded soldiers and not be changed by the experience."

We are also advancing the science and art of aeromedical evacuation (AE). We recently fielded a device to improve spinal immobilization for AE patients and are working as part of a joint Army and Air Force team to test equipment packages designed to improve ventilation, oxygen, fluid resuscitation, physiological monitoring, hemodynamic monitoring and intervention in critical care air support.

We are finding new ways to use specialized medical equipment for our wounded warriors. In October, we moved a wounded Army soldier with injured lungs from Afghanistan to Germany using Extracorporeal Membrane Oxygenation (ECMO) support through the AE system -- the first time we have used AE ECMO for an adult. The ECMO machine provides cardiac and respiratory support for patients with hearts and/or lungs so severely diseased or

damaged they no longer function. We have many years of experience with moving newborns via the 59th Medical Wing (Wilford Hall) ECMO at Lackland AFB, Texas, but the October mission opened new doors for wounded care.

Another new tool in battlefield medicine is acupuncture. The Air Force acupuncture program, the first of its kind in DoD, has expanded beyond clinic care to provide two formal training programs. Over 40 military physicians have been trained. We recognize the success of acupuncture for patients who are not responding well to traditional pain management. This is one more tool to help our wounded Soldiers and Airmen return to duty more rapidly and reduce pain medication usage.

We've made progress with electronic health records in the Theater Medical Information Program Air Force (TMIP-AF), now used by AE and Air Force Special Operations. TMIP-AF automates and integrates clinical care documentation, medical supplies, equipment and patient movement with in-transit visibility. Critical information is gathered on every patient and entered into our deployed system. Within 24 hours, records are moved and safely stored in our databases stateside.

Established in May 2010 with the Air Force as lead component, the Hearing Center of Excellence (HCE) is located at Wilford Hall in San Antonio. This center continues to work closely with Joint DoD/VA subject matter experts to fine-tune concepts of operation. Together we are moving forward to achieve our goals in the areas of outreach, prevention, care, information management and research to preserve and restore hearing.

DoD otologists have worked internally and with NATO allies to investigate emerging implant technologies and have developed plans to test a central institutional review board (IRB)

in a multi-site, international study to overcome mixed hearing loss. The HCE is also pursuing standardization of minimal baseline audiometric testing and point of entry hearing health education within DoD. They are working with the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to establish evidence-based clinical practice guidelines for management of the post-traumatic patient who suffers from dizziness. The HCE has worked with analysts within the Joint Theater Trauma System to develop the Auditory Injury Module (AIM) to collect auditory injury data within the Joint Theater Trauma Registry (JTTR). These, among others, are critical ways the HCE supports the warfighter in concert with our partners at DCoE and the VA.

All of these advances I've addressed are critical to improving medical readiness, but the most important medical readiness assets are our people. Recruiting and retaining top-notch personnel is challenging. We continue to work closely with our personnel and recruiting partners to achieve mission success. Optimizing monetary incentives, providing specialty training opportunities, and maintaining a good quality of life for our members are all essential facets to maintaining a quality work force.

The AFMS continues to optimize the use of monetary incentives to improve recruiting and retention. We are working with the Air Force personnel and recruiting communities to develop a sustainment model specific for each of the AFMS Corps. Specifically, we are targeting the use of special pays, bonuses, and the Health Professions Scholarship Program (HPSP) to get the greatest return on investment. Congress' support of these programs has helped to maintain a steady state of military trained physicians, dentists, nurses, and mental health professionals.

The new consolidated pay authority for health care professionals allows greater flexibility of special pays to enhance recruitment and retention of selected career fields. While we use accession bonuses to attract fully qualified surgeons, nurses, mental health specialists, and other health professionals to the AFMS, HPSP remains the number one AFMS pipeline for growing our own multiple healthcare professionals.

We were able to execute 100 percent of HPSP in FY09 and FY10 and were able to graduate 219 and 211 new physicians, respectively, in these years. In FY10, 49 medical school graduates from the Uniformed Services University of the Health Sciences also joined the Air Force Medical Service. These service-ready graduates hit the ground running. Specialized military training and familiarity with the DoD health care system ensures more immediate success when they enter the work force. Once we have recruited and trained these personnel, it is essential that we are able to keep them. We are programming multiyear contractual retention bonuses at selectively targeted health care fields such as our physician and dental surgeons, operating room nurses, mental health providers, and other skilled healthcare professions to retain these highly skilled practitioners with years of military and medical expertise.

For our enlisted personnel, targeted Selective Reenlistment Bonuses, combined with continued emphasis on quality of life, generous benefits, and job satisfaction, positively impact enlisted recruiting and retention efforts. Pay is a major component of recruiting and retention success, but we have much more to offer. Opportunities for education, training, and career advancement, coupled with state-of-the art equipment and modern facilities, serve together to provide an excellent quality of life for Air Force medics. Successful and challenging practices remain the best recruiting and retention tool available.

We look 20 to 30 years into the future to understand evolving technologies, changing weapon systems, and changes in doctrine and tactics to protect warfighters from future threats. This ensures we provide our medics with the tools they need to fulfill the mission.

We continue to build state-of-the-art informatics and telemedicine capabilities. Care Point now allows individual providers to leverage our vast information databases to learn new associations and provide better care to patients. These same linkages allow our Applied Clinical Epidemiology Center to link health care teams and patients with best practices. VTCs are now deployed to 85 of our mental health clinics broadening the reach of mental health services, and our teleradiology program provides digital radiology systems interconnecting all Air Force MTFs, enabling diagnosis 24/7/365.

We are engaged in exciting research with the University of Cincinnati to enhance aeromedical evacuation, focusing on the challenges of providing medical care in the darkened, noisy, moving environments of military aircraft. We are studying how the flight environment affects the body, and developing possible treatments to offset those effects. Clinical studies are examining the amount of oxygen required when using an oxygen-concentrating device at higher altitudes. Simulators recreate the aircraft medical environments and are used extensively to train our medical crews. This new research expands our knowledge and training opportunities, and offers the possibility of future partnering efforts.

We are also developing directed energy detection and laser assisted wound healing; advancing diabetes prevention and education; and deploying radio frequency identification technology in health facilities. We partner with multiple academic institutions to advance knowledge and apply evidence based medicine and preventive strategies with precision. These

are some of the critical ways we seek to improve readiness, advance medical knowledge and keep the AFMS on the cutting edge for decades to come.

The Way Ahead

While at war, we are successfully meeting the challenges of Base Realignment and Closure as we draw near to the 2011 deadline. We have successfully converted three inpatient military treatment facilities to ambulatory surgery centers at MacDill AFB, Florida; Scott AFB, Illinois; and the USAF Academy, Colorado. By September of this year, the medical centers at Lackland AFB, Texas; and Andrews AFB, Maryland; are on track to convert to ambulatory surgery centers. The medical center at Keesler AFB, Mississippi, is poised to convert to a community hospital. Medical Groups at McChord AFB, Washington; and Pope AFB, North Carolina have been effectively realigned as Medical Squadrons. Military treatment facilities at Shaw AFB, South Carolina; Eglin AFB, Florida; McGuire AFB, New Jersey; and Elmendorf AFB, Alaska; have been resourced to support the migration of beneficiaries into their catchment areas as a result of BRAC realignments.

At Wright-Patterson AFB, Ohio, we have relocated cutting-edge aerospace technology research, innovation, and training from Brooks AFB. In tandem with our sister Services, we have also relocated basic and specialty enlisted medical training to create the new Medical Education and Training Campus (METC), the largest consolidation of training in DoD history.

Our strategy to control DoD healthcare costs is the right approach to manage the benefit while improving quality and satisfaction. Adjustments to the benefit such as minimally raising TRICARE enrollment fees for working retirees, requiring future enrollees to the U.S. Family Health Plan to transition into TRICARE-for-Life upon turning 65 years of age, paying sole-source community hospitals Medicare rates, and incentivizing the use of the most effective

outlets for prescriptions are prudent. There will be limited impact (prescription only) on Active Duty Family Members. By implementing these important measures we will be able to positively affect the rising costs of healthcare and improve the health of our population.

The AFMS is firmly committed to MHS goals of readiness, better health, better care and best value. We understand the value of teaming and treasure our partnerships with the Army, Navy, VA, academic institutions, and health care innovators. We will continue to deliver nothing less than world-class care to military members and their families, wherever they serve around the globe. They deserve, and can expect, Trusted Care Anywhere. We thank this Committee for your support in helping us to achieve our mission.

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) CHARLES B. GREEN

Lt. Gen. (Dr.) Charles B. Green is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Green serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Green has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,800 people assigned to 75 medical facilities worldwide.

General Green was commissioned through the Health Professions Scholarship Program and entered active duty in 1978 after completing his Doctorate of Medicine degree at the Medical College of Wisconsin in Milwaukee. He completed residency training in family practice at Eglin Regional Hospital, Eglin AFB, Fla., in 1981, and in aerospace medicine at Brooks AFB, Texas, in 1989. He is board certified in aerospace medicine. An expert in disaster relief operations, he planned and led humanitarian relief efforts in the Philippines after the Baguio earthquake in 1990, and in support of Operation Fiery Vigil following the 1991 eruption of Mount Pinatubo.

General Green has served as commander of three hospitals and Wilford Hall Medical Center. As command surgeon for three major commands, he planned joint medical response for operations Desert Thunder and Desert Fox, and oversaw aeromedical evacuation for operations Enduring Freedom and Iraqi Freedom. He has served as Assistant Surgeon General for Health Care Operations and Deputy Surgeon General, prior to his current assignment.

EDUCATION

1974 Bachelor of Science degree in chemistry, University of Wisconsin-Parkside, Kenosha
1978 Doctorate in Medicine and Surgery, Medical College of Wisconsin, Milwaukee
1981 Residency in family practice, Eglin Regional Hospital, Eglin AFB, Fla.
1987 Air Command and Staff College, by seminar
1988 Master's degree in public health, Harvard University, Cambridge, Mass.
1989 Residency in aerospace medicine, Brooks AFB, Texas
2000 Air War College, by correspondence

ASSIGNMENTS

1. June 1978 - July 1981, family practice resident, later, chief resident, Eglin AFB, Fla.
2. July 1981 - August 1984, flight surgeon, U.S. Air Force Hospital, Mather AFB, Calif.
3. August 1984 - September 1985, officer in charge, Family Practice Clinic, Wheeler AFB, Hawaii
4. September 1985 - August 1987, Chief of Clinic Services, Hickam AFB, Hawaii
5. September 1987 - June 1988, student, graduate aerospace medical resident, Harvard University, Cambridge, Mass.
6. June 1988 - July 1989, resident in aerospace medicine, U.S. Air Force School of Aerospace Medicine, Brooks AFB, Texas

7. July 1989 - August 1991, Chief of Aerospace Medicine, and Commander, 657th Tactical Hospital, Clark AB, Philippines
8. September 1991 - August 1993, Commander, 65th Medical Group, Lajes Field, Portugal
9. August 1993 - August 1995, Commander, 366th Medical Group, Mountain Home AFB, Idaho
10. August 1995 - January 1997, Commander, 96th Medical Group, Eglin AFB, Fla.
11. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
12. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command, U.S. Space Command and Air Force Space Command, Peterson AFB, Colo.
13. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
14. July 2003 - July 2005, Commander, 59th Medical Wing, Wilford Hall Medical Center, Lackland AFB, Texas
15. July 2005 - August 2006, Assistant Surgeon General for Health Care Operations, Office of the Surgeon General, Bolling AFB, D.C.
16. August 2006 - August 2009, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, D.C.
17. August 2009 - present, Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C.

SUMMARY OF JOINT ASSIGNMENTS

1. January 1997 - July 1999, Command Surgeon, U.S. Central Command, MacDill AFB, Fla., as a colonel
2. July 1999 - June 2001, Command Surgeon, North American Aerospace Defense Command and U.S. Space Command, Peterson AFB, Colo., as a colonel
3. June 2001 - July 2003, Command Surgeon, U.S. Transportation Command, Scott AFB, Ill., as a brigadier general
4. July 2003 - July 2005, Director, DOD Region 6 (TRICARE South) Lackland AFB, Texas, as a major general

FLIGHT INFORMATION

Rating: Chief flight surgeon
Flight hours: 1,200
Aircraft flown: B-52, C-5, C-9, C-21, C-130, C-141, H-53, KC-135, T-43, F-15, F-16, P-3, T-37, T-38, UH-1 and UH-60

MAJOR AWARDS AND DECORATIONS

Distinguished Service Medal with oak leaf cluster
Defense Superior Service Medal with oak leaf cluster
Legion of Merit
Defense Meritorious Service Medal
Airman's Medal
Meritorious Service Medal with four oak leaf clusters
Joint Service Commendation Medal
Air Force Commendation Medal with two oak leaf clusters
Air Force Achievement Medal
National Defense Service Medal with bronze star
Armed Forces Expeditionary Medal
Humanitarian Service Medal with bronze star
Philippine Bronze Cross

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS

American Medical Association
American College of Physician Executives
Fellow, Aerospace Medical Association
Fellow, American Academy of Family Physicians
Uniformed Services Academy of Family Physicians
Aerospace Medical Association
Society of U.S. Air Force Flight Surgeons (former President)
Air Force Association
Association of Military Surgeons of the United States

EFFECTIVE DATES OF PROMOTION

Captain June 18, 1978
Major May 26, 1984
Lieutenant Colonel May 25, 1990
Colonel May 31, 1994
Brigadier General Aug. 1, 2001
Major General Sept. 1, 2004
Lieutenant General Aug. 3, 2009
(Current as of February 2010)

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

MARCH 15, 2011

RESPONSES TO QUESTIONS SUBMITTED BY DR. HECK

Dr. WOODSON. The contracting authority for the contract is the U.S. Army Medical Research Acquisition Activity; the office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness administers the contract. (The Reserve Health Readiness Program (RHRP) is a Department of Defense (Health Affairs) program developed by Force Health Protection and Readiness, and executed by its contractor, Logistics Health Inc. (LHI).)

Unless the Service Components request new services (for example, mental health assessments) to augment their readiness, we do not plan to modify or re-compete this contract at this time. The Reserve Health Readiness Program (RHRP) contract for medical and dental readiness services was awarded to Logistics Health Inc. in September 2007, after a full and open competition, for a base year and four option years. The contract is currently in its third option year. The fourth option year, if exercised, will conclude at the end of September 2012.

The contract for the five-year period is capped at $790,295,941(the total value of the orders against the contract cannot exceed that amount).

We can and have documented such value added.

According to the most recent data from the Office of the Surgeon, U.S. Army Reserve Command, readiness rates have never been higher. From October 2008 to March 2011, the percentage of Army Reserve soldiers with a current Periodic Health Assessment (PHA) has risen from 45 percent to 88 percent; achieving dental readiness rose from 53 percent to 75 percent; and current immunizations increased from 34 percent to 79 percent. The percent that are medically ready to deploy immediately or within 72 hours has similarly risen from 24 percent to 64 percent.

Overall, the RHRP contract provides a broad array of services in response to requests by the Service Components to assist them in achieving medical readiness. The contract provides the PHA, Post-Deployment Health Reassessment, Mental Health Assessment, dental exam, dental treatment, and other Individual Medical Readiness services that satisfy key deployment requirements and supplement the Services' own efforts. Services are provided at the request of the Reserve Components and implemented per their guidance. The annual dental examinations, annual PHAs, and current immunizations for each Service member are required Department of Defense elements for medical readiness.

For Fiscal Year 2010, RHRP providers addressed approximately 650,000 reservists and guardsmen across all Military Services—conducting 218,000 dental examinations, 255,000 PHAs and 372,000 immunizations. Each of these adds value to medical readiness. [See page 21.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MARCH 15, 2011

QUESTIONS SUBMITTED BY MRS. DAVIS

Mrs. DAVIS. Several of the reserve components continue to see issues with medical readiness of its force. To ensure the readiness of its force, the Air Force National Guard and Reserve requires its personnel to be medically ready or they are not allowed to participate in drill or training exercises. Should this requirement be extended to the Army, Navy and Marine Corps? If not, what efforts should be undertaken to ensure the medical readiness of the reserve component?

Secretary STANLEY. No, not at this time and we do not recommend any change to the current policy. Preventing service members from attending drill or AT may compound the problem. Many commanders use these active duty periods for readiness activities that include medical and dental appointments. There are also certain aspects, such as annual preventive health assessments (PHA), which require members to meet face-to-face with military health providers.

Mrs. DAVIS. If not, what efforts should be undertaken to ensure the medical readiness of the reserve component?

Secretary STANLEY. The instructions may be drafted to ensure members can drill or be placed on orders to complete their medical/dental requirements, but will not drill for training until the issues are resolved.

Reservists may be placed on military orders for the purpose of receiving military medical/dental evaluation, or examination. Reservists receiving medical/dental care during a tour of duty will be voluntarily retained on Active Duty orders to continue treatment. Reservists not on military orders may be placed on invitational travel orders when directed by appropriate military medical authority to receive an examination or evaluation by military medical/dental facilities to meet military requirements. Invitational travel orders may also be issued to those reservists receiving military medical/dental care at military medical treatment facilities for the purpose of medical/dental appointments.

Reserve or Active Duty medical units do not extend, authorize the extension of, or issue military orders, or invitational travel orders. Order issuance or an extension is the responsibility of the commander.

Mrs. DAVIS. Can you explain what impact the current continuing resolutions are having on the Military Health System and on your particular Service?

Dr. WOODSON. While the Department worked vigorously to ensure that such stopgap funding measures would not directly impact patient care, the resolutions create inefficiencies hinder effective planning efforts and exacerbate the operational challenges associated with supporting mission requirements. For example, to limit the level of expenditures during the continuing resolution periods, the MHS undertook several actions including delayed hiring actions, restricted acquisitions, deferred life cycle replacements of medical equipment, and limited supply replacements.

Mrs. DAVIS. Health care costs of the Department continue to grow, and is a concern both to the Department and the Congress. Can you break down for the subcommittee, the cost growth figures over the past ten years? For example, could you determine how much of the health care cost growth is due to the increase in end strength for the Army and Marine Corps over the past several years, vice an increase in health care utilization among the population vice an increase in eligible beneficiaries returning to the system? If so, would you please provide that information to the subcommittee?

Dr. WOODSON. Excluding Overseas Contingency Operation (OCO) funding, health care costs for the Department grew approximately $30 billion from Fiscal Year (FY) 2000 to FY 2010.

Generally speaking, 35 percent of that increase was due to medical inflation; 36 percent was due to congressionally mandated benefits (with TRICARE For Life being the major contributor); 10 percent was due to the higher percentage of retirees and their families who are now using the Military Health System (MHS) as their primary coverage; and 20 percent was due to higher utilization and greater intensity of care among beneficiaries using the MHS.

Over that ten-year period, the number of beneficiaries unrelated to OCO funding has remained relatively stable or slightly declining, so the effect of total population was a small (less than 1 percent) reduction. However, the reduction would have

been greater if the Army and Marine Corps end strength had not increased. Those increases have returned 1 to 2 percent of the population to the overall growth.

Mrs. DAVIS. What are the strategic issues that the subcommittee should be looking at to ensure the success of the military health system?

Dr. WOODSON. The leadership of the Military Health System (MHS) has developed a strategic framework around which we assess our performance across four critical priorities: Readiness, Population Health, Patient Experience and Cost.

For each of these priorities, we have developed a series of specific goals, metrics and measures. At the center of our framework is readiness—our primary mission and obligation. There are two core questions pertaining to this priority: (1) Are the members of the Armed Forces medically ready to engage in combat (or non-combat) operations? (2) Are the medical forces ready to provide the full-spectrum of medical operations worldwide?

Based on our experience this past decade, we believe the answer is "yes" to each of these questions. We recognize that sustaining top performance requires continuous investment in medical research, technology, education and information, modernization and human capital management.

Our other strategic issues—population health, patient experience, and responsibly managing the cost of care—are interdependent priorities. We measure performance against ourselves over time and against leading civilian standards in each of these areas. Fundamentally, we must improve the health of our population in order to better manage costs. Cost control is nearly impossible with a population engaging in unhealthy behaviors, and we are seeking to change behaviors for all 9.6 million of our beneficiaries.

Mrs. DAVIS. Nearly two years after the original protest was filed, the Department recently announced the T3 award in the South, which has been protested again. What efforts is the Department taking to ensure that lessons learned from T3 are not repeated in T4, and can we expect that all of the T3 contracts to be successful resolved before the Department engages in T4?

Dr. WOODSON. Lessons learned are collected and documented in the final phases of the acquisition process. The documented lessons learned from previous acquisitions become key inputs to the planning phase for subsequent acquisitions. In other words, lessons learned from the original T–1 TRICARE contracts influenced the TNEX acquisition strategy which, in turn, influenced the T–3 strategy. Lessons learned from the TNEX acquisition were collected by a consultant contractor through a process that included surveying, interviewing participants and publishing a final report. TMA has hired a consultant contractor to perform an after-action review of the T–3 source selection evaluation process, and may seek a final report comparable to the TNEX product. All of this information and the Government Accountability Office (GAO) decisions will be provided to the T–4 acquisition strategy team. That team will develop an acquisition plan for T–4 that incorporates all the lessons learned and GAO findings. In addition, one of the objectives of the Peer Review process required by OUSD(AT&L)/DPAP policy is to facilitate the sharing of lessons learned and best practices across the Department of Defense. All the T–3 and T–4 acquisitions are subject to the Peer Review process.

The first T–3 contract award for the North region included health care delivery options through March 31, 2015 and the ability to add another calendar year of performance. The South and West regions will include option periods that run through at least March 31, 2017. The re-evaluation of the West will take a minimum of six and half months, but will be accomplished well before the T–3 NORTH contract expires. There should also be ample time to accommodate any directions from the ongoing GAO review of the South region award.

Mrs. DAVIS. Several of the reserve components continue to see issues with medical readiness of its force. To ensure the readiness of its force, the Air Force National Guard and Reserve requires its personnel to be medically ready or they are not allowed to participate in drill or training exercises. Should this requirement be extended to the Army, Navy and Marine Corps?

Dr. WOODSON. No, not at this time and we do not recommend any change to the current policy. Preventing service members from attending drill or AT may compound the problem. Many commanders use these active duty periods for readiness activities that include medical and dental appointments. There are also certain aspects, such as annual preventive health assessments (PHA), which require members to meet face-to-face with military health providers.

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Reserve or Active Duty medical units do not extend, authorize the extension of, or issue military orders, or invitational travel orders. Order issuance or an extension is the responsibility of the commander.

Mrs. DAVIS. Can you explain what impact the current continuing resolutions are having on the Military Health System and on your particular Service?

General SCHOOMAKER. The numerous continuing resolution (CR) extensions caused a general disruption of operations across the command this year. Despite ASD (HA) and OSD (Comptroller) efforts to respond to OMB's numerous data calls to validate Service Medical Department requests for exception apportionment, the temporary, short-term budgets caused activities to defer spending to preserve resources for must-fund bills like payroll. Although clinical service delivery was not compromised at any time, it appears that this behavior did contribute to a slowdown in the growth rate of program improvement required to meet the demands of a larger Army with increased benefits, utilization, and Wounded, Ill, and Injured workload.

CR limitations and associated administrative processes have had the following impact:

- Slowed down program improvements in access initiatives designed to match capacity to escalating demand resulting from increased end strength, rising utilization, benefit enhancement, and increasing level of effort to manage and process Wounded, Ill, and Injured.
- Strained internal compliance with BRAC-directed project milestones and/or validation of BRAC-related "incidental" costs at several locations due to artificial budget execution masking actual conditions.
- Delays in the augmentation of Occupational Health/Industrial Hygiene capability to address previously neglected remote area services for the Army's at-risk civilian workforce.
- Delays in Initial Outfitting and Facility transition of medical treatment facilities generated by extensive investment in MILCON and renewal projects in previous years.
- Delays in implementation of the enhanced, integrated Disability Evaluation System designed to streamline disability processing of separating service men and women.
- Delayed full-scale implementation of the Comprehensive Pain Management Plan.

Mrs. DAVIS. Given the reductions in the Services recruiting and retention budgets, how are you ensuring that we continue to recruit and retain the qualified medical providers that are necessary to support the military health care system?

General SCHOOMAKER. The mission to recruit our military health care providers rests with United States Army Accession Command. To date, we have received no indication of any significant funding constraints placed upon them that would affect recruitment of health care professionals. We have no indication that there will be any reduction in the number of health care recruiters in the field or that the funding to support them will be significantly decreased.

The Office of The Surgeon General is working diligently to maintain the level of funding support for the health professions officer special pays that are critical to the recruiting and retention efforts of the past years. As the Assistant Secretary of Defense for Health Affairs converts the Services programs from the legacy Special Pays to the Consolidated Special Pays, we do not anticipate any support for growth within these pays; however, we believe that in the near term we will be able to maintain the status quo. This includes support for the Health Professions Officer Accession and Retention Bonuses for Clinical Psychologists, Clinical Social Workers, Physician Assistants, and Veterinarians, as well as the Critical Wartime Skills Accession Bonus for Physicians and Dentists.

Mrs. DAVIS. As your Services move toward the Patient-Centered Medical Home (PCMH) concept, how will deployments of providers impact this process? Will PCMH providers need to be civilian or contract providers in order to maintain continuity of care?

General SCHOOMAKER. By limiting the size of our PCMH teams to 3–5 Primary Care Providers and ensuring a variable mix of military, civilian and contract providers, the Army decreases the impact of a military provider's deployment and relies upon the PCMH team to provide the patients with continuity of care. One of the core principles of the PCMH model is to ensure that there is a standardized, consistent and continuous relationship between the patient and the PCMH team which includes the assigned provider as well as the designated support staff. Under this model, providers deploy with the units to which they are assigned, providing Soldiers continuity of care before, during, and after the deployment. The Army does have a number of providers who will deploy with other units and in these situations other providers in the PCMH provide coverage during the deployment.

Mrs. DAVIS. Where are [we] on the transition and closure of Walter Reed, and is the Army, Navy, and the Joint Task Force on National Capitol Region Medical (JTF CAPMED) prepared to ensure an orderly transition by September of this year?

General SCHOOMAKER. The majority of the medical Base Closure and Realignment (BRAC) construction at both the Bethesda and Fort Belvoir sites is complete. Current progress indicates that they will be finished in time to transition patients and clinical functions from Walter Reed Army Medical Center (WRAMC) by September 15, 2011. The Army, JTF CapMed, and the other Services are working together to ensure an orderly transition. Patient care and patient safety remain the top priorities related to the move and all stakeholders continue to pay close attention to the timeliness and milestones necessary to achieve the final moves.

Mrs. DAVIS. The U.S. Olympic Committee's Paralympic Military Program provides our wounded warriors the ability to compete in several adaptive sports. However, I understand that funding challenges may affect the future of this program. What efforts, if any, are the Services taking to ensure that such opportunities continue for our wounded warriors?

General SCHOOMAKER. The Army leverages the U.S. Olympic Committee's (USOC) Paralympics' Military Program as a critical complement in our efforts to improve the quality of life of our injured Soldiers while they are on active duty and during their transition to civilian life. The Army is addressing the future funding challenge by pursuing funding through the Defense Health Program for Adaptive Non-Clinical Reconditioning Activities (ANCRA). ANCRA includes Warrior Games participation and associated costs, pre-Warrior Games clinics and training camps, adaptive adventure training, the Army Center for Enhanced Performance (ACEP) trainers, and adaptive equipment. The goal is to instill ANCRA into the warrior care rehabilitation process.

Mrs. DAVIS. The Integrated Disability Evaluation System (IDES) started as a pilot program, and has recently been expanded across the country. While the program goals are to reduce the time wounded warriors spend going through the disability process, I understand that timelines have actually increased. What are the challenges each of your medical systems have been seeing as the IDES program has been implemented? What improvements have been made under the program? What challenges still remain under the program?

General SCHOOMAKER. The Army population that requires entrance to the physical disability evaluation system continues to grow and challenge our capacity to process them in a timely manner. The Army continues to take the necessary steps to address the challenges of the IDES program and has implemented numerous practices and process improvements to improve physical disability evaluation processing times. These improvements include: the development and implementation of a new IDES Narrative Summary format; implementation of the Medical Evaluation Board (MEB) processing guidance to standardize the MEB processes; assignment of dedicated MEB Physicians; improving staffing shortages; the implementation of the electronic Medical Board (eMEB) in July 2010; and the development of the IDES Implementation Plan that requires Senior Commanders play a central role in certifying that a IDES site is fully resourced, staffed, trained and ready to meet processing standards prior to Initial Operating Capability date. The major challenge is that the disability evaluation system remains complex.

Mrs. DAVIS. Can you explain what impact the current continuing resolutions are having on the Military Health System and on your particular Service?

Admiral ROBINSON. We continue to face challenges associated with operating under a potential continuing resolution for the remainder of the year, particularly in the areas of provider contracts and funding for facility special projects. The Defense Health Program (DHP) has taken specific actions as a result of the continuing resolution including: reducing the number of hours for patient care provider contracts; limiting medical facilities sustainment/maintenance contracts to only "life safety" implications; deferring life cycle replacement of medical equipment; maximizing utilization of existing inventory of supplies and medicines; and limiting

quantity of replacement pharmaceuticals. We continue to work with ASD (HA) to mitigate adverse effect on the quality and timeliness of healthcare provided to military members, retirees, and their families.

Mrs. DAVIS. Given the reductions in the Services recruiting and retention budgets, how are you ensuring that we continue to recruit and retain the qualified medical providers that are necessary to support the military health care system?

Admiral ROBINSON. Navy active duty (AC) medical recruiting has been successful in attaining overall accession goal in FY09 and FY10, and retention has been relatively stable across all health professions. Recruiting is projected to meet most FY11 goals for active component Medical Corps officers; however, direct accession physicians and dentists present challenges. Recruiting medical and dental students for the Health Professions Scholarship Program (HPSP) is the most vital contributor to Navy physician and dentist inventory, accounting for more than 80 percent of active duty accessions into the Medical and Dental Corps. Medical and dental HPSP accessions have been successful over the past two years due, in large part, to a $20,000 signing bonus.

Targeted special and incentive pays and bonuses are offered at critical career points to incentivize retention behavior. Medical Special and Incentive pays are critical to maintaining Navy Medicine professional inventory—doctors, dentists, nurses, psychiatrists, clinical social workers, and other providers.

Direct appointment recruiting of physicians and dentists for both active and reserve forces remains a challenge, primarily because these healthcare professionals have well-established medical practices and are very well compensated in the civilian market. Interrupting their civilian medical careers is often personally and financially unattractive to many private medical providers. In the case of both AC and RC Physician and Dentist recruiting, a credible recruiting bonus is critical to attracting these professionals.

We continue to evaluate the financial incentives within budgetary constraints to target specific communities that are, and will remain, critical to our mission.

Mrs. DAVIS. As your Services move toward the Patient-Centered Medical Home (PCMH) concept, how will deployments of providers impact this process? Will PCMH providers need to be civilian or contract providers in order to maintain continuity of care?

Admiral ROBINSON. As Navy continues to implement the Patient-Centered Medical Home (PCMH) model, we are seeking to structure the teams in a way that sustains deployment of military providers in support of operational commitments, while ensuring continuity of care for Navy beneficiaries assigned to the PCMH team.

Navy's approach has been to build PCMH teams that have both military and civilian (civil service and contract) assets integrated. Ideally, 50 percent of staffing on a Navy PCMH team is civilian, ensuring stability within the team that can withstand deployments, supports continuity while providing patient and family-centered care.

When an active duty PCMH provider deploys, Navy Medical Treatment Facilities (MTFs) are encouraged to use a strategy successfully applied at other sites. A contract provider is hired to cover the deployed provider's panel of patients (in a locum tenens type arrangement) and works within the PCMH team during the provider's absence. This allows the patient to keep the same primary care manager (PCM) during the deployment, but have identified coverage during their PCM's absence; patients can be notified of their PCM's pending deployment, length of absence and the provider providing temporary coverage using blast secure patient messaging.

When the deployed provider returns to the MTF, patient's can once again be notified regarding their pending return using secure messaging; the contract provider can then be utilized elsewhere in the MTF to cover another provider's practice while they deploy.

Mrs. DAVIS. Where are [we] on the transition and closure of Walter Reed, and is the Army, Navy, and the Joint Task Force on National Capitol Region Medical (JTF CAPMED) prepared to ensure an orderly transition by September of this year?

Admiral ROBINSON. Navy is committed to the successful transition of the new Walter Reed National Military Medical Center (WRNMMC) onboard the campus of the National Naval Medical Center, Bethesda. This realignment is significant and we are working diligently with DoD's lead activity, Joint Task Force Medical—National Capital Region, NSA Bethesda and WRAMC staff to ensure we are on track to meet the Base Realignment and Closure (BRAC) deadline of 15 September 2011.

Mrs. DAVIS. The U.S. Olympic Committee's Paralympic Military Program provides our wounded warriors the ability to compete in several adaptive sports. However, I understand that funding challenges may affect the future of this program. What efforts, if any, are the Services taking to ensure that such opportunities continue for our wounded warriors?

Admiral ROBINSON. All Service components collaborate with organizations outside the United States Olympic Committee (USOC), including Paralyzed Veterans of America, Challenged Athletes Foundation, Team Semper Fi (which supports Sailors, as well as Marines), Disabled Sports USA and the Lakeshore Foundation. These, along with numerous other adaptive sports organizations, offer competition opportunities and training in adaptive athletics for wounded warriors. Additionally, Navy Safe Harbor has appointed an Adaptive Athletic Program Manager and Headquarters Transition Coordinator, to include adaptive athletics opportunities in the rehabilitation plans of Sailors. In FY11, Safe Harbor has executed two adaptive athletic training camps at Naval Base Port Hueneme, CA.

Mrs. DAVIS. The Integrated Disability Evaluation System (IDES) started as a pilot program, and has recently been expanded across the country. While the program goals are to reduce the time wounded warriors spend going through the disability process, I understand that timelines have actually increased. What are the challenges each of your medical systems have been seeing as the IDES program has been implemented? What improvements have been made under the program? What challenges still remain under the program?

Admiral ROBINSON. The IDES process is achieving the primary goals that were intended when this process was designed in 2007. Most notable of these goals is that our Sailors and Marines receive both their post–service military *and* Veterans Administration benefits on the first day authorized by law. This eliminates the "benefits gap" experienced under the previous DES system. To achieve this significant benefit, the IDES process has the secondary impact of keeping our service members in uniform for a longer period of time. This is a concern because the length of time needed to process cases has direct proportional adverse impact on the services' readiness for their military mission. Those in the IDES spend longer in uniform which, for any given end-strength, reduces the number of active duty available for unrestricted assignment. Therefore, in the near term a principle focus must be on reducing the amount of time consumed by the process itself without debasing what we do for our Wounded, Ill and Injured (WII) service members.

The simplest and most direct means of monitoring the IDES process is through the observation of case flow—the time service members' cases spend transiting the IDES' waypoints. Tracking and evaluating process time brings clarity for resourcing decisions and process improvements. To this end, based on a review of data from IDES operations over the past six months (period ending March 31, 2011), we would like to reduce the average time taken by the Medical Evaluation Board (MEB) Phase of the IDES by approximately 100 days. However, since some of the processing events occurring within this phase are controlled by the Military Treatment Facilities (MTFs) and some are controlled by the Veterans Administration, reducing the average MEB Phase time requires both Departments to ensure resources and internal processes are aligned to support timeliness goal.

To significantly reduce the overall processing time, Navy Medicine has implemented four main improvement initiatives. Navy Medicine has highlighted MTF MEB timeliness as a Strategic Goal, providing increased awareness by reviewing monthly metrics. Development of a SharePoint tool will allow for enhanced program management of data between the MTF and Veterans Tracking Application data. Thorough evaluation of MTF business practices and throughput has allowed for identification for appropriate resourcing to address areas of need. Additionally, innovations to leverage existing programs, technologies, and resources are ongoing, such as the use of Armed Forces Health Longitudinal Technology Application (AHLTA) electronic medical record vice narrative summaries. Finally, the Department of the Navy has recommended specific changes to "remodel" the IDES. This IDES Remodel allows us to keep what is good about the current IDES process while making needed improvements and renovations. The recommended IDES Remodel can be implemented under current laws, avoids any post-service benefit gap, maintains the service member's due process rights and can be completed in significantly less time required by the current IDES process. This remodel is currently under review by both DoD and the VA for possible near-term implementation. By seizing process design change opportunities, properly resourcing the processes we decide to deploy and better leveraging existing capabilities, both the WII service member and readiness for our military mission will benefit.

Mrs. DAVIS. Can you explain what impact the current continuing resolutions are having on the Military Health System and on your particular Service?

General GREEN. Contracting: The Air Force Medical Service (AFMS) is holding $62M in contracting actions until we have an approved budget. The more we delay passing an appropriations act, the more pressure and undue burden is placed on the Air Force Base Contracting Office to get the contracting documents processed once a full budget is received.

Restoration and Modernization (R&M): The AFMS programmed $61.4M for R&M projects. Under the numerous FY11 Continuing Resolutions (CRs), the AFMS has only released $34M for emergency military treatment facility repairs or time sensitive facility renovation. Additionally, the AFMS has approximately $120M in estimated R&M projects that still need to be completed. If full year funding is not received in FY11, the AFMS will be forced to put R&M projects at risk to fund higher priority issues. Withheld R&M funds will be used to offset lack of funding for patient care and other urgent bills. If CRs continue, the AFMS may not be able to fund R&M in FY11. The lack of FY11 funding will simply push the requirement into FY12 at a potentially higher cost.

Medical Equipment: The AFMS has minimized medical equipment purchases to emergency items only during the numerous CRs. AFMS programmed $75M and have currently only funded $2M for emergency equipment buys to prevent mission stoppage and prevent patient safety issues.

Administrative: The numerous CRs place an exorbitant amount of extra work to process documents. It is comparable to having six fiscal year closeouts in one year.

Mrs. DAVIS. Given the reductions in the Services recruiting and retention budgets, how are you ensuring that we continue to recruit and retain the qualified medical providers that are necessary to support the military health care system?

General GREEN. Reductions in the recruiting and retention budgets for the Services add to a challenging environment for accessing and retaining health care professionals. Air Force (AF) recruiting is limited by many of the same shortages the Nation faces in health care professions such as: nursing, general surgery, family practice, psychology, and oral maxillofacial surgery. Our recruiting difficulties lie in accessing fully qualified professionals, not our training pipelines. We face keen competition for fully qualified specialists from the private sector and other Federal agencies where multiple deployments are not an issue, such as the Department of Veterans Affairs hospitals and the Public Health Service. Also, there are significant pay disparities between military and private sector employers, especially those surgical specialties crucial for wartime support. These disparities hinder our ability to retain experienced providers. The changing demographics of health professions with increased numbers of women entering the profession, who may be less inclined to choose military service, provide a challenging environment in which to recruit. Additionally, current data suggests less than 7 percent of eligible graduates consider entering military service.

Using feedback from exit interviews and informal counseling as well as our experiences with various incentives, the Air Force Medical Service (AFMS) confronts the recruiting and retention challenges in a three-pronged approach addressing: (1) education, (2) compensation, and (3) quality of life.

(1) Education: Due to historical difficulties recruiting fully qualified specialists, the AFMS deliberately places increased emphasis and funding into educational scholarship opportunities rather than continually focusing on a manpower intensive program that has shown only moderate success. With this change, we have found great success in "growing our own," either through the scholarship programs or through training in the Uniformed Services University of Health Sciences (USUHS). Historically the highest retention occurs when we control the educational environment and service obligations associated with these advanced training programs. The Health Professions Scholarship Program (HPSP) is a resounding success with over 1,400 students currently enrolled, projected to be 1,568 by the end of this fiscal year. As reflected in the DOD budget for FY13, AF has a programmed budget to support an ultimate increase to 1,666 students. We have also optimized our enlisted commissioning programs, such as the InterService Physician Assistant Program (37 graduates per year) and the Nurse Enlisted Commissioning Program (50 graduates per year). Additionally, the AF receives small numbers of new health professionals through other training venues, such as the Airman Education Commissioning Program, Reserve Officer Training Corps, and United States Air Force Academy. The Nurse Transition Program is a robust recruiting tool. It provides an incentive for new graduates to consider AF nursing as a career option upon graduation. However, there are various limitations with our training programs. As a result of fiscal guidance from AF and Congress, under Section 2124 of Title 10, HPSP enrollment DoD-wide is capped at 6000 students. USUHS programs have physical constraints of the facility and academic accreditation constraints of oversight committees. Third, enlisted commissioning programs are constrained by the number of training-years programmed and funding against all enlisted training. Even with these limitations, education has proven the most successful avenue of accession and retention of health professionals.

(2) We also seek to entice fully qualified specialists into the AF and retain them through competitive compensation using accession bonuses and other financial incentives. Under the auspices of Health Affairs, the AF has funded accession bonuses and incentive pays to target fully qualified specialists in selected areas. For FY11, the AF has sufficiently budgeted $13M towards accession bonuses for personnel in fully qualified critical specialties based on historical rates of accession. Historically, as outlined in the first paragraph and under section (1), above, our physician and dental specialist accession bonuses have been of limited success due in part to statutory bonus restrictions, as section 301d and 301e of Title 37 are mutually exclusive of section 302k and 302l of Title 37. Because these accession bonuses cannot be taken with a multiyear special pay, only 2 of 22 fully qualified physicians entering in FY10 took the accession bonus. Our dental officer recruiting had limited success with 10 of 14 fully qualified dentists accessed in FY10; however, none of them took the accession bonus due to the statutory restrictions. In contrast, with new accession bonuses and incentive pays, our nursing program had great success with 296 selected out of 290 requirements. Overall, we have found compensation helps, but does not entirely ease the burden of multiple deployments. As we migrate our compensation portfolio under the new pay authority of section 335 of Title 37, we will be able to initiate specialty pays for the mental health care providers and other critical wartime or shortage specialties that previously were excluded from accession and incentive pays. We feel this move will be of great benefit to the Air Force and military health care in general, allowing targeted accession bonuses, incentive pays, and retention bonuses to address the manning shortages in the health professions. Due to the complexity of medical specialty and incentive pays and entitlements, the scheduled migration of these contractual agreements under the Assistant Secretary of Defense, Health Affairs, will take time to fully implement. In general, recruiting success of many fully qualified specialists without accessions bonuses is extremely limited.

(3) Finally, no recruit enters, and few medical providers stay in the military, without discussing quality of life issues, whether this is family services, medical practice, educational or leadership opportunities, or frequency of moves and deployments. We address many of these issues amongst the AF agencies. Ongoing AFMS projects include the Family Health Initiative, which is a medical model that better leverages our personnel. In addition, we are building force sustainment models in collaboration with AF Manpower and Personnel, evaluating promotion opportunities, and developing a more proactive approach to provide additional opportunities for advancement. In specialties with increasing wartime deployments, we are better able to distribute the deployment requirements more evenly among our members. Restructuring of our medical groups and the deliberate force development of our personnel allow increased opportunities for all health professions to become leaders in the AF.

We remain committed to providing the best in health care for our Nation' s military and their family members through enhanced recruiting and retention efforts maximizing the tools provided for education, compensation and creative quality of life efforts of new health professionals.

Mrs. DAVIS. As your Services move toward the Patient-Centered Medical Home (PCMH) concept, how will deployments of providers impact this process? Will PCMH providers need to be civilian or contract providers in order to maintain continuity of care?

General GREEN. PCMH providers do not need to be civilian. In the Air Force Medical Service most of the PCMH providers are active duty and roughly 10% of these providers are deployed at any given time. In the past year, we have averaged 32 family physicians deployed, with overlap of rotations transiently raising this level as high as 40–45 for periods of 1–2 months. With a current workforce of 299 family physicians in clinical billets, this is over a 10 percent loss of family physicians. This loss is compounded by the fact that our current fill rate for active duty family physician billets is 78.6 percent.

Hiring of replacements for these deployed providers with overseas contingency operations (OCO) funding has met with varied success depending on location. At locations where hiring has occurred, the impact on PCMH has been lessened. The presence of these civilian providers who fill in for the deployed provider decreases the impact, but there is still an impact on continuity. At locations where hiring has not occurred, these deployments cause not only loss of continuity, but also some diminution in access to care.

While the use of civilian and contract providers in Air Force military treatment facilities (MTFs) is and will continue to occur, we have a large number of Air Force

MTFs in locations where hiring of quality civilian providers has consistently been difficult. As such, we will continue to balance the use of active duty providers in addition to civilian and contract providers.

Mrs. DAVIS. The U.S. Olympic Committee's Paralympic Military Program provides our wounded warriors the ability to compete in several adaptive sports. However, I understand that funding challenges may affect the future of this program. What efforts, if any, are the Services taking to ensure that such opportunities continue for our wounded warriors?

General GREEN. We budgeted approximately $85K to support the 2011 Warrior Games to cover coaching support and travel expenses for our athletes attending the two Air Force training camps.

With the help of OSD, we have funded adaptive equipment for archery, track and field, aquatic lifts for swimming pools, basketball, volleyball, and a variety of cardio equipment for our wounded warriors and customers with disabilities. In addition, we send 20 Air Force personnel each year to Penn State University to received training on inclusive recreation. Penn State University provides them with fundamental skills sets which allow them to offer programs and services to meet the needs of Air Force community members with disabilities. We will continue to support programs serving our wounded warriors.

Mrs. DAVIS. The Integrated Disability Evaluation System (IDES) started as a pilot program, and has recently been expanded across the country. While the program goals are to reduce the time wounded warriors spend going through the disability process, I understand that timelines have actually increased.

General GREEN. The legacy Disability Evaluation System (DES) which includes a separate Department of Defense (DoD) and Veterans Affairs (VA) process, takes ~500 days to completely process a service member's case through the DES. The estimated timeline for processing cases within the IDES is ~295 days however, the Air Force is currently processing cases within 340 days; a 160 day improvement from the legacy DES. While the IDES timeline has drastically decreased to less than a year, the AF is committed to continue and improve the IDES process. We expect the timeline for the IDES process to continue to decrease as we implement "lessons learned" from the other sites during the rollout process.

Mrs. DAVIS. What are the challenges each of your medical systems have been seeing as the IDES program has been implemented?

General GREEN. Within the Air Force Medical Service (AFMS), the greatest challenge is completing the Medical Evaluation Board (MEB) package that is ultimately submitted to the Informal Physical Evaluation Board (IPEB). There are several variables affecting the completion of the MEB package. They are:

- Completion of the Compensation and Pension (C&P) examination from the VA: Predominantly, these exams are complete, but there are instances when a health condition has not been thoroughly evaluated and/or another condition is identified requiring further examination before the MEB Narrative Summary (NARSUM) can be written.
- Military Treatment Facility (MTF): Continuity of care is sometimes a challenge. For example, if a physician deploys or changes duty stations before completing a NARSUM, a new physician must be assigned the case and allowed time to become familiar with the medical history before writing the NARSUM.
- Unit Commander: The MEB package must include input from the Airman's unit commander. The Commander's letter provides the IPEB with insight on the Airman's health condition such as, how it affects his or her ability to perform duties, and the impact on the distribution of workload within the unit. If the Commander's input is not received in a timely manner, the Physical Evaluation Board Liaison Officer (PEBLO) must track it down before forwarding the MEB package.
- Line of Duty (LOD) determinations: For Reserve Component members, the health conditions that caused the MEB referral must be accompanied by a LOD determination to determine if the injury or illness was incurred in the LOD and was not as a result of negligence or misconduct. Delays in completing the LOD determination will inadvertently delay the MEB package.

Mrs. DAVIS. What improvements have been made under the program?

General GREEN. Within the AFMS, PEBLOs are being encouraged to be more proactive in securing the NARSUM from military physicians and to engage the Medical Director's for assistance before the MEB becomes late. For MTFs with increasing MEB workload, additional PEBLOs are being hired or other assigned personnel from within the MTF are being directed to assist with case management and/or administrative requirements. Additionally a comprehensive training website is already available for the PEBLOs. The website includes MEB guidance, training slides, and

other tools. Lastly, training for physicians involved in the MEB process has also been developed. Physicians may access pertinent information under the AFMOA SGH Link on the Knowledge Exchange, which is a separate location from the PEBLOs.

Mrs. DAVIS. What challenges still remain under the program?

General GREEN. The main challenge is the time it takes to process Airmen through the IDES. Although the IDES has drastically improved its timeline, the overall IDES process remains cumbersome and lengthy. To improve the overall IDES process, OSD (P&R) directed a working group comprised of all the Services, in collaboration with the VA, to focus on reducing the IDES timelines. Other improvement objectives are to properly resource activities and better leverage existing capabilities to ensure Airmen with service-incurred or service-aggravated disabilities are expeditiously processed through the IDES.

Mrs. DAVIS. Your testimony indicates that the Air Force will begin to add 36 full-time Special Needs Coordinators at 35 medical treatment facilities to assist families with a special needs child. Since these coordinators are not expected to be brought on-board until October of this year, what is currently in place to assist families with special needs?

General GREEN. There are currently Special Needs Coordinators appointed by the Medical Treatment Facility (MTF) Commanders at each MTF available to assist sponsors and special needs family members. These have traditionally been Mental Health officers who performed this role as an additional duty. Given the increased demands now seen for Mental Health, Air Force (AF) determined additional manning is needed to provide dedicated support to uniformed personnel who have a special needs child or spouse. Additionally, AF is incorporating the use of existing Health Care Integrators, Case Managers or Utilization Managers to provide specific support to families with special needs until the new coordinator being brought on board is in place and to provide support at those installations that will not receive a full-time Special Needs Coordinator.

QUESTIONS SUBMITTED BY DR. HECK

Dr. HECK. Who is the formal approving authority for the LHI Contract?

Dr. WOODSON. The contracting authority for the contract is the U.S. Army Medical Research Acquisition Activity; the office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness administers the contract. The Reserve Health Readiness Program (RHRP) is a Department of Defense (Health Affairs) program developed by Force Health Protection and Readiness, and executed by its contractor, Logistics Health Inc. (LHI).

Dr. HECK. Is the Army considering any other options or modifications to the contract?

Dr. WOODSON. No. Unless the Service Components request new services (for example, mental health assessments) to augment their readiness, we do not plan to modify or re-compete this contract at this time. The Reserve Health Readiness Program (RHRP) contract for medical and dental readiness services was awarded to Logistics Health Inc. in September 2007, after a full and open competition, for a base year and four option years. The contract is currently in its third option year. The fourth option year, if exercised, will conclude at the end of September 2012.

Dr. HECK. What is the overall cost of the contract?

Dr. WOODSON. The contract for the five-year period is capped at $790,295,941 (the total value of the orders against the contract cannot exceed that amount).

Dr. HECK. How can we document whether or not the LHI contract has provided any value added service to our medical readiness?

Dr. WOODSON. According to the most recent data from the Office of the Surgeon, U.S. Army Reserve Command, readiness rates have never been higher. From October 2008 to March 2011, the percentage of Army Reserve soldiers with a current Periodic Health Assessment (PHA) has risen from 45 percent to 88 percent; achieving dental readiness rose from 53 percent to 75 percent; and current immunizations increased from 34 percent to 79 percent. The percent that are medically ready to deploy immediately or within 72 hours has similarly risen from 24 percent to 64 percent.

The Reserve Health Readiness Program (RHRP) contract provides a broad array of services in response to requests by the Service Components to assist them in achieving medical readiness. The contract provides the Periodic Health Assessment (PHA), Post-Deployment Health Reassessment, Mental Health Assessment, dental exam, dental treatment, and other Individual Medical Readiness services that satisfy key deployment requirements and supplement the Services' own efforts. Serv-

ices are provided at the request of the Reserve Components and implemented per their guidance. The annual dental examinations, annual PHAs, and current immunizations for each Service member are required Department of Defense elements for medical readiness. For Fiscal Year 2010, RHRP providers addressed approximately 650,000 reservists and guardsmen across all Military Services, conducting 218,000 dental examinations, 255,000 PHAs, and 372,000 immunizations. Each of these adds value to medical readiness.

The Army Reserve leadership uses the RHRP almost exclusively for its medical readiness services. According to the most recent data from the Office of the Surgeon, U.S. Army Reserve Command, its readiness numbers have never been higher. From October 2008 to March 2011, the percentage of Army Reserve soldiers with a current PHA has risen from 45 percent to 88 percent, achieving dental readiness rose from 53 percent to 75 percent, and current immunizations increased from 34 percent to 79 percent. The percent that are medically ready to deploy immediately or within 72 hours has similarly risen from 24 percent to 64 percent.