

DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2008

WEDNESDAY, MARCH 7, 2007

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:10 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Mikulski, Murray, Stevens, Bond, and Shelby.

DEPARTMENT OF DEFENSE

MEDICAL HEALTH PROGRAMS

STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY, SURGEON GENERAL, DEPARTMENT OF THE ARMY

OPENING STATEMENT OF SENATOR DANIEL K. INOUE

Senator INOUE. I would like to welcome all the witnesses today as we review the Department of Defense (DOD) medical programs. There will be two panels this morning. First we will hear from the service Surgeon Generals, General Roudebush, Admiral Arthur, and General Kiley. Next we will hear from our Chiefs of Nurse Corps, General Melissa A. Rank, Admiral Christine Bruzek-Kohler, and General Gale Pollock.

We are all witnesses to the amazing advances in modern medicine which not only affect the daily lives of everyone in this room but also the impacts of lifesaving measures for our Armed Forces serving in harm's way.

One of the true unsung heroes in this effort is the military medic. He or she is on the front lines every day, making critical decisions and delivering immediate medical care that determines the fate of our service members.

So much has changed for the medic since I served in the military, yet the one thing that remains constant on the battlefields is the call for a medic from a wounded service member. Medics often endure the same hardships as the front line infantry soldier.

When the Rangers came ashore on D-Day, their medics were right there, treating them on the beach. Seven of them were killed and another 25 wounded on that day. During World War II, medics worked miracles with few supplies. They had bandages, tourniquets, sulfa powder, and morphine.

Medics played an equally critical role in both Korea and Vietnam. With the arrival of the mobile army surgical hospitals, military medicine was able to advance many of the lifesaving measures applied by the medic on the battlefield, but the tools of the medic's trade had not changed substantially.

The global war on terrorism continues to utilize the critical skills of the medic, but today their tools contain advanced therapy and bandages to stop bleeding that once was considered uncontrollable. They also prevent the deadly effect of shock with the ability to warm injured shoulders far forward in the theater.

With their tools, tourniquets, techniques, and skills, our medics have achieved groundbreaking results. Never before in our history has combat mortality been so low. I believe it's 0.25 now, whereas it used to be 2.5 in World War II. I was one of the lucky ones to leave after suffering serious injury, but today service members are surviving much worse injuries.

However, this means many more of our service members are returning home with significant injuries. Not only can these injuries take many months to recover, but we have yet to fully comprehend and diagnose the long-term effects of certain injuries such as traumatic brain injury or post-traumatic stress.

Our challenge is to respond to these new challenges and realities. How we handle, treat, communicate, and house our service members and their families should be of the utmost importance to all of us. After everything they have gone through and continue to endure, our Government must ensure we are doing everything possible on their behalf.

As recently exposed in the press, there is an area we have not addressed adequately. It now requires our complete attention and scrutiny. It affects both the Department of Defense and the Veterans Administration (VA), and it is not just a matter of medical care.

We must recognize the changing indications of our service members surviving life-threatening injuries and the fact that many of them have the utmost desire to return to active duty. This process must not be rushed, but handled with appropriate manner and timeframe, with constant communication to the service members and their families.

I look forward to the findings and recommendations from the task force established by Secretary Gates, and working with the Department to ensure the necessary resources are provided for this effort. But as one member I express my hope that it not be a finger-pointing exercise, or we should not be looking just for sacrificial lambs. I hope it will be something meaningful.

And so, with that, I hope that the many issues related to the Department of Defense medical programs will be addressed this day. I look forward to your statements. I would like to welcome you all once again, and I now call upon our first witness, General Kiley.

General KILEY. Thank you, Mr. Chairman, Senator Stevens, and distinguished members of the subcommittee.

Senator INOUE. Before we proceed, do you have any statement. Excuse me, sir.

STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. I would just repeat your statement, sir. I second everything you said, and welcome the Surgeon Generals and the Chiefs of the Nursing Corps. I look forward to working with you to try and fix some of these challenges that you have mentioned. Thank you very much.

Senator INOUE. Senator Shelby.

STATEMENT OF SENATOR RICHARD C. SHELBY

Senator SHELBY. Mr. Chairman, I'll be short. I'll be short here.

Over the last 2 weeks, along with the rest of the country, I've been shocked to learn about the appalling and unacceptable conditions in which some wounded war veterans are living at Walter Reed Army Medical Center. I think that how well we care for our wounded service members when they return home from war in itself has profound moral implications.

Does this instance show that we're failing to meet our most basic obligations to those who fight our battles? I believe that we all agree that our service members, in particular our combat veterans, deserve the best facilities and care in the world. Reports that our war injured are recuperating in substandard housing have shed light on a massive failure which I believe is inexcusable on every level.

Yet what is perhaps more disturbing is, this problem is likely not the isolated incident I hoped it would be. The problem clearly goes deep, beyond the facilities at Walter Reed. And, Mr. Chairman, I commend you for this hearing. We're not looking for scapegoats, but we're looking for responsibility and we're looking to correction because we owe it to our soldiers.

Thank you, Mr. Chairman.

[The statement follows:]

PREPARED STATEMENT OF SENATOR RICHARD C. SHELBY

Over the last two weeks, I, along with the country, have been shocked to learn about the appalling and unacceptable conditions in which some wounded war veterans are living in at Walter Reed Army Medical Center.

How well we care for our wounded servicemembers when they return home from war, in itself, has profound moral implications. Does this incident show that we are failing to meet our most basic obligations to those who fight our battles?

Since 2002, we have sent hundreds of thousands of our armed forces into combat zones. With great medical advances in battlefield care, more of our servicemembers are surviving than in any previous war—nearly 50,000 from the conflict in Iraq and Afghanistan alone. The killed-in-action rate for Operation Enduring Freedom and Iraqi Freedom is 12.5 percent, compared to 18.6 percent for the first Gulf War and Vietnam, and 25.3 percent for World War II. The care a servicemember receives in a combat zone or immediately following should be commended. Yet, what the Walter Reed incident shows is that there is clearly a major breakdown in our military health care system once a servicemember returns home. And this should not be the case.

I believe we all agree that our servicemembers, and in particular our combat veterans, deserve the best facilities and care in the world. Reports that our war-injured are recuperating in substandard housing have shed light on a massive failure, which is inexcusable on every level.

Yet, what is perhaps more disturbing is that this problem is likely not an isolated incident. This problem clearly goes beyond the facilities at Walter Reed. That is why we must take steps to improve the quality of the facilities at Walter Reed, but also to ensure that these standards are maintained throughout the entire Department of Defense health care system.

If these issues are not addressed now, they will only get worse as the system becomes further stressed with more veterans returning from Iraq and Afghanistan.

Our support for our men and women who wear the uniform cannot end when they leave the battlefield. The cost of war cannot simply include funding our weapon systems. It must include the cost of taking care of our servicemembers who fight in it. To deliver anything other than the very best would be shameful.

Senator INOUE. Senator Murray.

STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman and Senator Stevens, and I want to thank our witnesses for being here today, and I want to thank those service members who care for their sick and injured comrades, both in theater and back here at home.

I am very concerned that while we have dedicated people, they are working in a system that is failing our soldiers. From what I have been hearing, Walter Reed is just the tip of the iceberg. This morning the Seattle Times detailed serious problems at the medical holdover unit at Madigan Army Medical Center in my home State.

It detailed soldiers who are left to languish in medical units for nearly 2 years, soldiers who are being hurried out of DOD care before they receive the surgery they need, being given low disability ratings that don't reflect their injuries and deny them an Army disability pension, and being pressured to sign their medical evaluations to get them off the DOD books. If these reports are true, then the Pentagon is failing our service members at exactly the time that they need the most support, and that is really shameful and unacceptable.

The Seattle Times article quotes Pamela Lane, whose husband, Specialist Steve Lane, was sent home without being diagnosed for traumatic brain injury. His wife said, "I want people to know that if their loved ones are there, they will have to fight for their care. If they do not, they will get lost in the system."

The article says that soldiers who push for help are branded as malcontents, and there are conflicting reports. One soldier told the Tacoma News Tribune that he received excellent care and generally good casework at Madigan, but he also said, and I quote, "If you want your care, you really have to fight for it. Their strategy," and I'm quoting him, "is to get you so disgruntled that you just say screw it and go home."

So we've got, Mr. Chairman, very talented medical professionals who are trapped in a system that doesn't let them do their jobs fully, and to me that is an outrage. General Kiley, you're in charge of this system. I hold you accountable for every disturbing story I'm hearing in my home State, and I'm here today because I want answers.

Walter Reed exposed the problems with military medical care, and the latest stories out of my home State show that the problems are much deeper and more painful than moldy walls and redtape.

General, I want you to know many soldiers are very worried that if they speak out publicly, they're going to be punished or it will end their military careers. I want your personal assurance today that any soldier who blows the whistle on substandard care will not be retaliated against.

Senator INOUE. I thank you very much.

Senator Mikulski.

STATEMENT OF SENATOR BARBARA A. MIKULSKI

Senator MIKULSKI. Thank you very much, Mr. Chairman and members of the military. First of all, I think today we all know we were filled with shock and awe about what we have learned about the dysfunctional outpatient care system, both with military medicine as well as VA.

We know that within this subcommittee we've been dealing with some of the structural issues confronting military medicine, the intensity of the nursing shortage and other allied health people supporting our doctors. We know the ops tempo has literally been a high burnout rate, as well as the grim and ghoulish injuries that are faced in theater. We actually salute those men and women in military medicine that have been delivering acute care from the battlefield until they arrive back home in these hospitals.

But, however, we have now 22,000 Purple Heart men and women. We owe them a debt of gratitude related to what we need to do in terms of the next steps, and the next steps fall into outpatient care, rehabilitation medicine, and long-term care and assisted living. We have to look at care, facilities, social workers, and even the dysfunctional disability system itself.

Yes, we have visited Walter Reed, and yes, we have visited other places. Some aspects are working wonderfully. Many staff are performing heroically, both in danger to their own lives on the battlefield, but at the ops tempo, whether it's in Germany or back here.

We want to get to the bottom of this, so that we not just have phrases and yellow ribbons and "We're going to stand up for our wounded warriors." I believe promises made are promises kept. We said, "If you will go and fight for us, we will fight for you when you come back home." That's what we're here to do. We're here to fight for those wounded warriors, and all those who were wounded that we might not yet know how they were wounded, Mr. Chairman.

Senator INOUE. I thank you very much, Senator Mikulski.

PREPARED STATEMENTS OF SENATORS BOND AND MC CONNELL

Before you start General Kiley, I have received statements from Senators Christopher Bond and Mitch McConnell which I will place in the record at this point.

[The statements follow:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER S. BOND

Thank you for appearing here today. The reports detailing the conditions at Walter Reed Army Medical Center have gotten just about everyone's attention and if that means the quality of care for our military forces and our veterans improves then who can complain?

LT GEN Kiley, your staff should have relayed to you my interest in revisiting an investigation I conducted along with my colleague Senator Leahy on the conditions for soldiers on a medical hold status at Fort Stewart back in October 2003. We issued a report on our findings, dated October 24, 2003. Paragraph three of the report, under the Summary, reads like a current recount of problems at WRAMC. "The situation at Fort Stewart unfortunately was, and remains, hampered by an insufficient number of medical clinicians and specialists, which has caused excessive delays in the delivery of care. Exacerbating the situation, was the Army's placement

of wounded and injured soldiers in housing totally unsuitable for their medical condition.”

I call your attention to this report because the problems at WRAMC have been encountered before and they relate directly to the quality, and timeliness of care, and the administrative processing for injured soldiers. Furthermore, shortly after our staff visited Fort Stewart, they traveled to Fort Knox and observed that the military care system there was not optimized to care for, and expeditiously process, soldiers injured in Iraq and subsequently determined to be unqualified for further duty.

Fast forward to 2007 and we find similar problems. Our findings do not negate the tremendous care and support so many of our soldiers and their families are receiving. One of the reasons for my visit was to meet a fellow Missourian recovering from a sniper's bullet that he encountered just four days prior to his scheduled end of tour date. This soldier and his mother were thankful for the care he was receiving and remain confident that they are receiving the finest care available—anywhere. I also met a soldier recovering from PTSD in the outpatient clinic. I asked this soldier about the quality of care and was told that it was outstanding. I asked her how she would explain the recent media reports on WRAMC and she replied, “I should know, I am here every day, they are not.” I do not mean in any way to question the reports of others, but I recount a few of my conversations to share my observation that the best service the Army provides can be sullied in a moment by failing to serve just one soldier properly. I am sure you realize the gravity of the situation we are in. Perceptions are hard nuts to crack and we in government now must work overtime to regain the public's confidence.

PREPARED STATEMENT OF SENATOR MITCH MCCONNELL

I am deeply concerned about the recent details that have come to light regarding the Walter Reed Army Medical Center. Our brave soldiers deserve the best possible care and the situation at Walter Reed is unacceptable.

I commend both Secretary Gates and the President for their responsive action to this urgent problem. I am pleased they have acted quickly to address the long-term needs of our active duty warriors and veterans—not only at Walter Reed—but at military health service facilities across the country.

My home state of Kentucky is home to Ireland Army Community Hospital at Fort Knox and Blanchfield Army Community Hospital at Fort Campbell. Kentucky is home to 360,000 veterans. The Kentucky National Guard has sent more than 3,200 men and women into combat operations in Iraq and Afghanistan. For Kentuckians, the situation involving the health care of our brave men and women in the military and veterans is not an abstract issue. It is a very real and immediate one.

Senator INOUE. May I now recognize General Kiley.

General KILEY. Thank you again, Mr. Chairman and Senator Stevens and distinguished members. Thank you for the opportunity to discuss the current posture of the Army Medical Department and any of the subjects that you have raised. I'll be happy to talk to the best of my knowledge on that.

On any given day more than 12,000 Army medics, physicians, dentists, veterinarians, nurses, and other allied health professionals, administrators, and combat medics are deployed around the world, supporting our Army in combat, participating in humanitarian assistance missions and training throughout the world.

The modern battlefield is incredibly complex, and Army medicine is engaged in every phase of deployment. Every soldier who deploys must meet our individual medical readiness standards, and once deployed our health professionals not only care for the wounded but sustain medical readiness to ensure combat effectiveness of deployed units.

More than 50 percent of the Army Medical Department has deployed at least once to care for soldiers, sailors, airmen, and marines during the global war on terrorism, and their superb perform-

ance during this war cannot be understated. They are involved in more than caring for combat casualties.

Last year Army medics supported our Nation's national military strategy, not only in Iraq and Afghanistan but through nation-building and humanitarian assistance in other countries. Our medical logistics system has moved more than 17,000 short tons of medical supplies into Iraq and Afghanistan, and more than 70 percent of the patient care in Iraq is for Iraqi forces and Iraqi civilians injured in fighting.

The toll has been high in terms of cost and human sacrifice. Army medics have earned over 220 awards for valor and more than 400 Purple Hearts. One hundred and one Army medical personnel have given their lives in Iraq and Afghanistan.

These heroes represent all our corps. They are truly the best our Nation has to offer and will make any sacrifice in defense of their Nation and, most importantly, for the care of their patients.

Despite these sacrifices, the morale of our healthcare professionals does remain strong, but I do have concerns about the long-term morale of our serving Army medical force, as well as the ability to recruit into the future. For the second consecutive year the Army fell short of its goal for awarding health profession scholarships in both Medical and Dental Corps.

To help make up for these scholarships and make it more attractive, the Congress authorized an increase in the monthly stipend paid to these recipients, and I thank you for taking this important step to improve this critically important program. We are working hard to ensure every available scholarship is awarded this year, and I would be happy to discuss initiatives during the question period.

The Army Medical Department is quickly integrating lessons learned from the battlefield into our training and doctrine, not only in military medicine but throughout the United States. Army medicine continues to lead the Nation in adopting new trauma casualty management techniques. Since 2003 we have provided rapid fielding of tourniquets, pressure dressings, hemostatic bandages, and the use of factor VII, teaching these new lessons at the Army Medical School and Center and in 18 new medical simulation training centers where we train our medics on the latest tactics, techniques, and procedure in combat medicine, to include operations in the tactical environment and evacuation. Today more than 17,000 combat medics have been trained in these training centers.

As you have already recognized, post-traumatic stress syndrome and traumatic brain injury present long-term challenges to our soldiers, our healthcare system and our disability evaluation system. We know at least from some surveys that 10 to 15 percent of soldiers will be diagnosed with post-traumatic stress disorders (PTSD) within the first year after combat, and we know as many as one-third will exhibit some symptoms of PTSD, depression, or anxiety over time.

Our screening also suggests that as much as 12 to 20 percent of our soldiers have reported experiencing a traumatic brain injury (TBI) event, which is a significant number, at some point during their deployment. But we know very little about the most effective

treatment strategies to apply in the first year after combat for TBI, and I'd be happy to talk some more about that also.

During the last several months I've had the privilege of co-chairing the Department of Defense Mental Health Task Force with Dr. Shelley MacDermid from Purdue University. This task force, comprised of military, civilian, Department of Veterans Affairs, and Department of Health and Human Services representatives, have conducted site visits around the world to evaluate our mental health systems, identify trends and problems, and recommend changes to our mental health services. We are now drafting our report and will anticipate submitting it to Congress on time in May.

In December 2006 I chartered an Army task force on traumatic brain injury, to review our policies, resources, research, therapeutics, and the way ahead for traumatic brain injury support to our soldiers and their families. This task force, led by Brigadier General Don Bradshaw, will include subject matter experts from across the Army. He has also included representatives from the Wounded Warrior Program, the Navy, Marine Corps, Air Force, and the Department of Veterans Affairs, and I expect General Bradshaw to provide me a report and recommendations in late spring of this year. I'll come back and report those findings to you if you're interested.

America and Congress have known the long, rich legacy of excellence at Walter Reed Army Medical Center, and it is a very highly regarded facility. Over the last 3 weeks you have learned that we are not living up to that legacy, and for that I am personally and professionally sorry, and I apologize to the soldiers and their families, the Department of Defense, to the Members of Congress and to the Nation, for this. I am the commander and I share in these failures.

I also accept the responsibility and the challenge for rapid corrective action. Secretary Gates expects decisive action now, and he and our soldiers will get it. We're taking immediate actions to improve the living conditions at Walter Reed. The last soldier in that building, it was reported to me this morning, will be leaving to go home today. All the other soldiers that were in that building are on the campus in our Abrams Hall.

We're taking steps to improve responsiveness of our leaders in our medical system and to enhance support services for families of our wounded warriors. We're taking action to put into place longer-term solutions for the very complex and bureaucratic medical evaluation process that, in fact, does impact on our soldiers.

America's soldiers go to war with the confidence that if they are injured, the finest military medical system in the world will take care of them, evacuate them, sustain them, and ultimately save them. As I have said several times, no soldier will charge an objective out of sight of a combat medic or corpsman, and by extension, all the way back through the evacuation system, Walter Reed is part of that confidence.

I am committed to regaining confidence not just in Walter Reed but across our entire military system. My entire professional life is dedicated to the sustainment of that confidence. I am worried that

these soldiers, at Walter Reed and across the world, will lose that confidence if we do not act decisively, and I will.

In closing, let me emphasize that the service and sacrifice of our soldiers and their families cannot be measured with dollars and cents. The truth is, we owe far more than we can ever pay to those who have been wounded and to those who have suffered. Thanks to your support, we have been very successful in developing and sustaining healthcare delivery systems that honor that commitment of our soldiers, retirees, and their families to our Nation. I know with your continued support we can overcome the present challenges and make this superb military healthcare system even better.

PREPARED STATEMENT

Thank you for inviting me today to participate in this presentation, and I look forward to answering your questions.

Thank you, Mr. Chairman.

Senator INOUE. Thank you very much, General Kiley.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY

Mr. Chairman, Senator Stevens, and distinguished members of the subcommittee, thank you for the opportunity to discuss the current posture of the Army Medical Department (AMEDD). During the past 5 years, military medicine has constantly exceeded any measure of success we could establish. By now America is well aware of many of the successes of our medical capability and the challenges we face as our Army remains engaged in combat operations in Afghanistan and Iraq. During these operations we have recorded the highest casualty survivability rate in modern history. More than 90 percent of those wounded survive and many return to the Army fully fit for continued service. Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, and reassuring them that the health of their families is also secure.

Army medicine is an integral part of Army readiness and, like the Army, is fully engaged in combat operations around the world. On any given day more than 12,000 Army medics—physicians, dentists, veterinarians, nurses, allied health professionals, administrators, and combat medics—are deployed around the world supporting our Army in combat, participating in humanitarian assistance missions, and training throughout the world. These medics are recruited, trained, and retained through an integrated healthcare training and delivery system that includes the AMEDD Center and School at Fort Sam Houston, Texas; 36 medical centers, community hospitals, and clinics around the world; and, combat training centers and 18 Medical Simulation Training Centers wherever our combat formations are located. It is the synergistic effect of this system that enables us to place in our combat formations the Nation's best trained medical professionals while always ensuring the soldier is medically and dentally ready to withstand the rigors of the modern battlefield.

The modern battlefield is an incredibly complex environment and Army medicine is engaged in every phase of deployment. Every soldier who deploys must meet individual medical readiness standards. These standards are designed to ensure soldiers are medically and dentally prepared to withstand the rigors of modern combat. Army medicine ensures each soldier is medically fit, has appropriate immunizations, and has no active dental disease before they leave the United States or Europe.

Once deployed, our healthcare professionals not only care for those wounded but sustain medical readiness to ensure the combat effectiveness of deployed units. More than 50 percent of the Army Medical Department has deployed to the Central Command area of responsibility in support of combat operations. Twenty-six combat support hospitals have deployed (4 more than once); 41 forward surgical teams have deployed (11 more than once); 11 medical brigade/medical command headquarters have deployed (3 more than once); 21 aeromedical evacuation units have deployed (11 more than once); and 13 Combat Stress Control units have deployed (6 more

than once). Like the rest of the Army, this operations tempo is beginning to take its toll on the equipment and people who are vital to success.

The superb performance of our healthcare professionals during the global war on terror cannot be understated. What America doesn't know about these people is they are involved in much more than caring for wounded soldiers. AMEDD personnel supported nation building engagements not only in Iraq and Afghanistan but in 15 countries during 25 medical readiness training exercises during fiscal year 2006. Our medical logistics system has moved more than 17,000 short tons of medical supplies into Iraq and Afghanistan. More than 70 percent of the workload in our deployed combat support hospitals is emergency care provided to Iraqi forces and Iraqi citizens injured in fighting. Today, we maintain one combat support hospital split between two detainee facilities in Iraq—providing the same care available to American soldiers in Iraq and in compliance with all internationally-recognized laws and mores for care of detained persons.

The toll has been high in terms of cost and human sacrifice. Army medics have earned 220 awards for valor and more than 400 purple hearts. One hundred and one AMEDD personnel have given their lives in Iraq and Afghanistan. These heroes represent every aspect of Army medicine including Combat and Special Forces medics, Army Nurse Corps, Army Medical Specialist Corps, Army Medical Service Corps, Army Medical Corps, and Army Veterinary Corps. These men and women are truly the best our Nation has to offer and will make any sacrifice in defense of their Nation and, most importantly, for the care of their patients.

Despite these sacrifices the morale of our healthcare professionals remains strong. Some data indicates that a deployment leads to increased retention for our physicians and we are looking carefully at the impact of deployments on nurses and other health professionals. The Deputy Surgeon General recently hosted a Human Capital Strategy Symposium to address growing concerns within Army medicine about accessions/retention, including well-being issues which have a direct impact on morale. In an effort to maintain and improve the morale of the Army's medical force, my staff has been working to make improvements to the monetary incentives offered as accessions and retention tools. Most recently, we established a 180-day deployment policy for select specialties, established a physician's assistant critical skills retention bonus to increase the retention of physician's assistants, increased the Incentive Special Pay (ISP) Certified Registered Nurse Anesthetist, and expanded use of the Health Professions Loan Repayment Program (HPLRP). The physician's assistant and nurse anesthetist bonuses have been very successful in retaining these providers who are critically important to our mission on the battlefield.

However, I do have concerns about the long-term morale of our serving Army medical force as well as our ability to recruit our future force. Fiscal year 2006 presented Army medicine with challenges in recruiting healthcare providers. For the second consecutive year, the Army fell short of its goals for awarding Health Professions Scholarships in both the Medical Corps (79 percent of available scholarships awarded) and Dental Corps (70 percent of scholarships awarded). These scholarships are by far the major source of accessions for physicians and dentists. This presents a long-term manning challenge beginning in fiscal year 2009. As part of the 2007 National Defense Authorization Act, the Congress provided important authorities to allow the Secretary of Defense to increase the monthly stipend paid to scholarship recipients. These increases will make this program more attractive to prospective students and ease the financial burden they face as students. Thank you for taking this important step to improve this critically important program. We are working hard to ensure every available scholarship is awarded this year. In conjunction with United States Army Recruiting Command (USAREC) we have initiated several new outreach programs to improve awareness of these programs and to increase interest in a career in Army Medicine.

The Reserve Officer Training Corps (ROTC) is a primary source for our Nurse Corps Force. In recent years, ROTC has had challenges in meeting the required number of Nurse Corps accessions and as a consequence, USAREC has been asked to recruit a larger number of direct accession nurses to fill the gap. This has been difficult in an extremely competitive market. In fiscal year 2006, USAREC achieved 84 percent of its Nurse Corps mission (goal of 430 with 362 achieved). To assist USAREC we have instituted an accession bonus for 3-year obligation and have increased the bonus amount for those who obligate for 4 years. Additionally, we raised the dollar amount that we offer individuals who enter our Army Nurse Candidate Program to \$5,000 per year for max of 2 years with a \$1,000 per month stipend. In 2005, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a re-

vamped Professional Filler system to improve deployment equity is helping to retain CRNAs.

The Reserve Components provide over 60 percent of Army Medicine's force structure and we have relied heavily on these citizen soldiers during the last 3 years. They have performed superbly. But accessions and retention in the Army National Guard and Army Reserve continue to be a challenge. In fiscal year 2005 we expanded accessions bonuses to field surgeons, social workers, clinical psychologists, all company grade nurses and veterinarians in the Army National Guard and Army Reserve. We also expanded the Health Professions Loan Repayment Program and the Specialized Training Assistance Program for these specialties. In February 2006, we introduced a Baccalaureate of Science in Nursing (BSN) stipend program to assist non-BSN nurses complete their 4-year degree in nursing. This is an effective accessions and retention tool for Reserve Component Nurses who have only completed a 2-year associates degree in nursing. Working with the Chief of the Army Reserve and the Director of the Army National Guard, we continue to explore ways to improve Reserve Component accessions and retention for this important group.

The high operations tempo has also placed strain on our equipment. The fiscal year 2007 Emergency Supplemental Appropriation request and the fiscal year 2008 budget request adequately funds the replacement and reset medical equipment in Iraq and Afghanistan as well as equipment organic to units deploying to and redeploying from the Middle East. One area that requires our focused attention is the need for an armored ground ambulance. Because our current ground (wheeled) ambulances are not armored they are not employed outside the Forward Operating Bases on a regular basis. When the ground ambulances have operated outside the FOB perimeter it has led to the death of some medical personnel, and it reduces a maneuver commander's ability to employ ground ambulances in support of combat operations. The Army's modernization plan addresses this issue and your continued support of the Future Combat System, which includes an armored ground ambulance, will help alleviate this problem.

America does not know that the Army Medical Department is a learning organization that seeks to quickly integrate lessons learned from the battlefield into healthcare training and doctrine not only in military medicine but throughout the United States as well. Most of the emergency medical response doctrine in practice in the United States today evolved from medical experiences in the jungles of Southeast Asia in the late 1960's. Today, Army medicine continues to lead the Nation in adopting new trauma casualty management techniques. Since 2003 we have provided rapid fielding of improved tourniquets, new pressure dressings, and the use of hemostatic bandages that promote clotting. Training for all soldiers in initial entry training has been revised and we continually revise Combat Lifesaver and Combat Medic training based on lessons learned on the battlefield.

These lessons learned are incorporated in our doctrine taught at the Army Medical Department Center and School and in 18 new Medical Simulation Training Centers across the Army designed to ensure all Combat Medics are trained on the most current combat casualty care techniques under fire, in a tactical environment, and during evacuation. To date, more than 17,800 Combat Medics have received training in these Medical Simulation Training Centers which use computerized mannequins that simulate human response to trauma. Medics can practice their skills in combat scenarios at their duty station. Live tissue training is an integral part of Brigade Combat Team Trauma Training, building the confidence of 68W combat medics and providers in extremity hemorrhage control with use of various hemostatic agents. Use of live tissue best simulates the challenges and stress inherent in stopping real bleeding.

The Improved First Aid Kit (IFAK) is the first major improvement in individual soldier care in the past 50 years. Today every soldier carries a first aid kit that provides intervention for the leading causes of death on the battlefield. The Vehicle Warrior Aid Litter Kit (WALK) has enhanced the capability of soldiers to save lives when vehicles are attacked in theater. This is an expanded version of the IFAK with the addition of a collapsible litter to facilitate ground/air medical evacuation.

Hypothermia was leading to poor casualty outcomes and, as a result, the Army added new equipment for patient warming and fluid warming to medical equipment sets including the combat medic's aid bag, ground and air ambulances, the battalion aid station, the Forward Surgical Team, and the Combat Support Hospital.

The Joint Theater Trauma Registry is proving invaluable; rapidly collecting the lessons learned and guiding decisions about training, equipment and medical supplies based on near real-time data. An organized, systematic method to collect information and use it to drive improvements will be a key component of future military medical operations. As knowledge of the actual experience of U.S. medical units in Iraq and Afghanistan has grown, Army medicine has developed a Theater Combat

Casualty Care Initial Capabilities Document under the Joint Capabilities Integration and Development System that captures the required capabilities and capability gaps in combat casualty care to guide research and development efforts and effect changes in doctrine, organizations, training, materiel, leadership, personnel and facilities.

At the same time we are rapidly introducing new medical products and practices on the battlefield we are transforming our deployable units to better support the Army in combat. Last year we completed a reengineering of our aero-medical evacuation units, placing them under the command of the Army's General Support Aviation units to improve maintenance and training for our Dustoff units. We reviewed the doctrinal employment of forward surgical teams to ensure we are making the best use of this light, very mobile, far forward surgical capability. We also redesigned our Professional Officer Filler System (PROFIS) to improve the equity of deployments across regions and medical specialties.

But our successes are evident in other aspects of medical care as well. America does not know that U.S. Army Medical Command is a \$7 billion a year business that provides care for more than 3 million beneficiaries world-wide. Civilian healthcare executives are frequently surprised to find that all of our hospitals and clinics are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Our civilian peers are further surprised when they learn of the quality of our graduate medical education programs and the superb quality of Army healthcare professionals as evidenced by medical board scores, board qualified rates, and graduate and post-graduate education rates.

This healthcare delivery system is essential to our success on the battlefield. It is within this system that our healthcare professionals train and maintain their clinical skills in hospitals and clinics at Army installations around the world every day. These facilities provide day-to-day healthcare for soldiers to ensure they are ready to deploy; allow providers to train and maintain clinical competency with a diverse patient population that includes soldiers, retirees, and families; serve as medical force projection platforms, and provide resuscitative and recuperative healthcare for ill or injured soldiers. To accomplish this ambitious mission, we constantly strive to sustain appropriate staffing ratios, facility workspace, workload productivity and patient case-mix in our direct-care facilities while maintaining the right balance with an appropriately sized and supportive network of civilian providers for healthcare services we cannot effectively or efficiently provide on a day to day basis. In order to remain successful, however, we must transform Medical Command along with our battlefield system of care.

The combination of Base Realignment and Closure (BRAC) decisions, Army Modular Force (AMF) redesign and stationing, and the transformation of the Global Defense Posture (GDP) have presented us with a significant challenge to adapt in support of rapid change. But more importantly, these initiatives offer an unprecedented opportunity to improve the way we care for patients at affected installations. We are working with the Army Corps of Engineers to improve the historically long-lead time necessary to plan and execute military medical construction projects, especially given limited funding and low fiscal thresholds that we must work within. Although it will be a significant challenge, the Army Medical Department approaches this epoch as an opportunity to make significant strides not only to transform, realign and improve our vast and aging infrastructure, but also to integrate exciting new acquisition methodologies, cutting edge medical technologies, our robust information management system and emerging concepts of patient treatment and care, such as Evidence Based Design. I am confident that with the help of Congress, we will be able to leverage this once in a lifetime opportunity to advance healthcare further, by properly aligning and improving the enabling facility infrastructure.

Despite our operations tempo, we have maintained and improved the quality of care and timely access to care for soldiers, their families, and our retirees. Private sector care enrollment and workload is increasing as we continuously evaluate and optimize our facilities' enrollment to ensure appropriate personnel and facilities are available to meet healthcare demand. We have prioritized workload to support casualty care and deployment medical screening, shifting a portion of our family member and retiree care to the private sector to ensure they will continue to receive continuous high quality care during ongoing deployment of our medical personnel. Additionally, families of mobilized reserve component soldiers now have TRICARE available to them as their health insurance in many areas where military facilities do not exist or do not have the capacity to absorb additional enrollees.

Going to war affects all soldiers. The number of soldiers with Post Traumatic Stress Disorder (PTSD) and other stress-related symptoms has gradually risen. The AMEDD has been supporting our soldiers at war for 5 years, during 9/11 at the Pentagon, in Afghanistan, in Iraq and around the globe. But America does not know

about the extensive array of mental health services has long been available for soldiers and their families. Since 9/11, the Army has augmented behavioral health services and post-traumatic stress disorder (PTSD) counseling throughout the world, but especially at Walter Reed Army Medical Center and at the major Army installations where we mobilize, train, deploy, and demobilize Army forces. Demand for these services will not decrease in 2007 and we are committed to providing the long-term resources necessary to effectively care for soldiers and families dealing with a wide variety of stress-related disorders.

Soldiers are also now receiving a global health assessment, with a focus on behavioral health, 90 to 180 days after redeployment. This assessment, the Post-Deployment Health Reassessment (PDHRA), includes an interview with a health care provider. The PDHRA provides soldiers an opportunity to identify any new physical or behavioral health concerns they may be experiencing that may not have been present immediately after their redeployment. This new program has been very effective in identifying soldiers who are experiencing some of the symptoms of stress-related disorders and getting them the care they need before their symptoms manifest into more serious problems.

The AMEDD is also performing behavioral health surveillance and research in an unprecedented manner. There have been four Mental Health Advisory Teams (MHATs) performing real time surveillance in the theater of operations, three in Iraq and one in Afghanistan. Colonel Charles Hoge has led a team from the Walter Reed Army Institute of Research in a wide variety of behavioral health research activities. His research shows that generally the most seriously affected by PTSD are those most exposed to frequent direct combat.

Since the beginning of Operation Iraqi Freedom (OIF) in 2003 there has been a robust Combat and Operational Stress Control presence in theater. Today, more than 170 Army behavioral health providers are deployed in Iraq and another 25 are deployed in Afghanistan. Air Force and Navy mental health teams are also deployed and supporting soldiers, sailors, airmen, and marines in Iraq and Kuwait. The MHAT reports demonstrate both the successes and some of the limitations of these combat stress control teams. Based on MHAT recommendations, we have improved the distribution of behavioral health providers and expertise throughout the theater. Access to care and quality of care have improved as a result.

There is a perceived stigma associated with seeking mental health care, both in the military and civilian world and we must take action to address this problem. Therefore we are moving to integrate behavioral health care into primary care, wherever feasible. Our pilot program at Fort Bragg, Respect.Mil, which provides education, screening tools, and treatment guidelines to primary care providers, was very successful. We are in the process of implementing this program at 13 other sites across the Army.

We continue to assess the access to and quality of our services using both internal and external methods. I directed and funded a review of behavioral healthcare services available across Army installations. This review is just being completed and will augment the impressions I have been developing as the co-chair of the Department of Defense (DOD) Mental Health Task Force, created by the fiscal year 2006 National Defense Authorization Act. This task force, comprised of military, civilian, Department of Veteran's Affairs, and Department of Health and Human Services representatives is conducting site visits around the world to evaluate mental health systems, identify trends and to recommend changes to our mental health services. The task force will complete its work and submit its report to Congress in May 2007.

Training in behavioral health issues is ongoing in numerous forums. The Walter Reed Army Institute of Research has developed a training program called "Battlemind". Prior to this war there were no empirically validated training strategies to mitigate combat-related mental health problems, and we have been evaluating this post-deployment training using scientifically rigorous methods with good initial results. This new risk communication strategy was developed based on lessons learned from Colonel Hoge's Land Combat Study and other efforts. It is a strengths-based approach that highlights the skills that helped soldiers survive in combat instead of focusing on the negative effects of combat. Two post-deployment training modules have been developed, including one version that involves video vignettes, that emphasizes safety and personal relationships, normalizing combat-related mental health symptoms, and teaching soldiers to look out for each other's mental health.

The acronym "Battlemind" identifies 10 combat skills that if adapted will facilitate the transition home. An example is the concept of how soldiers who have high tactical and situational awareness in the operational environment may experience hypervigilance when they get home. The post-deployment Battlemind training has

been incorporated into the Army Deployment Cycle Support Program, and is being utilized at Department of Veterans' Affairs Vet Centers and other settings. We have also been developing pre-deployment resiliency training for leaders and soldiers preparing to deploy to combat using the same Battlemind training principals, as well as training for spouses of soldiers involved in combat deployments.

Traumatic Brain Injury (TBI) is emerging as a common blast-related injury. TBI is a broad grouping of injuries that range from mild concussions to penetrating head wounds. An overwhelming majority of TBI patients have mild and moderate concussion syndromes with symptoms not different from those experienced by athletes with a history of concussions. Many of these symptoms are similar to post-traumatic stress symptoms, especially the symptoms of difficulty concentrating and irritability. It is important for all providers to be able to recognize these similarities and consider the effects of blast exposures in their diagnoses. Through the Defense and Veterans Brain Injury Center (DVBIC), headquartered at Walter Reed, we understand a lot about moderate to severe TBI, including severe closed head trauma, stroke, and penetrating head wounds. What we do not fully understand is the long-term effects of mild concussion or multiple mild concussion on soldier performance. Through Congress' support of the DVBIC has been instrumental in providing the DOD with a firm foundation to quickly improve our understanding of mild TBI, but we must move quickly to fill this knowledge gap.

In December 2006 I chartered an Army Task Force on TBI to review our policies and resources dedicated to TBI from scientific research, acute diagnosis and treatment, to long-term rehabilitation. This task force, led by Brigadier General Don Bradshaw, will include subject matter experts from across Army medicine. I have also invited the Navy, Air Force, and Department of Veterans' Affairs to have representatives participate in the task force. I expect General Bradshaw to provide me a report and recommendations by late spring 2007.

America does not know that rapid growth in national healthcare costs threaten our medical system and, ultimately, Army readiness. The Army requires a robust military medical system to meet the medical readiness needs of active duty service members in both war and peace, and to train and sustain the skills of our uniformed physicians, nurses, and combat medics as they care for family members, retirees, and retiree family members. Therefore we share the DOD's concern that the explosive growth in our healthcare costs jeopardizes our resources, not only to the military health system but in other operational areas as well.

DOD continues to explore opportunities to help control costs within the DHP and in many of these initiatives the Army leads the way in implementation and innovation. In 2006, I implemented a performance-based budget adjustment model throughout the Army Medical Command. This model accounts for provider availability, workload intensity, proper coding of medical records, and the use of outcome measures of as quality indicators to adjust hospital and clinic funding levels to reflect the actual cost of delivering healthcare. The Southeast Regional Medical Command implemented an early version of this system in 2005 where it showed great promise. This enterprise-wide model focuses command attention on the business of delivering quality healthcare. It is a data-driven methodology that enables commanders at all levels to receive fast feedback on their organization's performance. Finally, the use of clinical practice guidelines encourages efficiency by using nationally accepted models for disease management. These adjustments provide my commanders the ability to reward high-performing activities, encourage best-business opportunities, and exceed industry-standard wellness practices.

Fiscal year 2007 and fiscal year 2008 will be challenging years for the Defense Health Program (DHP) and Army medicine. Our estimates for cost growth through 2013 are not complete, but we are still witnessing sizable growth in the number of TRICARE-reliant beneficiaries in our system, and the pressures on the defense budget grow. Military health care costs continue to increase substantially. The fiscal year 2008 President's budget request includes a legislative proposal that aligns TRICARE premiums and co-payments for working age retirees (under age 65-years) with general health insurance plans. The Department may modify or supplement this request after it considers recommendations from the Department of Defense Task Force on the Future of Military Health Care that has been recently established with distinguished membership from within the Department, other Federal agencies and the civilian sector. A key area the task force will study and on which it will make recommendations is "beneficiary and government cost-sharing structure." We believe this and the other recommendations they make will markedly benefit the MHS in the future.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit to better manage the long-term cost structure of our program. Failure to do so will harm military

healthcare and the overall capabilities of the Department of Defense—outcomes we cannot afford.

The Army continues to support the development of a Unified Medical Command and is working closely with our sister services and the Joint Staff to realize the full potential of this initiative. A fully functional unified command represents an opportunity to reduce multiple management layers within DOD's medical structure, inspire collaboration in medical training and research, and gain true efficiencies in healthcare delivery. These changes need to be made in conjunction with BRAC implementation and other actions to sustain the benefit if we are to realize the full potential of a streamlined, more responsive command and control structure.

The DHP is a critical element of Army medical readiness. Healthy soldiers capable of withstanding the rigors of modern combat; who know their families have access to quality, affordable healthcare, whether the soldier is home with them or off to combat; and who are confident when they retire they will have access to that same quality healthcare is an incredibly powerful weapon system. Every dollar invested in the DHP does much more than just provide health insurance to the Department's beneficiaries. Each dollar is truly an investment in military readiness. In OIF and OEF that investment has paid enormous dividends.

America has long known of the rich legacy of excellence for which Walter Reed Army Medical Center is so highly regarded. The issues highlighted in the Washington Post articles are not due to a lack of funding or support from Congress, the administration, or the Department of Defense. Nor are they indicative of any lowering of standards by the WRAMC leadership. We are aggressively working to address the problems highlighted in the media, both internally and in conjunction with the independent review panel appointed by the Secretary of Defense. Walter Reed represents a legacy of excellence in patient care, medical research and medical education. I can assure you that the quality of medical care and the compassion of our staff continue to uphold Walter Reed's legacy. But it is also evident that we must improve our facilities, accountability, and administrative processes to ensure those systems meet the high standards of excellence that our men and women in uniform so richly deserve.

In closing let me emphasize that the service and sacrifice of our soldiers—and their families—cannot be measured with dollars and cents. The truth is that we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss. Thanks to your support, we have been very successful in developing and sustaining a healthcare delivery system that honors the commitment our soldiers, retirees, and their families make to our Nation by providing them with world-class medical care and peerless military force protection.

Thank you again for inviting me to participate in this discussion today. I look forward to answering your questions.

Senator INOUE. And may I now recognize Vice Admiral Donald C. Arthur, Surgeon General of the Navy. Admiral?

STATEMENT OF VICE ADMIRAL DONALD C. ARTHUR, SURGEON GENERAL, DEPARTMENT OF THE NAVY

Admiral ARTHUR. Good morning, Senator Inouye, Senator Stevens, distinguished members of the subcommittee. Thank you very much for recognizing the corpsmen and, by extension, the medics, and their contribution to the warfight.

We have throughout history relied on our corpsmen to provide the first level of care, and although we have very well trained surgeons, nurses, and others far forward to do surgery, no marine, no soldier gets to a surgeon without having first been cared for by a corpsman or combat medic. We take our obligation to them seriously. Through the lessons learned system we have modified and improved their trauma training throughout their training back here at home, so that they are proficient at their combat skills when they get into combat.

I also appreciate the collaboration between the three services, so that a soldier or a marine can get care at a Navy or an Army facility on the ground, be flown by the Air Force with their critical care air transport teams to Landstuhl and back to the United States in

36 to 48 hours, and be met by their family at one of our facilities back home. We are in combat today. We take that obligation very, very seriously.

We are in combat also here in the United States, within our own system. We have been given efficiency wedges which have cut our budget. We have been given military-to-civilian conversion objectives. We have had our staff cut without conversions. And with these financial and personnel challenges, we may very well find it difficult to meet our combat missions in the future.

We have been given many medical readiness review assumptions that minimize the number of casualties that are expected in the future, minimize the number of deployments that we will have, minimize the biological or chemical warfare agent threat, minimize or even eliminate the homeland security/humanitarian assistance and homeland defense components of our mission, and we will find, I think, those missions to be very difficult to meet in the future.

We are concentrating very heavily during this war on traumatic brain injury and post-traumatic stress disorders because we have come to have a new realization of the magnitude of the combat stress that each of our veterans experience. When I first became Surgeon General, I had a brief that said that 25 percent of people that go into combat are significantly affected by the experience. I disagreed, and still do. I think it's 100 percent.

Having been in combat myself with the marines in 1991, I can tell you that everyone who experiences combat is significantly affected by the experience, and they develop a debt that we need to repay as soon as they come back. We need to be sensitive to their needs to readjust. The challenge is great for us because we do not want to see it in their employers, in their families or other indicators, where we have failed to recognize it first and taken effective action.

I think we are becoming even more sensitive to mild traumatic brain injury and its effects on cognition, on mental function. I am acutely aware of this. You know that last year I was in a motorcycle accident with significant period unconsciousness which followed that, and I can tell you that it took many months to regain my memory, calculation, and some of my higher executive skills after that injury. That was a mild traumatic brain injury. So I'm sensitive to the fact that you may not pick it up in the normal tests that we give to our casualties.

It may come up with the casualty coming to us and saying, "You know, I have trouble reading a menu. I can't decide what to have. Even though I know what I want, I can't make a decision." And that may be a subtle sign of traumatic brain injury.

We look forward to additional collaboration with the Veterans Administration as we become really one seamless system of Federal care for our veterans. We know that there are challenges with the medical records system, and we're dedicated to providing all of the medical record information that our veterans need to get care in the system.

We know that the Veterans Administration has polytrauma centers and has the expertise in traumatic brain injury, spinal cord injury, and other very serious veterans' injuries, and we work with them in collaboration with all their centers. We use them not only

for care of veterans who are discharged from the service but also for some of our veterans who will come back to active duty. I think the Navy's DOD/VA collaboration in Great Lakes, where we have truly combined the two facilities, is a good benchmark for how it can be done and also a test bed for where we can further integrate our electronic medical record systems.

PREPARED STATEMENT

Senator Inouye, Senator Stevens, I have 2 days ago submitted my request for voluntary retirement after 32 years of naval service. It is my time to turn over to the next Surgeon General of the Navy, and I want to tell you how very honored I have been to wear this uniform for 32 years, to be in front of you with great pride in how we are serving our veterans. We have a philosophy in our system, that the honor of our care should be directly proportional to the courage of our veterans.

Thank you very much, and I look forward to your questions.

Senator INOUE. Admiral, I'm certain I speak for the subcommittee. I thank you very much for your service to our Nation.

Admiral ARTHUR. It's been an honor, sir.

[The statement follows:]

PREPARED STATEMENT OF VICE ADMIRAL DONALD C. ARTHUR

INTRODUCTION

Chairman Inouye, Senator Stevens, distinguished members of the subcommittee, I welcome the opportunity to share with you how Navy medicine is taking care of our Nation's sailors, marines, and their families across the globe and at home.

Navy medicine remains steadfast in its commitment to provide care on the battlefield and meet the health care needs of our beneficiaries, active duty, reservists, military retirees, and family members, as our Nation continues to be engaged in combat operations fighting the Global War on Terror (GWOT).

We are dedicated to maintaining a healthy and fit force that is ready to deploy and to deploying medical personnel to provide the best health care to our warriors on the battlefield. And when that is not enough, we are committed to restoring the health of those injured on the battlefield.

At the same time, we are responsible for ensuring access to world-class health care for all eligible beneficiaries. Meeting these missions are an exceptional team of military, active and reserve, and civilian health care professionals who perform their duties with the same enthusiasm in deployed settings as well as at our Medical Treatment Facilities (MTFs).

DEFENSE HEALTH PROGRAM AND NAVY MEDICINE BUDGET FOR FISCAL YEAR 2008

In recent years, Navy medicine faced many fiscal challenges and anticipates that some will continue throughout fiscal year 2008. The President's budget for fiscal year 2008 funds healthcare operations; authorizes 1,011 military to civilian conversions; includes funding for the GWOT requirement; and assumes savings and efficiencies in several areas.

Fiscal year 2008 provides funding challenges in that the efficiency wedge increases and certain assumptions regarding savings opportunities may not be borne out in execution. These reductions represent leadership and management challenges, which we must meet. We are vigorously integrating our fiscal challenges, and our military to civilian conversion program, into an ongoing business process review that is designed to make Navy medicine an efficient, effective care provider.

As you know, the Department of Defense faces tremendous difficulty with balancing the growing costs and long-term sustainability of the military health system. We will need to consider all options available to ensure a superior benefit remains available for the long term and we look forward to the recommendations on fiscal and other issues that will come from the Department of Defense Task Force on the Future of Military Health Care that has recently been established with distin-

guished membership from within the Department, other Federal agencies, and the civilian sector.

COMBAT CASUALTY CARE

We have made significant advances in combat casualty care and have redefined trauma management for military operational medicine. Navy medicine is continuously assessing its medical capabilities to make improvements resulting in real time adjustments to ensure the right health care capabilities are deployed as far forward as possible. These improvements are based on our experience and lessons learned, and on the requirements mandated by the warfighter. As a result of these improvements, only 2–3 percent of service members who are wounded and who reach medical care within 60 minutes are dying from their injuries.

One of the most important contributors to saving lives on the battlefield, historically and currently, is Navy corpsmen—Navy medicine's first responders on the battlefield. The platoon corpsmen are supported by a team of field surgeons, nurses, medical technicians and support personnel in theater, who are supported by medical evacuation teams and overseas MTFs working together with MTFs in the United States—this is the Navy medicine continuum of care.

Combat casualty care is a “continuum-of-care,” which begins with corpsmen in the field with the marines; progresses to forward resuscitative care; on to theater level care; and culminates in care provided in route during patient evacuation to a military hospital. Medical care is being provided in Iraq and Afghanistan by organic Marine Corps health services units which include Battalion Aid Stations (BAS), shock trauma platoons, surgical companies, and Forward Resuscitative Surgical Systems. Our forward-deployed assets include Navy surgical capabilities located in Al Asad and Taqaddum. These units are the first oasis of care for many warfighters who are seriously wounded fighting insurgents. At Al Asad the majority of the injuries treated have been from improvised explosive devices (IEDs). They provide patient resuscitation and stabilization for helicopter medical evacuations to higher-capability medical facilities, something no other medical unit in the surrounding area can offer.

Sailors at the medical unit in Taqaddum treat the most serious of patients from the entire area of operations, most arriving by helicopter directly from the battlefield. The platoon is staffed by dedicated and highly skilled uniformed medical personnel who stand in harm's way ready to fight for the lives of our wounded service members.

Changes have been made in the training of the physicians, nurses and corpsmen who first encounter injured service members, as well as to the way certain types of injuries are treated. In addition, new combat casualty care capabilities such as one-handed tourniquets and robust vehicle first-aid kits for use during convoys are being deployed. Navy fleet hospital transformation is currently redesigning Expeditionary Medical Facilities (EMFs) to become lighter, modular, more mobile, and interoperable with other Services' facilities in theater.

As EMFs continue to evolve, so do Navy Medicine's Forward Deployable Preventive Medicine Units (FDPMU). These units include environmental health and preventive medicine professionals who play a critical role in force health protection services, including environmental site assessments, water quality analysis, and disease vector surveillance and control. The Marine Corps' remain the FDPMU's primary customer, however, these teams also provide preventive medicine support to Naval Construction Battalions/Seabee Units, Army, and Air Force personnel. Currently, the Navy has four FDPMUs, with teams that have deployed for Operation Iraqi Freedom (OIF).

Navy medicine's commitment to the warfighter is clearly seen in the combat casualty care provided to injured and ill marines and sailors engaged in Operation Enduring Freedom (OEF) and OIF since the beginning of the GWOT.

Navy medicine is constantly looking at the next steps in improving combat casualty care. Our current efforts center on expansion of our health surveillance, combat and operational stress control programs, and improving care for certain types of injuries such as traumatic brain injury (TBI). Combat casualty care is not limited to the care received while in theater, but extends to the information and training we provide to service members to prevent physical and mental health injuries before, during and after deployment.

Providing preventive and treatment services as early as possible is the best way to avoid or mitigate the long-term effects of war. Navy medicine is committed to monitoring the health of deployed service members with the use of pre- and post-deployment health assessments. These assessment tools are designed to identify potential issues of concern, both physical and mental. The program also provides serv-

ice members information on how to access medical services for any physical or mental health issues that may occur after returning from deployment.

We know that all service members who witness or are engaged in combat will experience some level of combat stress. To specifically address this challenge, Navy medicine launched the Operational Stress Control and Readiness (OSCAR) pilot project in January 2004, which embedded psychiatrists and psychologists at regimental levels in ground Marine Corps units. The primary goal of this program—to effectively manage operational stress at the tactical level—is central to the readiness of the Marine Corps as a fighting force. To date there are three OSCAR teams, one associated with each of the three active USMC Divisions: 1st MARDIV located at Camp Pendleton, 2nd MARDIV located at Camp Lejeune, and 3rd MARDIV located at Camp Butler (Okinawa). The personnel for the OSCAR teams are sourced from Navy MTFs or drawn from elsewhere within the Marine Corps structure.

At Navy and Marine Corps bases across the country, Navy medicine is coordinating with line commanders and their organic medical assets to establish 13 Deployment Health Clinics (DHCs) to facilitate these health assessments. The DHCs serve as a non-stigmatizing point of entry for military personnel with deployment health and/or military readiness needs. These clinics by design will complement and augment primary care services that are offered at the MTFs or in garrison at the unit level such as BAS. Services provided will vary with patient and health concern, but the services will include screening, counseling and initial treatment for family problems, diet and exercise, substance abuse, sexual practices, injury prevention, stress, primary care and mental health concerns. The goal is to provide appropriate treatment for deployment-related concerns in an environment that reduces the stigma associated with the service member's condition. The clinics are staffed to support increased referrals as deploying units return from the theater of operations.

In order for combat casualty care to be effective, Navy medicine has incorporated service members' families into the care model. We first launched this concept at the National Naval Medical Center several years ago and are now making it part of the way we treat our combat casualties at every Navy MTF. Recent developments in this area include the establishment of the Comprehensive Combat Casualty Care Center (C5) at Naval Medical Center San Diego.

C5 is based on the models for amputee care developed at Walter Reed and Brooke Army Medical Centers, but is expanded to include other types of injuries such as TBI and Post-Traumatic Stress Disorder. C5 will monitor and coordinate the medical care of the service member in and outside of the MTFs. In addition, C5 will provide support to the families in every way possible and focus on ensuring that the service members and their families have a smooth transition to civilian life or continued military service. When completed, NMCCSD will be the Department of Defense's comprehensive combat casualty care "center of excellence" for the west coast.

HUMANITARIAN AND JOINT MISSIONS

The role of Navy medicine has played in OEF and OIF illustrates only part of the increased operational tempo of our medical personnel across the spectrum of Navy medicine in recent years. We have new expanded missions which include humanitarian efforts, missions in support of joint military operations, and a greater role in homeland security.

As demonstrated with the Pakistan earthquake in 2005 and return visits to areas struck by the Indonesian tsunami, America's compassion and generosity are a powerful force of good will. These missions have transformed fear into trust and animosity into handshakes—medical diplomacy—a recognized impact on the GWOT.

The Navy and Marine Corps responded to the earthquake in Indonesia in June 2006 and the medical team treated over 2,000 patients. The earthquake's destruction displaced hundreds of thousands of Indonesians. A mobile medical unit was set up at a local soccer field in Sewon and provided a variety of medical services including surgeries and vaccinations. The vaccination efforts focused on reducing the significant risk of contracting tetanus, a devastating bacterial infection that usually originates from a contaminated laceration.

USNS *Mercy* (T-AH 19), our hospital ship home-ported in San Diego, completed a humanitarian assistance mission to Southeast Asia last year. *Mercy* provided direct aid to more than 87,000 people in Indonesia, Bangladesh and the Philippines. *Mercy's* team included an unprecedented group of volunteers and professionals, civilians and military, men and women, dedicated to saving lives, restoring hope and spreading good will. The team included a dozen non-governmental organizations (NGOs); U.S. Army, U.S. Air Force, and Public Health Service medical personnel, naval construction forces and medical professionals from Canada, India, Malaysia, Australia and Singapore.

Mercy's deployment was an exciting and important opportunity to bolster security, stability and prosperity—both at sea and ashore—in a region where we have important interests. *Mercy's* deployment was a model of cooperation and deliberate planning with NGOs and partnering nations. This international collaboration underscores the Navy's commitment and tradition of providing medical and humanitarian assistance where and when needed and added a new dimension to forward presence.

The hospital ship's state of the art operating rooms, CT scan equipment, laboratories and her ability to electronically transfer medical information allowed the staff to consult with physicians in other locations. The international team performed over 1,000 surgeries and cared for over 60,000 patients. *Mercy* visited 10 locations in four countries and demonstrated the great capability and capacity the ship brings without requiring a significant presence ashore. *Mercy's* crew played an important role as American good will ambassadors. Their actions demonstrated to thousands of people the true values and ideals we hold as Americans.

Later this year, the Navy plans to deploy our East coast-based hospital ship, the USNS *Comfort* (T-AH 20), in support of a humanitarian mission to nations in the Caribbean and Central/South America. In addition, a robust medical staff based out of San Diego will deploy aboard the USS *Pelelieu* to the Western Pacific to continue our humanitarian efforts in that region.

Also in 2006, Joint Forces Command (JFCOM) tasked the Navy with providing medical staffing in support of the Army's Landstuhl Regional Medical Center (LRMC) Germany. Upon arriving in November, this group of more than 300 Navy medical reservists and 30 active duty personnel became part of the LRMC team and are providing superior medical, surgical and preventive health care to wounded warfighters returning home. This mission demonstrates how our active duty and reserve components seamlessly integrate the talents and strengths of our reservists to accomplish the mission. This call to meet Landstuhl personnel needs also demonstrates the increased operational requirements and tempo to which Navy medicine has been responding since the beginning of OEF/OIF.

The Expeditionary Medical Facility Kuwait (EMF-K) is in its third year as Navy medicine detachments staff the U.S. military hospital in Kuwait and its nine outlying clinics. This facility averages over 17,500 monthly patient encounters and is staffed by Navy personnel from 26 medical activities around the world.

U.S. Military Hospital Kuwait is a Level 3 medical facility that provides outpatient, as well as inpatient, care and specialty services such as cardiology, pulmonary, critical care, internal medicine, general surgery, optometry, orthopedics, gynecology, laboratory, pharmacy, radiology, mental health, dental and physical therapy. Between December 2005 and October 2007, over 75 percent of troops who came to the facility were able to remain in theater. EMF-K also provides health care to Department of Defense personnel and Coalition forces stationed in the U.S. Army Forces Central Command area of responsibility—Kuwait, Qatar, Afghanistan, and Iraq.

Joint initiatives are underway across the full spectrum of military medical operations around the world. Navy medicine is committed to increasing the ways we jointly operate with the Army and Air Force. Ideally, all U.S. medical personnel on the battlefield—regardless of service affiliation—should have the same training, use the same information systems and operate the same equipment because we are all there for the same reason—to protect our fighting forces. It should not matter whether the casualty is a soldier, sailor, airman, marine, or coast guardsman, or what color uniform the medical provider wears. Injured warfighters should receive the same level of care delivered by personnel with the necessary training, equipment and information systems to maximize our efficiency and achieve the best patient outcomes.

MEDICAL PERSONNEL AND QUALITY OF CARE

On an average day in 2006, Navy medicine had over 3,800 medical personnel from the active and reserve components deployed in support of operations, exercises or training around the world. While continuing to support our missions we have been challenged to ensure that sufficient numbers of providers in critical specialties are available to fill both the wartime mission and sustain our beneficiaries at home.

Navy medicine is continually monitoring the impact deployments of medical personnel have on our staff and our ability to provide quality health in our MTFs. We continue to pursue an economic and quality-centered strategy focused on maintaining the right mix in our force to sustain the benefits of our health care system. Together with the network of TRICARE providers who support local MTFs, beneficiaries have been able to continue accessing primary and specialty care providers as needed. We closely monitor the access standards at our facilities using tools like

the peer review process, to evaluate primary and specialty care access relative to the Department of Defense's standard.

Providing quality medical care is Navy medicine's priority and we earn the trust of our beneficiaries by ensuring our health care providers embrace the highest standards of training, practice and professional conduct. Another means used to ensure quality is our robust quality assurance and risk management programs that promote, identify, and correct process or system issues and address provider and system competency issues in real time. Our program promotes a patient safety culture that complies with nationally established patient safety goals and we have an extensive, tiered quality assurance oversight process to review questions related to the standard of medical care.

Navy medicine also promotes healthy lifestyles through a variety of programs. These programs include: alcohol and drug abuse prevention, hypertension identification and control, tobacco use prevention and cessation, and nutrition and weight management. Partnering with other community services and line leadership enhances their effectiveness and avoids duplication. We have established evidence-based medicine initiatives and currently measure diabetes, asthma and women's breast health. Soon, we will add dental health and obesity.

RECRUITMENT AND RETENTION EFFORTS OF MEDICAL DEPARTMENT PERSONNEL

Navy medicine continues to face challenges in reaching the end-strength targets for our medical communities. This has resulted in shortages in several critical wartime specialties. Unfortunately, medical professionals are not considering the military for employment, especially as civilian salaries continue to outpace the financial incentives available.

We are optimistic that new initiatives authorized in the National Defense Authorization Act for Fiscal Year 2007 (NDAA FY07) will enable the medical department to address many recruiting issues. Some of the improvements include: increases to the Health Professions Scholarship Program (HPSP), increases in direct accession bonuses for critical wartime specialties, and expanded eligibility for special pay programs.

Our losses have outpaced gains over the past several years and fiscal year 2006 was no exception, ending the year with a 93.5 percent manning across the Navy medical department. Our primary concern is attrition within critical wartime specialties. Additionally, concerns over excessive deployments and mobilization of certain specialties, especially in the Reserve Component where Reservists fear the potential loss of their private practice, have been a major deterrent to entering the Navy's medical department in recent years.

As of December 2006, the Medical Corps remained below end-strength targets and continues to experience acute shortages in critical wartime subspecialties. Recruiting challenges continue to exist within the HPSP, the primary student pipeline for Medical Corps officers. The HPSP met only 56 percent of goal in fiscal year 2005 and 66 percent in fiscal year 2006 for medical students. These shortfalls will be realized in fiscal year 2009 and 2010 with 230 fewer accessions than required. Retention issues continue to be of concern for this community and the effect of increased medical special pay rates offered for fiscal year 2007 will not be known until the end of the fiscal year.

The Dental Corps continues to remain under end-strength (at 90 percent manned), especially in the junior officer ranks where attrition is high and accessions have been a challenge in recent years. The HPSP, also the primary student pipeline for the Dental Corps, met 76 percent of its goal in fiscal year 2006. However, like the Medical Corps, it is expected that program improvements recently approved will have a positive impact on our recruitment efforts. Finally, with regard to dentists, a Critical Skills Retention Bonus (CSRB) was recently approved to grant a \$40,000 contract for 2 years of additional service to general dentists between 3 and 8 years of service. It is anticipated that this bonus will help mitigate the civilian/military pay gap, making Navy Dental Corps more competitive with civilian salaries, thus improving retention.

The Medical Service Corps assesses to vacancies in subspecialties and success in meeting direct accession goals is largely dependent on the civilian market place. Last year the Medical Service Corps fell short of their direct accession goal by over 30 percent for the second year in a row, directly impacting the ability to meet current mission requirements. Retention of specialized professionals such as clinical psychologists and physician assistants remains the greatest challenge as deployment requirements increase for these professions. Shortages in these critical wartime communities are being addressed with increased accession goals and a CSRB for clinical psychologists. In addition, Navy Medicine is working within Navy to ex-

plore other incentive programs for this specialty. The Health Professions Loan Repayment Program has been a successful recruiting and retention tool for hard to fill specialties and is being expanded, as funding will allow, providing recruiting command with additional incentives.

Navy Nurse Corps is the only medical department specialty projecting to meet fiscal year 2007 accession goals. The national nursing shortage and competition with the civilian market and other military services have continued to challenge recruiting efforts for scarce direct accession resources. To counter this, the Nurse Corps Accession Bonus was increased in fiscal year 2007 and the Navy Nurse Corps has continued to shift more emphasis onto its highly successful Nurse Candidate Program (NCP), requesting a permanent increase in new starts for this program and decreasing direct accession goals. Retention rates have slightly decreased, especially among clinical specialties with a high operational tempo.

We met 99 percent of the active enlisted Hospital Corpsman (HM) goal and 94 percent of the Reserve enlisted medical corpsman goal. From January 2006 to January 2007, Navy medicine retained 52 percent of corpsmen in Zone A, 55 percent in Zone B, and 84 percent in Zone C. HM is slightly below overall Navy retention rates for Zone B, but is improving. The other two HM zones are either at or exceed overall Navy retention rates and exceeds goals set.

The outlook of the medical department shows we have some significant challenges ahead, and Navy medicine is grateful for Congress' willingness to step in and help when needed. We continue to reach out to universities and medical and dental schools to encourage these students to join us and practice medicine where keeping service members and their families healthy, and not just treating disease, is our primary mission.

RESEARCH AND DEVELOPMENT EFFORTS

Navy medicine is actively engaged in the research, development, testing and evaluation of new technologies that improve the health of all beneficiaries, especially those technologies focused on enhancing performance and decreasing injury of deployed warfighters. A significant part of our R&D efforts are aimed at improving the tools available to combat support personnel, as well as disease prevention and mitigation of our forces at home and abroad. Our R&D efforts include specific areas of expertise such as undersea medicine, trauma and resuscitative medicine, and regenerative medicine. We have partnered with the other services and with world-class organizations like the National Institutes of Health.

Navy medicine's researchers have recently begun phases two and three of Food and Drug Administration (FDA) approved trials for a vaccine developed to stop the adenoviral illness that can make sailors ill. This illness is caused by viral pathogens, or germs, that can make sailors sick and causes loss of valuable time in training. The results from this trial, which is led by the Army, could eventually reduce illness in as many as one-fifth of sailors in basic training. The U.S. Naval Health Research Center based in San Diego (NHRC) has a long history of successful research on respiratory infections, especially adenoviral infections, and NHRC houses the Navy Respiratory Disease Laboratory, making it the ideal partner with the Army research team.

After years of research into malaria, the deadly mosquito-borne infection that kills more than 1 million people every year, Naval Medical Research Center (NMRC) in Silver Spring, Maryland, will begin human testing on an experimental malaria vaccine. Although there have been no malaria deaths of U.S. military personnel since 2002, when an Army Special Forces soldier died following a mission to Nigeria, the disease can have a significant negative effect on troop readiness. In August 2003, during a Marine Corps deployment to Liberia, a mission was aborted when 44 percent of the members of the Marine Expeditionary Unit acquired malaria after spending nights at the Monrovia airport.

As I mentioned before, our high combat casualty survival rates are due to the training and commitment of our corpsmen, our willingness to implement lessons learned, and improvements in life-saving technologies. Navy Medicine R&D is evaluating the effectiveness of more than a dozen new hemostatic agents and devices. The outcome of this critical study will drive the Marine Corps selection of the component to be deployed as part of the Individual First Aid Kit that every marine and sailor is issued when entering the combat theater. NMRC evaluates the effectiveness of these devices, which are designed for application under battlefield conditions and removal in the operating room. In addition to the Navy and Marine Corps, we expect other services and civilian police departments to benefit from this development.

Navy medicine is beginning the evaluation of devices that detect the early signs of TBI. We have seen an increased incidence of TBI resulting from exposure to explosive devices in theatre, particularly IEDs. Fielding such a device will allow earlier intervention and treatment that could prevent the longer term, often devastating, effects of TBI. Such devices are designed to detect even mild TBI and indicate to our corpsmen and physicians which casualties require further monitoring and treatment.

Navy medicine R&D is working side by side with the Marine Corps finalizing development of a critical component of the En Route Care System. Called the MOVES (Mobile Oxygen, Ventilation, and External Suction), this single integrated device provides a capability for casualty management that reduces the weight and cube over current systems by nearly 75 percent. Because it does not require external oxygen, the device will allow our airlift assets to operate without dangerous high-pressure oxygen cylinders onboard. The MOVES is scheduled for delivery for field testing in fiscal year 2008.

NAVY MEDICINE AND THE DEPARTMENT OF VETERANS AFFAIRS

As the number of injured service members who return in need of critical medical services increases, and due to the severity and complexity of their injuries, increased cooperation and collaboration with our Federal health care partners is essential to providing quality care. As an extension of Navy medicine's ability to care for patients, partnerships with the Department of Veterans Affairs' (VA) medical facilities continue to grow and develop into a mutually beneficial association. The VA's Seamless Transition Program to address the logistic and administrative barriers for active duty service members transitioning from military to VA-centered care is at most Navy MTFs with significant numbers of combat-wounded. This program is working well and continues to improve as new lessons are learned.

Navy medicine and the VA also continue to pursue increased collaboration in resource sharing, new facility construction, and joint ventures. Using our sharing authority, we are rapidly moving toward functionally integrating the Naval Hospital Great Lakes and the North Chicago Veterans Affairs Medical Center and expect to fully complete the project by 2010. This facility will seamlessly meet the needs of both VA and Navy beneficiaries. Other locations identified for future physical space sharing with the VA include: Naval Hospital Charleston, Naval Hospital Beaufort and Naval Hospital Guam.

Navy medicine is also exploring new relationships with the VA such as the Balboa Career Transition Center. NMCS D recently entered into an agreement with the U.S. Department of Labor, the VA and the California Employment Development Department to provide quality VA benefit information and claims intake assistance, vocational rehabilitative services, career guidance, and employment assistance to wounded and injured service members and their families. This unique program will successfully coordinate all of the services available to these individuals.

CONCLUSION

Chairman Inouye, Senator Stevens, distinguished members of the committee, thank you again for the opportunity to testify before you today about the state of Navy medicine and our plans for the upcoming year.

It has been a privilege to lead Navy Medicine for the last 3 years as Navy medicine has risen to the challenge of providing a comprehensive range of services to manage the physical and mental health challenges of our brave sailors and marines, and their families, who have given so much in the service of our Nation. We have opportunities for continued excellence and improvement, both in the business of preserving health and in the mission of supporting our deployed forces. I thank you for your tremendous support to Navy medicine.

Senator INOUE. May I now recognize the Surgeon General of the Air Force, Lieutenant General James Roudebush.

STATEMENT OF LIEUTENANT GENERAL JAMES G. ROUDEBUSH, SURGEON GENERAL, DEPARTMENT OF THE AIR FORCE

General ROUDEBUSH. Thank you, Senator Inouye, Senator Stevens.

Senator INOUE. Can you pull that mike up? I can't hear you.

General ROUDEBUSH. Thank you. Senator Inouye, Senator Stevens, distinguished members of the subcommittee, thank you for

the opportunity and the privilege of being here today to tell you about Air Force medicine on the battlefield and at home station.

Up front, I would like to note that Air Force medicine is not simply about support and not simply about reacting to illness and injury. Air Force medicine is a highly adaptive capability, tightly integrated into Air Force expeditionary capability and culture.

We build a healthy, fit force, fully prepared to execute the mission from each of our bases, whether deployed or here in the States, because every Air Force base is an operational platform. Whether launching bombers from Whiteman Air Force Base, or sitting alert in a missile control facility at Warren Air Force Base, or providing close air support from Balad Air Base in Iraq, we project airpower for our joint forces and provide sovereign options for our national leadership, all from our bases of operation.

Air Force medicine supports that warfighting capability at each of our bases, and is, in fact, designed to prevent casualties and sustain our fighting strength. The result is the lowest nonbattle injury rate in the history of warfare, but when there are casualties, Air Force or joint, your Air Force medics are there with world-class care.

In the deployed arena, our medical teams operate closer to the front lines than ever before, allowing us to provide warfighters advanced medical care within minutes. Underpinning this world-class healthcare for our joint warfighters is our system of joint enroute care. It does begin with a Navy corpsman or an Army medic providing lifesaving first aid at that point of injury.

The casualty is then moved to the next level of care. For us in the Air Force that's our theater hospital at Balad Air Base, the hub of the joint theater trauma system, where lifesaving, damage control surgery is performed by Air Force surgeons and, on occasion, teaming with Army surgeons to provide that surgical care.

The casualty is then prepared for safe and rapid movement in our Air Force air medical evacuation system to Landstuhl, an Army hospital manned by Army, Air Force, and Navy medics. Retriage and restabilization is then accomplished, and the casualty prepared for air evacuation back to definitive care at Walter Reed, Bethesda, Brooke Army, Wilford Hall, Navy Balboa, or perhaps a VA hospital.

These capabilities combine to achieve an average patient movement time of 3 days from battlefield to stateside care. This is certainly remarkable when compared to the 10 to 14 days required during the Persian Gulf war and the average of 45 days it took in Vietnam, and it's especially remarkable when you consider the severity and complexity of the wounds that our forces are sustaining.

In short, Air Force medicine is a key and central player in the most effective joint casualty care and management system in military history. Having just returned from Afghanistan and Iraq just last weekend, I personally observed this capability from that far forward care all the way home on the air evacuation to the United States, and it's truly lifesaving work.

As our casualties move back to Landstuhl and on to our stateside military medical centers, our Air Force casualties are followed closely by their unit through an assigned family liaison officer to ensure needs of the casualty and their family are met. And if going through the disability evaluation process is the next step for our

wounded airmen, the Air Force Palace Helping Airmen Recover Together (HART) program ensures the commander, we medics, and the family liaison officer continue eyes-on and hands-on throughout the disability process.

Our Air Force medical capabilities go beyond home station healthcare and support of our warfighters. Our Air Force medics are globally engaged in training our allies, supporting humanitarian missions, responding to disasters, and winning hearts and minds in key areas around the globe.

And as we focus on care for our warfighters, I believe it's vitally important to note that caring for the families of our airmen is also a mission-critical factor. Knowing that their loved ones are well cared for back home gives our airmen the peace of mind to do a critical job in a stressful and dangerous environment. The care we provide is an important factor in building the trust that is fundamental to attracting and retaining an all-volunteer force.

This demanding operations tempo at home and deployed also means that we must take care of our Air Force medics. This requires finding a balance between these extraordinarily demanding duties, time for family, and time for personal recovery and growth.

And it means developing the next generation of Air Force medics. My charge is to ensure that we recruit the best and brightest, prepare them to expertly execute our mission, and sustain and retain them to support and lead these important efforts in the months and years to come.

In summary, the talent and dedication of our military medics ensure an incredible 97 percent of the casualties that we see in our deployed and joint theater hospitals will survive today. For our part in this extraordinary system, Air Force medics have treated and safely evacuated more than 40,000 patients since the beginning of Operations Iraqi Freedom and Enduring Freedom.

Globally, we have provided compassionate care to 1.5 million people on humanitarian missions over the last 6 years, and at home station we continue to provide high quality health care for 3 million patients every year.

PREPARED STATEMENT

Thank you for your support and assistance in meeting this incredibly demanding and critically important mission. I assure you we will continue to work hard with you in the months and years ahead to sustain and improve our medical capabilities for this fight and for the next. Thank you, and I look forward to your questions.

Senator INOUE. Thank you very much, General Roudebush.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL JAMES G. ROUDEBUSH

Mr. Chairman and esteemed members of the committee, as the Air Force Medical Service's (AFMS) Surgeon General, it is a pleasure and honor to be here today to tell you about Air Force medical successes on both the battlefield and home front.

The Secretary and Chief of Staff of the Air Force set our priorities: Supporting the global war on terrorism, caring for airmen and their families, and recapitalizing our assets. The AFMS fully supports these priorities by: Taking care of joint warfighters and our Air Expeditionary Force; taking care of our Air Force family; and building the next generation of Air Force medics. And please note that when I say "medics," I am referring to all our Air Force medical personnel-officer and enlisted.

Upfront, I'd like to say, Air Force medicine is not simply about support, not simply reacting to illness and injury, and Air Force medicine is definitely not a commodity. Air Force medicine is a highly adaptive capability, a key part of Air Force expeditionary capabilities and culture. Our proactive and visionary work contributes heavily to a healthy fit force that is leveraged and designed, in fact, to prevent casualties. But . . . when there are casualties, we are there with world class care.

We provide the same quality of care—and access to care—for all of our nearly 3 million beneficiaries. Our stand out health care and health service support worldwide ensures total force personnel are healthy and fit before they deploy, while deployed, and when they return home. This is our hallmark, and the result is the lowest disease, non-battle injury and died of wounds rates in the history of war. We are committed to providing the very best health care to our Air Force and joint warfighters.

TAKING CARE OF OUR EXPEDITIONARY FORCE AND JOINT WARFIGHTER

Our medical teams operate closer to the front lines than ever before, enabling us to provide warfighters advanced medical care within minutes. Without question, every day, Air Force medics save the lives of soldiers, sailors, marines, airmen and civilians; Coalition, Afghani and Iraqi; friend and foe alike. Underpinning this world-class health care for our joint warfighters is our system of en route care. We ensure joint warfighters receive seamless care through the continuum of care from first battle damage surgery to definitive care and recovery back in the United States. En route care relies on our unique capabilities in Expeditionary Medical Support (EMEDS) and Aeromedical Evacuation (AE).

Aeromedical Evacuation

Aeromedical evacuation is distinctly Air Force, and a critical component of the Air Force's global reach capability. We safely care for and transport even the most severely injured patients to definitive care.

Our expeditionary medical system and AE system combine to achieve an average patient movement time of 3 days from the battlefield to stateside care. This is remarkable when compared to the 10–14 days required during the 1991 Persian Gulf War or the average 45 days it took in Vietnam.

Our modern AE teams—which include Active Duty, Guard and Reserve forces—coupled with our innovative Critical Care Air Transport Teams (CCATT), operate flying intensive care units in the back of virtually any airlift platform. This success resulted from our shift to designated, versus dedicated, aircraft and training universally qualified AE crew members able to execute their AE mission on any airlift aircraft. This transformation of AE has been repeatedly proven in the global war on terrorism, as evidenced by the safe and rapid transfer of more than 38,000 Operation Enduring Freedom and Operation Iraqi Freedom patients from overseas theaters of operation to stateside hospitals!

To illustrate this capability, consider Marine Sergeant Justin Ping's story. As a result of a suicide bomber attack in Fallujah, Iraq, Sergeant Ping sustained severe burns to his face and hands, blast injuries to his right arm, and shrapnel embedded in his leg and right eye. Without immediate care, the shrapnel to his eye would have undoubtedly resulted in permanent loss of sight. After receiving superb first aid from his Navy corpsman immediately after injury, Sergeant Ping was flown from the battlefield to the Air Force theater hospital at Balad where his injuries were stabilized. It was quickly determined that Sergeant Ping's injuries would be best treated in the United States. Major (Dr.) Charles Puls, (a CCATT physician) provided full life support for Sergeant Ping during the 17-hour, 7,500 mile aeromedical evacuation flight from Balad to Brooke Army Medical Center, San Antonio, Texas. Major Puls said, "The patient was stable throughout flight . . . we cared for him prior to and during the flight," referring to his team comprised of Captain William Wolfe, a nurse, and Senior Airman Bertha Rivera, a respiratory therapy technician. His team ensured Sergeant Ping received the best en route care and most expeditious transport all the way back to definitive care. There is no doubt that this superb en route care saved Sergeant Ping's eyesight. Sergeant Ping is doing quite well today thanks to all the medics—Navy, Army, and Air Force—who were dedicated to his care.

Barbara Wynne, spouse of our very own Secretary of the Air Force, recently expressed the importance of our capability when she wrote in a letter to all airmen, "We visited the hospitals in Balad, Landstuhl, and at Walter Reed . . . The doctors, nurses and technicians are the cream of the crop. Their expertise, saving so many lives, is the silver lining to this conflict. It truly is the "Miracle of Iraq and Afghanistan."

Commitment to Jointness

I am proud to say that the AFMS is all about “Joint.” Not only do we run the renowned Air Force theater hospital in Balad, as well as smaller facilities in Kirkuk and Baghdad, 300 Air Force medics jointly staff Landstuhl Medical Center, Germany. Additionally, we are about to assume operational control of the theater hospital at Bagram Air Base in Afghanistan this month.

The AFMS has been deeply involved in establishing the most effective joint casualty care and management system in military history. Whether stabilizing a casualty, preparing a casualty for transport, providing continual care at stops along the way, or moving the patient in our AE system; what matters is providing the very best care possible to every injured or ill warfighter at every point in the care continuum. Everything medical in theater is designed to support moving casualties from the point of injury to the right level of care, at the right place, in the least amount of time.

To that end, we believe it is critically important to work closely with our sister Service medics in leveraging our joint capabilities. Working to improve our common “enabling” platforms—such as logistics, information management, information technology, and medical research and development—will serve to make all medics better prepared to support the Joint warfighter. Side by side with our Service counterparts, we recently concluded a 72-day humanitarian and civic assistance deployment with the Navy on board the USNS Mercy. Yes, we are all about jointness and supporting the joint warfighter.

However, our focus is not just the war. Our Air Force medics are globally engaged in training our allies, supporting humanitarian missions or responding to disasters. To assist in this role, this year the Air Force built a new type of unit—the Humanitarian Operation Relief (HUMRO) Operational Capabilities Package (OCP)—a streamlined package of 91 medics and 133 base support personnel designed to support a humanitarian relief mission. This HUMRO OCP will provide a rapid and tailorable response to a disaster; and by leaving the deployable hospital and medical equipment, it will provide an enduring medical capacity for the host nation following redeployment of our U.S. Air Force personnel.

Delivering this remarkable medical care across the full spectrum of missions takes trained, clinically current physicians, nurses and technicians. The AFMS concentrates on joint medical education programs and has developed clinical training platforms providing surgical and trauma care experience. Our readiness training platforms, including training arrangements with Baltimore Shock Trauma, Cincinnati-Center for Sustainment of Trauma and Readiness Skills (C-STARS), and St. Louis-C-STARS, ensure our Air Force medics are the best trained in history.

Taking care of the expeditionary force and warfighter is job number one. But crucial to that mission is taking care of our Air Force family.

TAKING CARE OF OUR AIR FORCE FAMILY

When our airmen join the Air Force, we make a commitment to them and their families that we will care for them throughout their period of service, and into retirement for career airman, whether at their home station Medical Treatment Facility (MTF), in a deployed MTF, or through private sector care Tricare contracts. To that end, we have an integrated delivery system throughout our Air Force community to support our airmen’s health, including physical, mental, and dental needs. We work closely with the Department of Veterans Affairs and our Tricare networks to provide seamless care.

Warfighter Fitness and Deployment Health

We begin by ensuring a fit and healthy force at home station. We maintain every warfighter’s health and fitness through periodic assessments of their health and workplace, and support them with an effective physical fitness training and testing program. Before they deploy, we ensure they are medically ready.

In theater, our preventive aerospace medicine teams assess the austere environment to which our forces deploy, and continue to provide surveillance of their health and environment while deployed. If our airmen and joint warfighters become ill or injured, we rapidly transport them with cutting edge en route medical care to expeditionary medical support and then to definitive stateside care.

Prior to deployment and upon redeployment home, we evaluate our airmen’s health—physical, mental, and emotional—through the use of a Pre- and Post-Deployment Health Assessment (PDHA). We then reevaluate at 3 to 6 months post deployment using the Post Deployment Health Reassessment (PDHRA) as the next link in the continuum of care. To date, 70 percent of required PDHRAs are completed. Thirty-eight percent of them were considered positive due to a possible phys-

ical or emotional condition, with 2 percent reporting a Post Traumatic Stress Disorder (PTSD) symptom. Less than 0.5 percent have been positively diagnosed as actually having PTSD. Each positive finding is assessed by health care providers and appropriate treatment provided if required.

The AFMS is committed to providing our airmen the most current, effective, and empirically validated treatment for PTSD. To meet that goal, we are training our behavioral health personnel to recognize, assess, and treat PTSD in accordance with the VA/DOD PTSD clinical practice guidelines. Using nationally recognized civilian and military experts, we have trained 89 psychiatrists, psychologists, and social workers representing 45 Air Force installations. Our goal is to equip every behavioral health provider with the latest PTSD research, assessment modalities, and treatment techniques.

Caring for the families of our airman has a mission impact. Assuring high quality and timely care for our family members at home gives our airman the peace of mind they need to do a critical job in stressful and dangerous environments.

Partnerships

Our commitment to the health of our airmen and their families also includes partnerships with leading civilian institutions. For instance, the AFMS and University of Pittsburgh Medical Center have teamed in collaborative efforts to prevent and/or delay type II diabetes, including associated complications, through education, early treatment modalities and community outreach. Other critically important efforts include the development of collaborative relationships with various Department of Veterans Affairs facilities and a robust Tricare network. Throughout this continuum, we work closely with our sister Services and civilian counterparts to provide preventive health care, interoperable surveillance, research and development, outreach, and treatment. Caring for our Air Force team and family also means taking care of our medics. We ensure that they are healthy and prepared for the mission they will face. With that in mind, our next priority involves taking care of our Air Force medics.

TAKING CARE OF EACH OTHER

The AFMS is committed to providing our Air Force medics the resources needed to perform the mission. To this end, we developed a new "Flight Path" to guide our organizational structure and the development of each of our Air Force medical personnel.

Professional Development

We created a clear "Flight Path" to match Air Force needs with individual professional growth requirements. The overall goal of the "Flight Path" is to develop a streamlined, consistent medical group structure, from clinic to medical center, that provides a ready and fit medical force in support of the Air Expeditionary Force. It assures military and functional medical competence; provides a power projection platform to deploy medics forward; and delivers high quality, cost-effective care.

The "Flight Path" fosters corps-specific force development, requirements-driven leadership opportunities, and balanced leadership teams within the MTF. It also assures compliance with military and civilian certification requirements, access to graduate medical education, and cost-effective mission support at home and when deployed.

In these ways, our "Flight Path" is helping us develop the next generation of Air Force medics. The way I view it, my charge is to ensure we recruit the best and brightest people, prepare them to expertly execute our mission, and retain them to support and lead these important efforts. Ideally, we do this in a way satisfying for them, and in a fashion that enables a balance between duty and family.

Balance

An essential part of taking care of each other is to make sure our medics have the right balance in their lives between their professional duties and their families. We create better balance through staffing, finding the right mix of military, civilians and contractors, and by focusing our recruiting and retention efforts to maintain this mix. In these ways and others, we are recapitalizing our greatest resource, our people.

Air Expeditionary Force and Constant Deployer Model

We believe the Air Expeditionary Force (AEF) rotational construct is the right construct for the AFMS. It provides the predictability needed for planning, training, deploying and reconstituting our force that leads to an effective long-term strategy and, just as crucial, outstanding quality of life for our airmen.

Another innovation geared toward taking care of our people is our Constant Deployer Model (CDM), which provides a continuous deployed capability with sustained access to care at home station as well as maintaining a balance between our people's deployed, professional and personal lives. This model has ensured access to care at home via contracted personnel and improved quality of care at deployed locations. We believe working in more efficient ways lends itself to taking care of each other.

Air Force Smart Operations for the 21st Century, AFSO21

An important tool—implemented Air Force-wide by the Secretary of the Air Force, Michael W. Wynne and the Air Force Chief of Staff, General T. Michael Moseley—is the Air Force Smart Operations 21 program. Using a variety of tools, including Lean and Six Sigma, AFSO21 is being used to streamline operations through process changes to improve efficiency and reduce waste.

As medics, AFSO21 will make us more effective in supporting both the Air Force expeditionary mission and the joint mission. The use of process analysis and lean thinking will be essential in making sure that we are both relevant and cost-effective in support of our mission today, and tomorrow.

Challenges Ahead

Today we are faced with the most challenging of times. We must implement BRAC while we simultaneously support the global war on terrorism. The BRAC process has given us a tool to reposture several of our key MTFs. We are also creating efficiencies outside of the BRAC process, restructuring some MTFs to better meet today's demands.

Attracting and retaining the very best medics builds morale and trust to sustain the all volunteer force. Professional development, AEF rotations, AFSO21, BRAC, and military construction work together to recapitalize our Air Force Medical Service. Air Force medicine cares for our most treasured national asset—America's sons and daughters.

SUMMARY

The talent and dedication of military medics ensures that an incredible 97 percent of the casualties we see in our deployed and joint theater hospitals will survive today. We safely aeromedically evacuated and treated more than 38,000 patients from theaters of operations since the beginning of Operations Iraqi Freedom and Enduring Freedom, provided compassionate care to 1.5 million people on humanitarian missions over the past 6 years, and continued to care for 3 million patients annually all over the world.

Despite our successes, Mr. Chairman and members of the committee, we are far from a position where we can rest on our laurels. I assure you we will continue to work hard with you in the months and years ahead to perfect the joint continuum of care for this fight, and the next! Thank you for your outstanding support.

Senator INOUE. Senator Stevens.

Senator STEVENS. Thank you very much.

BASE REALIGNMENT AND CLOSURE RECOMMENDATION

General Kiley and Admiral Arthur, I am told that less than 87 percent of the medical facilities' sustained restoration and modernization requirement is funded in the budget through 2008, and we all know that base realignment and closure (BRAC) funding was reduced by \$3.1 billion in the enactment of the continuing resolution. Under these extreme circumstances—I would like both of you to comment—do you still believe that the BRAC recommendation to consolidate Walter Reed and the Navy hospital at Bethesda should go forward?

General KILEY. Go ahead.

Admiral ARTHUR. Senator Stevens, we have already been in process of merging the two facilities, and General Kiley and I have been very active with our staffs. The plan, the vision is to have a state-of-the-art medical center at Bethesda, on that campus, that modernizes the facilities and provides the care that people need in

the northern part of the national capital area, with the southern part of the national capital area being cared for by an enriched facility at Fort Belvoir.

If the plans were to change, it would, of course, change the shape of what our plans are at Bethesda, but I think in the future we have a vision of a very fine facility at Bethesda that combines the talents of the Army and the Navy and the Uniformed Services University of the Health Sciences and the National Institutes of Health (NIH) and the Suburban Hospital Trauma Center that's adjacent to NIH. So the plans are for a very robust, modern, and state-of-the-art facility.

But there is a lot of advantage to combining the facilities, combining the staffs, and having a single DOD mission at a joint command.

Senator INOUE. Do you agree, General?

General KILEY. Sir, I have said since the law was passed and the decision was made to move Walter Reed over to the National Naval Medical Center, that the challenge and the risk was in properly funding this. To get to the vision that the BRAC saw, of a unified program on the Bethesda campus and a large 150-bed facility at Belvoir to manage the healthcare of the population to the south, was going to take a lot of money, and I think it still remains a significant risk to do this thing, this process, properly.

In addition, consistent with what we have seen in the news in the last 3 weeks, the combat casualty care at Walter Reed is not just about in-hospital operating capability, it's about continuing to care for soldiers and families on the campus. The Chief of Staff has made it clear this is a long war, so my concern is, are we going to have an ability to maintain for however long we're in combat operations around the world, this same capability which we'll get right here real quick at Walter Reed, maintain that while making the moves and the building and the construction to transform it?

My comments in other hearings were that this might require some more national discussion, that we may need to take a look at this, and I'm not in a position to proffer a recommendation at this time, but I clearly think it needs to be looked at in light of our current operations and our proposed future operations.

Senator STEVENS. I opposed it in the beginning because I didn't think it was timely in view of the flow of combat wounded coming back at this time. I don't know why we would spend money on modernization and really on consolidation. I think that money ought to be spent to take care of these people that are coming back, and I really hope it's looked at again in terms of the time. It's a wonderful vision when the war is over, but right now I think our first call ought to be to put all the money we can find in treating these people properly and getting them home, and getting the post-medical treatment piece of this care that's so needed right now, getting it funded.

MILITARY-TO-CIVILIAN CONVERSION

I am told that the medical readiness review directed you, Admiral Arthur, to convert an additional number of medical billets to civilians, and I wonder about that. General Roudebush, you're involved in this, too. I'm told you're converting 123 of the nurses to

civilians. I don't know how you can do that with the nursing shortage that exists in civilian life.

I really wonder about some of these instructions you all have received, particularly in view of the fact that we're going to increase the end strength of the Army and Marine Corps. How can we find enough physicians and corpsmen to support the additional marines if we're going through this conversion to civilian positions? Can you all comment on that? Are you going to be able to do it? General Roudebush?

General ROUDEBUSH. Sir, in terms of the conversions that we currently have programmed, we have done both the analysis to look at whether the capabilities are available and affordable, and what we have programmed at the moment, we believe we can convert and sustain.

Now, going beyond that, however, we think is going to be very problematic, and we're very concerned about going any further than we've gone as we have currently programmed. So that is a matter of great concern to us, and what we need to do is to examine very closely our success in both converting and hiring as we go forward with those that we have currently programmed, and I think that will dictate in many regards the success of whether we can sustain this or not. So that has yet to be told.

Senator STEVENS. Any comments, Admiral?

Admiral ARTHUR. Yes, sir. We have planned to come down from about 36,000 active duty members to a little over 30,000. I think that the assumptions that were made in the medical readiness requirements review were overly optimistic about the small number of casualties, the small number of missions, and the extent of deployments that we'll have to do in the future.

For example, no one is planning to deploy multiple times to a theater of operations. I think we're setting ourselves up to disappoint our line commanders in not being able to provide combat service support.

The military-to-civilian conversions that we have already been trying to do have been successful to about the 80 percent level. We are not able to fill about 20 percent of those positions. My fear, as we get into the more critical skills, is that we'll not be able to find the people that we need with the skills that we require for the money that we're offering, and they will answer a contract for money. There aren't many people who are on active duty today, although they earn their paycheck, who are working primarily for the money. They work for other values and other principles.

For example, we have a radiologist in the Navy. The programming rate for that radiologist is \$124,000. The composite rate, with bonuses, is \$168,000. And we are only able to hire them, we just hired one at Bethesda, for \$400,000. Now, the difference in pay is one thing, but when you place—

Senator STEVENS. \$400,000?

Admiral ARTHUR. Yes, sir, and that's cheap for a radiologist. And when you place a \$400,000 radiologist right next to an active duty service member who's making less than half of that, the morale factor for retention of those good active duty officers is striking. The contractor is making Lexus payments and our radiologists are

making Toyota payments, not that Toyota is a bad car, but to sit side by side, there is an effect on retention.

When you combine the military-to-civilian conversions with the various wedges that we have been given in our funding—for example, next year Navy medicine is predicted to have a wedge of \$343 million out of about a \$2.4 billion budget—we are not going to be able to maintain services at the level that we have now with a one-sixth cut in our funding.

So we are facing a number of challenges that are coming together in a perfect storm. It's the funding, it's the people, and it's the increasing mission not only for combat service support but for those casualties who are coming back, who need even more services. There are places where we have physicians who are doing their own administrative work, filling out workers' compensation forms and other paperwork, because we don't have the support staff because they have been systematically cut over the last few years. It's degrading our efficiency, it's degrading our morale, and it's degrading our ability to take care of combat-wounded veterans.

Senator STEVENS. General?

General KILEY. Senator, I echo everything my fellow Surgeon Generals say. The Army's numbers were in some cases smaller, but the Army's Medical Department has been working for several years now with the Army, attempting to capture spaces to build brigade combat teams. And so in support of the Army's effort to do that, the Army Medical Department, active duty, enlisted, and officer have been part of the pool that has been looked at.

To date we have been able to do the military-to-civilian conversion, as they say. DOD and the Army have given us the replacement dollars. As Admiral Arthur has outlined, we have attempted to avoid—in fact, we have avoided—converting some of the more expensive specialties, as you've heard, and radiology is only one of them.

But we're at the point now where my concern is along the lines of second and third order effects of this, and we've talked about recruiting and retention and morale. We've talked about a rotating base of active duty. More than 50 percent of our medical personnel have deployed at least once, and so if we talk to doctors about coming into the service and they know a lot of doctors have already deployed, we have to show them this is about service to the Nation.

We got full support from the Congress as it relates to resources, and by that I mean money, to contract healthcare personnel of every level in taking care of our wounded soldiers. And I can talk some more about the impacts of other pieces of caring for wounded soldiers. Our core budget, though, as Admiral Arthur has alluded to, we are now facing this wedge, which is a notional decrease in our budget which the Department of Defense is—

Senator STEVENS. That was going to be my next question. Efficiency wedge, I think it's called, right?

General KILEY. Yes, sir, and I don't believe I was the Surgeon General when these decisions were originally made, but the intent was to motivate, I think, the medical services facilities in an effort to improve their efficiencies, find ways to save money, and identify those dollars so that you were actually not spending as much as

years went on, in an effort to control a not insignificant inflationary rise in the DHP.

This year it's \$80 million in my core budget. Next year it's on the order of \$142 million. I can make some adjustments this year to an extent. Working with the Department of Defense in budgeting, as we show that they're doing more work, they are rewarding us with more resources in a more businesslike environment. Now, that's not just for combat soldiers. That's for all our family members, retirees, et cetera.

But I absorbed it last year. We were fully funded last year. This year we're challenged. It remains to be seen whether we'll close the budget this year. I can't find \$142 million in efficiencies, and I have asked my hospitals to transform and to become more businesslike, so we can document what we're doing and show the Congress that we are getting the most bang for the buck, if I may, for that.

So I am concerned about military to civilian. We're watching it very carefully. As you know, the Army may be expanding. We may have a larger mission, and we're dealing almost daily with the Army on this. And our numbers appear to be consistent with what the MRR asked for, so at this point we're not in the same position as the other two services with MRR.

EFFICIENCY WEDGES

Senator STEVENS. And I can't take any more time. I'm appalled. I note this efficiency wedge, Army for 2008 is \$142.3 million, Navy \$147 million, and Air Force \$197.5 million. For 2009, however it goes up: the Army, \$227.3 million, \$234 million for the Navy, and \$323.7 million for the Air Force.

That's on top of the assumption that we're going to enact the increased deductibles and charge annual enrollment fees for TRICARE. That has not been approved by any congressional committee that I know of. The assumptions, I think, Mr. Chairman, we need to get the budgeteers in here and ask them to explain to us where they found all these numbers.

It is shocking to see, at a time when military medical facilities need more money, that we have budget people directing reductions on the basis of efficiency or increased payments that the military people have to make, that are unrealistic, totally unrealistic. I'm really, really alarmed at that.

As I've said, I've taken too much time. I congratulate you on what you're doing, but I do think that the conversion at Walter Reed ought to slow down. I think the movement of the troops from Germany to Italy ought to slow down. I think we ought to start spending the money where it's needed right now, on the people who have been wounded in these combat activities, and follow them through, and put on hold a lot of these things the Department is suggesting.

So I'm hopeful that we'll get the Department back in here again, and we'll have a chance to discuss these assumptions that you can make these changes and still deliver the quality care that these guys and ladies deserve for having served our country so well. Thank you, Mr. Chairman.

Senator INOUE. Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

General Kiley, as I said in my opening statement, I was deeply disturbed by what I was reading in my Washington State papers today. As you can imagine, since we've heard about what happened at Walter Reed, my office and others have been hearing from a number of soldiers who are on medical hold in our State. They have been talking to us, but as I sort of indicated, they have been very worried to talk publicly.

We can't get to the bottom of this and we can't do our job unless we know exactly what's happening out there, and I want your personal assurance, if you would please give that to me, that no soldier who blows the whistle on substandard care will be retaliated against.

General KILEY. Senator, you have my word. There's a law that prevents that also, the whistleblower law, and I share your concern that soldiers either feel that they can't talk, certainly talk to their representatives, certainly we want them to talk to us, but we've never put a prohibition or a threat of retaliation, for example, if they talk to the press.

And I would ask that I, at your convenience, come back and report to you. I spoke to the hospital commander this morning. She's investigating that, and I think——

Senator MURRAY. The retaliation, or what's in——

General KILEY. No, ma'am, the issues that were—and I have not seen the article, but she has identified issues, the concern about asbestos in the living facility where the soldiers are, as an example. And I am told that yes, there is asbestos, and it is sealed. It has been investigated. It is not a risk to the soldiers.

So there are issues that we need to deal with across the Medical Department. Many of them, and I've said this in other testimony, really revolve around this very complex and inefficient and in many cases confrontational process between the medical boarding process and the physical evaluation boarding process. Soldiers don't feel like they've gotten the respect they deserve for their sacrifices when they're given a small disability from the Department of Defense.

Senator MURRAY. Well, let me ask you a number of questions. First of all, I am hearing from soldiers who say they are languishing for months and even years in military holdover units without the care that they need. The Seattle Times article that I mentioned to you tells the story of a woman, Captain Mary Maddox, who said, "The biggest problem with Madigan is that they are understaffed and overworked, and I ended up getting bounced from clinic to clinic."

Other press reports mention other soldiers who have been in medical hold for years. How can this be happening, 4 years into this war? Is it lack of staff? Is it lack of accountability? Is it a lack of caseworkers? A lack of leadership? What is happening?

General KILEY. It's not acceptable to have soldiers languishing, and I'll be the first to say that, and clearly we are taking action to make sure we don't. But I have said before that there are some soldiers who feel like it has taken a long time for their evaluation, and other soldiers——

Senator MURRAY. What do you think is a long time?

General KILEY. Well, this is what I was getting to. It depends on the condition. And the problem that we face across our military systems is that these are not simple injuries and diagnoses. They are——

Senator MURRAY. Is 18 months too long?

General KILEY. It may not be too long, ma'am, if there are a series of operative procedures that a soldier needs, and then they need to fully recover from each one of those. It may not be too long if they have a condition like TBI and PTSD and they're undergoing therapy, rehabilitative therapy. It may take as long as 1 year for us to get to a point where the soldier and the physicians feel that that soldier has reached the maximum therapeutic benefit.

Senator MURRAY. Well, you can understand what it's like for 18 months for someone to sit there day after day, appointment after appointment, being told one thing or another, and feeling like their life is absolutely on hold.

General KILEY. Yes, ma'am.

Senator MURRAY. You can imagine what it's like for their families. So we——

General KILEY. It's very difficult, I agree with you, and we're going to take——

Senator MURRAY. It seems to me way too long. I think it's an issue we need to address.

Let me focus on artificially low disability ratings—you mentioned that a second ago—which we all know will limit their military disability pension. It has a huge lifetime impact. I understand that lifetime pension requires a 30 percent disability rating?

General KILEY. Yes, ma'am.

Senator MURRAY. Well, one soldier told us that in more than 1 year he has only seen one person receive a 30 percent rating. There is a woman named Sergeant Jane Sullivan. She was granted only a 10 percent disability rating. She's in a wheelchair. Her medical problems include a back injury and heart condition.

And I have to tell you there is a suspicion that medical and physical boards are giving artificially low disability ratings simply to save money for the Army. At a hearing yesterday it was revealed that while other branches grant full disability about 20 percent of the time, for the Army it's only about 4 percent.

So, General Kiley, I want to know, has anyone suggested to you or have you suggested to anyone that there are problems with giving service members high disability ratings?

General KILEY. First of all, Senator, the medical personnel do not give the disability rating. The medical personnel do not do that. The personnel community does that, through the G-1 of the Army and the TAG of the Army down through the physical disability system. What the medical personnel do is, they treat and document the conditions and then present them.

I agree that the system that we have and that we have had since we first developed this is clearly perceived as unfair, particularly when it is compared with the VA system of disability. And I have suggested and we have already started discussions to change that. Some of this is in the law, some of it is in Department of Defense directives, and some of it is in Army regulations.

The other day General Cody used an example of an individual—the Department of Defense disability makes the determination that a soldier is unfit for a particular condition, as an example, if a soldier loses an eye, they are unfit for further service.

Senator MURRAY. Yes.

General KILEY. That's a disability of 40 percent. Now, the soldier may have other conditions that the VA would increase the disability, but the Department of Defense can't do that.

Senator MURRAY. I understand that. Will you send guidance to all of your board members, telling them that you expect disability ratings to reflect accurately a service member's injury?

General KILEY. I will send to all of my medical personnel to ensure that the medical evaluation board, which is in my lane, which is my responsibility, will, in fact, accurately reflect that. Yes, ma'am.

TRAUMATIC BRAIN INJURY

Senator MURRAY. Okay, and let me ask you one other quick question, and that's regarding traumatic brain injury. Many of you mentioned it. You know this is the signature issue of this war. We have a guardsman at Madigan who was sent home for a different injury, and it was his wife—who kept saying, "Well, he's not remembering things"—that actually got him back in.

The Department of Veterans Affairs announced several days ago that they are going to start screening for this, but I want to know if the Army and other services are going to start screening service members when they come home, before they have to wait forever to get into the VA system to discover this.

General KILEY. Yes, ma'am, and I agree that that's something that we have not done a good job at, for the simple reason that some of the mildest TBI can be difficult to diagnose, and in the face of all of these conditions——

Senator MURRAY. But it seems to me that if you are asking soldiers if they've been in the vicinity of an explosion, you will have an indication——

General KILEY. Yes, ma'am.

Senator MURRAY [continuing]. Fairly soon that they should be watched for this, that they should have the knowledge that this may be happening, so if they see symptoms, or their family does, they can get care immediately rather than struggling for months not knowing what has happened to them. So I would like to ask a commitment from you that we start screening these soldiers and finding out if they have been in the vicinity of an explosion, so that they don't get lost for months on end.

General KILEY. Yes, ma'am, and Secretary Winkenwerder, as I understand it, is in the process of changing the post-deployment screening to specifically ask soldiers that, number one. Number two, my TBI task force is about to come back to me with recommendations of exactly how to go about doing that, what's the best format, and then what are the best therapeutic modalities. So I'm taking that on very——

Senator MURRAY. And I hope that's soon, because every day that goes by we're losing.

General KILEY. Yes, ma'am. I agree.

Senator MURRAY. Thank you.

Admiral ARTHUR. May I add that we don't wait until they come back? We have the military acute concussion evaluation that we do in theater for people who are in the vicinity of a blast and they have a concussive injury, and we do that evaluation, and if they are deemed to have an injury, then we take them out of—

Senator MURRAY. So you ask everyone before they leave the theater?

Admiral ARTHUR. If they are in the vicinity of a blast. We don't screen everyone in theater, but when we do have a blast, an improvised explosive device (IED), and there are casualties who are moved out but there are others who are in the vicinity, we do an evaluation on them.

Senator MURRAY. Do you have any indication of the percentage of marines who have been impacted by that?

Admiral ARTHUR. No, and it's very difficult, especially with mild traumatic brain injury, to assess very slight cognitive—

Senator MURRAY. Do you have any numbers of how many marines have been in the area of a blast?

Admiral ARTHUR. No, I don't, but we could get that.

Senator MURRAY. I would like to know.

Admiral ARTHUR. There are also confounding variables of combat stress and others that we have to tease out. It is a stressful environment and it's difficult to assess mild traumatic brain injury, in theater or even when they first come back, with all the confounding stress issues.

Senator MURRAY. Thank you very much.

Admiral ARTHUR. Yes, ma'am.

Senator MURRAY. Thank you, Mr. Chairman.

[The information follows:]

The Navy/Marine Corps does not maintain an electronic database to track Sailors and Marines that have been in the area of a blast. Given the erratic nature of combat theater and the likelihood of taking indirect fire, all service members are at risk, both inside and outside the wire. Navy Medicine's approach has been to focus on effective screening, identification, and treatment for all service members.

Navy medical personnel in theater utilize the Navy-Marine Corps Combat Trauma Registry (CTR) to assess and document Traumatic Brain Injury (TBI) in those service members treated at Level 1 and 2 medical facilities for battle injuries. The consistent use of the CTR to identify TBI is in an early stage of development and available data is being analyzed by Naval Health Research Center (NHRC). Preliminary analysis of data from CTR for 5,087 service members injured in the Iraq area of operations from March 2004 to January 2007 suggests that approximately 1,700 personnel were diagnosed with a mild to severe TBI (33 percent). NHRC estimates that approximately 80 percent of TBI diagnoses were blast related, and that most service members were returned to duty. Currently, NHRC is evaluating level of risk by occupational specialty. It is important to note that reporting by field units has been inconsistent and that CTR data is limited to diagnoses in theater.

The Post Deployment Health Re-Assessment (PDHRA), administered to service members 90 to 180 days post deployment, includes the question: "Do you have any persistent major concerns regarding the health effects of something you believe you may have been exposed to or encountered while deployed [such as] blast or motor vehicle accidents." Approximately 4 percent of Navy and Marine Corps active and reserve personnel responded yes to this question. It is not possible to differentiate between members exposed to a blast and a motor vehicle accident. DOD/Health Affairs has recently directed additional TBI-related screening questions to the PDHRA, the Post Deployment Health Assessment (PDHA), and the Periodic Health Assessment (PHA).

Finally, the Marine Corps has issued guidance strongly encouraging the use of the Military Acute Concussion Evaluation (MACE) to screen injured personnel for possible TBI. Medical personnel document MACE results in the service member's field

medical record. Currently, the data is not tracked in a centralized database. As a result, we are unable to provide Congress with an accurate number of Sailors and Marines that were in the area of a blast and received the MACE at this time.

General ROUDEBUSH. Senator Murray, if I might add, since we do a great deal of the definitive care through our theater hospital, both in Bagram and at Balad, as well as our combat stress teams which are out working with their Army and Navy counterparts, one of the things in my recent trip was an awareness of traumatic brain injury and the fact that the stress teams, for example, are much more sensitive to that, since that can be a very much related issue. So the awareness is there. I cannot give you the numbers, but awareness of this as an issue and the effort to both identify and vector toward treatment I think is moving in very much the right direction.

Senator MURRAY. We're 4 years into this conflict. We've had thousands of people impacted that have gone home and are out of the system. We need to really work on this, Mr. Chairman.

Senator INOUE. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

General Kiley and panel, when we neglect our wounded soldiers, basically we stain the reputation of America regarding the support for our soldiers. Would you agree with that?

General KILEY. Yes, sir.

Senator SHELBY. Okay. That's obviously, to all of us, shameful and unacceptable. We know that Walter Reed has been not just a premier hospital, it has a worldwide reputation as a premier hospital. A lot of us have spent time there. We know it has been a good hospital.

You were the commander, is that correct, at Walter Reed?

General KILEY. Yes, sir.

Senator SHELBY. And from what year to what year?

General KILEY. 2002–2004.

Senator SHELBY. And during that time, did you ever go to, is it Building 18?

General KILEY. No, sir, I did not.

Senator SHELBY. You didn't? Why not?

General KILEY. For several reasons, the first of which was that I didn't have patients in that building when I was the commander there.

Senator SHELBY. What was in that building?

General KILEY. We had transient students, student trainees.

Senator SHELBY. Students training in a medical profession?

General KILEY. Yes, sir, but not patients. We did not have patients there when I was there.

Senator SHELBY. As commander, did you visit all the other facilities at Walter Reed?

General KILEY. Yes, sir.

Senator SHELBY. Except Building 18?

General KILEY. Yes, sir.

Senator SHELBY. And that's the only one you failed to—

General KILEY. Well, I can't say I was in every office of every building, but it was my intent to visit the buildings that we had combat casualties in, Malone House, Delano Hall.

Senator SHELBY. Is Building 18 basically a dilapidated building? Is that a fair assessment?

General KILEY. I don't believe that's a fair statement.

Senator SHELBY. How would you describe it?

General KILEY. I would describe it as an old building with some humidity problems that requires constant maintenance and upkeep.

Senator SHELBY. Have you visited Building 18 in the last several weeks?

General KILEY. Yes, sir.

Senator SHELBY. Who was assigned to Building 18?

General KILEY. Until today, there were soldier patients assigned to 18.

Senator SHELBY. Wounded soldiers?

General KILEY. Yes, sir, wounded and ill. Yes, sir.

Senator SHELBY. And how many would be there assigned, roughly?

General KILEY. Sir, even in the last couple weeks the numbers fluctuated between mid-70s and mid-60s. I think it has 54 rooms. It has a maximum capacity of about 100, 108.

Senator SHELBY. Had it ever come up through the command to you as the Surgeon General that there were deep problems at Walter Reed?

General KILEY. Not as it relates to these articles, no, sir.

Senator SHELBY. Nothing? In other words, you had no inclination—you're the Surgeon General, a former commander of Walter Reed—you had no inclination, no knowledge, no information whatsoever that the conditions were deteriorating at Walter Reed?

General KILEY. I had no information that there were issues of mold and other maintenance problems in Building 18. I knew that Walter Reed had a large number of casualties that were recovering, with a very active amputee center, and that we had some of the same issues we have at all of our facilities with the MEB/PEB process.

Senator SHELBY. After you became Surgeon General of the Army, have you been to Walter Reed?

General KILEY. Yes, sir.

Senator SHELBY. Recently?

General KILEY. Yes, sir.

Senator SHELBY. And how many times have you been to Walter Reed?

General KILEY. Oh, pretty frequently, at least once every couple of months if not once a month, but not any more frequently than that.

Senator SHELBY. Did you ever ask questions of the commander who succeeded you as to the conditions at Walter Reed, were they understaffed, were the facilities in good shape, and so forth?

General KILEY. My discussions with General Farmer, who was my successor there for 2 years, were along the lines that they were with my other commanding generals of the regions, which was to continue to watch the process of receiving, and whenever they needed resources, if they had a problem that they needed my help with, they could come to me. And, as I have said before, for the

care of wounded soldiers, we have the resources in terms of money in our budget to help them.

Senator SHELBY. Shouldn't the care of our wounded soldiers be one of our highest, highest priorities?

General KILEY. Absolutely.

Senator SHELBY. And especially the Surgeon General of the Army, is that your highest priority?

General KILEY. Yes, sir, it is.

Senator SHELBY. Did you minimize these complaints when you read about them? Did you take them lightly, or were you cavalier about it?

General KILEY. Absolutely not, Senator. And I know that that's been perceived.

Senator SHELBY. Yes, it has been.

General KILEY. I apologize for that. This is very serious business. I was devastated, frankly, to read about some of these cases and to see that some of this was going on, and immediately began investigating.

Senator SHELBY. Did you go out there yourself, immediately, and see what was going on?

General KILEY. Yes, sir.

Senator SHELBY. You did?

General KILEY. Yes, sir.

Senator SHELBY. Did you take a team of your people with you?

General KILEY. Well, when all of this broke, we sat down with the commander and we started analyzing what was going on. Yes, sir. I have a team that has gone out subsequent to that, visiting other facilities.

Senator SHELBY. What are you doing about it? What three steps have you made since the revelations have come out regarding the conditions at Walter Reed, of all hospitals?

General KILEY. First, I think the command has taken on the infrastructure, the brick and mortar. The building was immediately repaired. The mold was removed. That was number one.

Number two, the commander directed formal AR 15-6 investigations, both into the chain of command and into the quality of care delivered in terms of medical records, appointments, et cetera. The Vice Chief of Staff established an action plan to make some other corrections, and to appoint a colonel to command and control the med hold. General Weightman was in the process of making changes and improving things. It was clear we needed to accelerate that.

Senator SHELBY. Sir, have you checked the record thoroughly to make sure that if there were any complaints bubbling up from the lower echelons at Walter Reed to the higher-ups that were never heeded, never considered?

General KILEY. Any complaints that came directly to me, I certainly would ask the commanders to brief me on what was going on.

Senator SHELBY. What about complaints now, as you look back, that came to others, that maybe should have come to you? Have you dug into that?

General KILEY. Not at this time, no, sir.

Senator SHELBY. Do you plan to? Don't you need to know everything about what was going on, or it never got to your desk, or your attention, perhaps, if it did, and how this could have been prevented?

General KILEY. Yes, sir, and I'm looking back at that. I intend to talk to my commanders. It's clear I need to have much closer, more intense supervision of this process so that I don't miss this again.

Senator SHELBY. But you're the Surgeon General of the United States Army. What's the chain of command as far as you are concerned in your duties over Walter Reed? You were the former commander, but you're the Surgeon General.

General KILEY. I'm the Surgeon General and the Commander of the U.S. Army Medical Command—

Senator SHELBY. Absolutely.

General KILEY [continuing]. So my next subordinate commander is now General Schoomaker for Walter Reed, and he is—

Senator SHELBY. So basically, as the Surgeon General, you are the overall responsible person dealing with the Army medical centers, wherever they are. Is that correct?

General KILEY. Yes, sir.

Senator SHELBY. Do you believe you have fulfilled your duty?

General KILEY. I believe that the management of Walter Reed and the accountability, which I am accountable for—

Senator SHELBY. Absolutely.

General KILEY [continuing]. Similar to my accountability for places like Landstuhl and Brooke, clearly it's not the only responsibility I have. I have many other responsibilities of a global nature, to include broad strategic and policy issues.

Senator SHELBY. Well, what's your number one obligation? It's the soldiers, isn't it?

General KILEY. Getting soldiers off the battlefield alive, getting them through Landstuhl, and getting them to all of my medical centers.

Senator SHELBY. Absolutely. Let's talk about Walter Reed and the future of Walter Reed. You know, this was made by the base closing commission.

General KILEY. Yes, sir.

Senator SHELBY. I think we have to think about today's care, that's very important, and the standard of that care at Walter Reed, or lack thereof. But we have to think about tomorrow, too, the new Walter Reed, because it seems to me to be very logical to build a state-of-the-art medical facility at Bethesda, where you have the medical school, where you have the NIH, where you have Bethesda. And of course you plan, I think, that we're going to name it Walter Reed, which is fitting. But we have to deal with the present, but we've got to deal with the future, too, and I think we can do both if we do it right. What do you think?

General KILEY. I absolutely agree with you, Senator, with the proviso that, one, it must be fully funded and, two, we must recognize, in the new Walter Reed at the National Military Medical Center Campus, that much of the work we're doing right now at Walter Reed as it relates to families and family support and outpatient work will have to continue in that new campus. And I think if we

recognize all that and we coordinate this process of transformation over to the Bethesda campus, I don't think we will drop a single soldier through this from our current operations. But it has to be fully resourced.

Senator SHELBY. Well, you're before the Defense Appropriations Subcommittee. We are responsible for funding the military, wherever they are, including our hospitals and everything. Do you believe that we have adequately funded our medical, Army medical team and so forth, including Walter Reed? And if not, would you speak out for it?

General KILEY. Yes, sir.

Senator SHELBY. This is where the money comes from, right here in this subcommittee.

General KILEY. Yes, Senator, I understand, and I have said in the previous 3 fiscal years that I have served as the commander that as it relates to the global war on terrorism and everything Army hospitals do, that everything I've asked for, you have given us, and I have not gone wanting there.

Senator SHELBY. Have you asked for everything you need to run a first-class hospital at Walter Reed and anywhere else that you have our wounded veterans?

General KILEY. I have asked. Part of that is a core budget that endures past combat operations, that may not have global war on terrorism funding, and in that respect we have had to deal with the wedge and efficiencies and taxes, and it has made it more challenging. And this wedge, this notional wedge in the coming budget, is going to make it even more challenging for us.

Senator SHELBY. I believe myself, as a member of this subcommittee, both sides of the aisle, Democrats or Republicans, we will fund whatever is necessary to treat our veterans more than right, the best in the world medical treatment, if you ask for it.

General KILEY. Yes, Senator. Thank you. Yes, Senator.

Senator SHELBY. Thank you.

Thank you, Mr. Chairman.

Senator INOUE. Thank you.

Senator Mikulski.

Senator MIKULSKI. Thank you very much, Mr. Chairman. I thank you and the ranking member, Senator Stevens, for your longstanding leadership and commitment on military medicine.

I think the issues raised by the leadership and the panel in the BRAC situation are really very well taken. We understand why there was this whole desire for a joint facility, but in a minute I'll get into privatization, which shows that perhaps some assumptions are dated. I'd like to suggest to the subcommittee we ask the military to review that, and also that the Dole-Shalala Commission take a look, so that at the end of their report we might have a comprehensive list on that, because my concern—well, first of all, you know, we have phrases like “wounded warrior.” They evoke nostalgia.

What we're talking about, we ought to start calling it the 50-year care program. We have men and women who were injured and they are 19 or 20 years old. They are going to be alive for 50 years, if it all works the way it should. So for 50 years, what does this mean to TRICARE? For 50 years, what does this mean to the VA?

Yes, we can look at Walter Reed. Then where do they go to rehab? And then when they leave rehab, where do they go from there? Are they going to go into nursing homes? Are they going to go into assisted living? If they get home healthcare, who is going to help the families, these 19-year-old brides, with assistance with living for a guy who may have 40 percent of his brain shot off, or no arms or no legs, and the stress on the family?

So we have to be thinking of this not as—I love the phrase, “wounded warrior.” It’s very respectful and shows an emotional commitment, but I think we have to start calling it the 50-year commitment. And then how do we do this? Because the facilities here at the acute care and the outpatient care are only the first step to a series of steps that will last 50 years, so let’s take a look at that.

PRIVATIZATION

But this question about what did you know and when did you know it and all that, I’d like to bring to the subcommittee’s attention and a question to General Kiley and to the other Surgeon Generals about privatization. I am concerned that the administration’s relentless pursuit of privatization has caused dire consequences at our facilities.

If we go to Walter Reed, there was a relentless effort to privatize the 300 employees who did building maintenance. Three hundred employees who did building maintenance. The administration spent \$7 million on an A-76 process and then another \$5 million to implement it, \$12 million to get rid of 300 employees. I protested it along the way, with my former colleague, Senator Sarbanes, but I wasn’t the only one. I wasn’t standing up for Maryland employees, though I was. I thought I was standing up for Walter Reed.

Then Colonel Garibaldi sent a letter or memo on September 6. This is the famous Garibaldi memo that said all of the contracting out of building maintenance was based on criteria for the year 2000, a year before 9/11 hit, 3 years before we went to war in Iraq—well, 2 years before Afghanistan, 3 years before Iraq. So we were functioning on outmoded data, once again not planning for war, not planning for the casualties of the war, not planning for the care of the casualties of the war. We took data from the year 2000.

Garibaldi says we’ve got to do this, we’ve got to staff and implement something very different here. He cries out, saying the Army initiated this study in 2000. The current workload in the hospital has grown significantly. He goes on that the A-76 in 2000 didn’t even think about what we were facing. And the punch line here, he says without favorable consideration of these requests—which means don’t do this—patient care and services are at a risk of mission failure.

Well, while he was writing his memo, Sarbanes and Mikulski were doing an amendment on the Senate floor to overturn that A-76. We lost it, 50 to 48. We went from 300 employees very quickly to 50, 300 employees to 50.

I’m going to ask that the Garibaldi memo be submitted for the record.

[The information follows:]

DEPARTMENT OF THE ARMY,
UNITED STATES ARMY GARRISON,
WALTER REED ARMY MEDICAL CENTER,
Washington, DC 20307-5001.

MEMORANDUM THRU MG George W. Weightman, Commander, NARMC and
WRAMC, 6900 Georgia Avenue NW, Washington, DC 30207
FOR COL Daryl Spencer, Assistant Chief of Staff for Resource Management,
MEDCOM, 2050 Worth Road, Bldg 2792, Suite 9, MCRM, Fort Sam Houston,
TX 78234-6009

Subject: Challenges Concerning the Base Operations A-76 Study and Resulting Reduction In Force (RIF) at Walter Reed Army Medical Center (WRAMC)

Walter Reed Army Garrison and Walter Reed Medical Center (WRAMC) requests approval and financial support as the Base Operations A-76 Study proceeds toward a reduction-in-force (RIF) and the date when the contractor will assume duties. Specifically we are requesting the following to prevent possible mission failure:

- Approval and funding of the personnel in the “bridge organization”, and fiscal year 2007 funding for VERA/VSIP.
- Establishment of a larger than approved Continuing Garrison Organization (CGO).
- Formal implementation of the Directorate Of Logistics (DOL) and Plans Analysis and Integration Office (PAIO) organizations.

Since the Army initiated the A-76 study in 2000, the current workload in the hospital and garrison missions has grown significantly in the past six years due to our need to care for and support Wounded Warriors from Operation Enduring Freedom, Operation Iraqi Freedom, and other outcomes of the Global War on Terrorism (GWOT). As a result, the Army performed the competition with dated workload data and expectations created before the GWOT began in 2001. Now in 2006, we need more personnel than the study had anticipated. To rectify this situation, we need more government employees to remain on staff and need to implement a garrison DOL and PAIO.

As a direct result of the A-76 study, its associated proposed RIF, and eventual Base Realignment and Closure (BRAC) of WRAMC's Main Post, we face the critical issues of retaining skilled clinical personnel for the hospital and diverse professionals for the Garrison, while confronted with increased difficulties in hiring. In our efforts to manage the RIF, we implemented a Voluntary Early Retirement Authority/Voluntary Separation Incentive Program (VERA/VSIP) effort. As a result we lost 21 personnel in June and nine more in July; an additional seven personnel will leave at the end of September while 30 to 35 more will depart after due course notification of Congress. Due to the uncertainty associated with this issue, WRAMC continues to lose other highly qualified personnel. A planned Priority Placement Program (PPP) registration will allow other employees to be placed into Department of Defense jobs at other locations. So far 67 personnel have registered for this program, which will become effective on 26 September 2006.

The bump and retreat process that follows a RIF will impact the Hospital's patient care mission as highly skilled and experienced personnel in the current workforce are moved in to other jobs or involuntarily separated. The danger of an “underlap” of personnel to perform vital functions could decrease our ability to complete the garrison mission and provide world class patient care. To ensure WRAMC's primary mission experiences little or no disruption, we request you approve a personnel “bridge organization” (attached as Enclosure 1) to support the transition process until the contractor performance period begins.

Compounding the issue is Medical Command's (MEDCOM's) non-concurrence with our requested residual organization, the Continuing Garrison Organization (CGO). Using the older workload data in 2004, WRAMC proposed a relatively small CGO of 25 government personnel. Earlier this year, with a better understanding of the greater workload requirements, the WRAMC Leadership submitted to MEDCOM a request for 63 CGO positions (Enclosure 2) to be spread across the WRAMC garrison to provide effective oversight and monitoring of contractor activities proposed to implement the BASOPS support. After MEDCOM reviewed the request and sent a manpower analyst to discuss the revised CGO with each of our directors proposal they reduced the approved CGO total to 26 slots (Enclosure 3).

WRAMC established its garrison command in 2002 when the Army established the Installation Management Agency (IMA). Consequently the A-76 study data in 2000 did not include other areas of the garrison command necessary to run a full service BASOPS organization. These include the DOL and the PAIO; therefore, the final contractor submission did not include positions for them. Furthermore,

MEDCOM did not approve any full time equivalents for the Garrison DOL or PAIO functions anywhere in the CGO.

No provisions were made for a PAIO which has created additional problems. The PAIO is the Garrison Commander's right hand in the areas of planning, assessment and improvement. Working hand in hand with the BRAC office, the PAIO facilitates and maintains the BIG PICTURE Garrison planning efforts. Working with cross-functional planning teams we truly considered all aspects of every challenge facing the Garrison during the A-76, the RIF and BRAC processes, as well as the programs and services we provide to our customers on a daily basis. The PAIO consolidates all Garrison plans (Master Plan, Human Resource Plan, etc.) into an over arching Garrison Strategic Plan governed by an Installation Planning Board. This board is designed to be made up of the Installation Chain of Command, MEDCOM representatives, other tenant organization representatives and chaired by the Installation Commander. It is imperative that we continue ongoing measurements, analysis, assessment and adjustments that result in our goals and objectives being met at the installation level. Meeting these goals and objectives guarantees improvement of the Garrison BASOPS mission for the MEDCOM, our tenant units, our soldier's and their family members.

Our last point has to do with section C.5.10 of the Performance Work Statement that was submitted for contracting, where DOL functions are represented. These functions relate to the "Hospital" DOL and do not consider Garrison DOL functions. The Garrison DOL is the property accountability and supply and services authority for the Garrison organization. Without these essential offices, WRAMC, MEDCOM, the Army and the U.S. taxpayer are vulnerable to property loss amounting to hundreds of thousands of dollars over the next five years. DOL's hand receipt system and follow on Financial Liability Investigation of Property Loss (FLIPL) process were implemented to hold hand receipt holders accountable for lost property and is a systematic and proven means of ensuring government property is tracked and accounted for. In addition, the disposition and transfer of property, equipment and facilities are all logistical functions and during BRAC the Vice Chief of Staff of the Army expects accountability from closing installations. Once the hospital is relocated this becomes a Logistics action and the hospital DOL will not be here to perform that function. After BRAC there could be a AAA Audit or GAO review to see that the correct steps were taken. The DOL also serves as a central office for supply acquisition and distribution thereby building a more efficient and effective means to procure supplies and equipment for the entire Garrison operation. A central supply system reduces redundancy and increases availability of supplies to Garrison organizations.

Without favorable consideration of these requests, WRAMC Base Operations and patient care services are at risk of mission failure.

Thank you for your interest in and support of our challenges. The POC is the undersigned at (202) 782-3355.

PETER M. GARIBALDI,
COL, MS, Garrison Commander.

Senator MIKULSKI. But I'm saying to General Kiley, the Surgeon General, could I have your word now that you're going to evaluate the privatization, to evaluate the privatization efforts that are going on at these facilities and the impact that this is having on patient care? I want to know, and this subcommittee wants to know, why did we spend \$12 million to get rid of 300 people so we now have 50 people? Okay, so that's the privatization. Can I have your word to do that?

General KILEY. Senator, I will take—

Senator MIKULSKI. Were you there during this A-76?

General KILEY. Oh, yes, Senator, I was.

Senator MIKULSKI. Well, what did you do about it?

General KILEY. Senator, the A-76 as I understood it was the law. It was required of us to do a privatization across—for MEDCOM purposes, across three—

Senator MIKULSKI. But you could have challenged it. The assumptions were based on the year 2000.

General KILEY. That's correct, and—

Senator MIKULSKI. Did you challenge the assumptions of the A-76 with your higher-ups and say, "Let's take another look here?" There were 16 different appeals.

General KILEY. Yes, ma'am, and at the time that that began, I was then the MEDCOM commander. And I know that General Farmer worked through that, to include the issue about 2000 data, and as I understand it, as it has been explained to me, they updated the data a little bit.

But you have identified the problem. The problem was as much a function of the morale of the employees, and the fact that Garibaldi—

Senator MIKULSKI. No, my identification of the problem was that the A-76 was based on 2000, the year 2000, data. That was the problem. And we spent \$7 million to implement something that was based on it. That was what the problem was. Did it have an impact on you now? Yes.

General KILEY. Yes, ma'am, it did.

Senator MIKULSKI. Okay, so yes, it did. What about you, Admiral Arthur?

A-76 STUDIES

Admiral ARTHUR. Yes, ma'am. We have not had similar incidents of A-76 studies on as grand a scale as Walter Reed has, but I would tell you in general whenever you promulgate an A-76 study, the very best people that we have start looking for other jobs, and we end up with a dearth of people in the billets that are currently filled. And very often I think it comes out that a government worker, someone on the General Schedule or one of our contractors, is at least as cost-effective as a privatization would be.

Senator MIKULSKI. I think this is something, again, that we need to be looking at, I mean truly looking at, and that also goes to Dole-Shalala.

Admiral ARTHUR. Yes, ma'am.

General KILEY. Yes, ma'am.

Senator MIKULSKI. General?

General ROUDEBUSH. Yes, ma'am. I think it's very pertinent to go back and look at the privatization issue, and I think that's an exercise that is certainly worthy and will press on that.

For us in the Air Force, we have a mix across our facilities of privatized contracts or base support. For us it has worked reasonably well. However, I think the opportunity to go back, revisit it, take a look, is something that we will certainly press on.

[The information follows:]

Approximately 72 percent (53 of 74) of Air Force Medical Service medical treatment facilities (MTFs) use contractors to provide day to day facility maintenance. The external accreditation body for health care facilities (Joint Commission on Accreditation of Healthcare Facilities) has had high praise for many of the contract maintenance companies in terms of processes and documentation of the work performed. Additionally, facility satisfaction with contract Maintenance is very high.

On March 9, 2007, the Air Force Surgeon General asked the Auditor General of the Air Force to provide audit support for oversight of contractors responsible for medical facility cleaning and maintenance.

While the Air Force Medical Service has never previously had an audit to evaluate the Performance of a contract maintenance provider, we take several measures to ensure we received quality maintenance. Each site has a contracting officer representative to ensure compliance with the specified level of maintenance. The con-

tractors are required to provide monthly status reports on their performance. Notably, we also have a central cadre of experienced technical staff that further reviews the performance status reports. This staff, comprised of military and government civilian experts, provides oversight and support to the local representatives. We manage preventive maintenance and demand maintenance needs of our MTFs through the Facility Management Module of the Defense Medical Logistics Support System allowing us to monitor the state of equipment and trend the performance of our contractors. We ensure past performance is a key evaluation factor when we award new contracts and decide to exercise option years. Our maintenance contracts are structured to place full life-cycle liability for covered building systems on the contractors; therefore, the contractors have an inherent incentive to accomplish appropriate maintenance. If a system fails, they are financially liable to make all repairs or replacements. Collectively, these measures ensure we are providing quality maintenance of our medical infrastructure.

CONTINUITY OF CARE

Senator MIKULSKI. Yesterday in the Levin hearings, the Assistant Secretary for Health said one of the most important things to ensure continuity of care was continuity of the caregivers, and he talked about the need for a cadre, and I'll use the term, of civil servants. It goes to, should military people even be running these hospitals? Should there be a cadre of civil servants that do this? And that also goes to the privatization question.

I'm not questioning that but, as you know, in the private sector doctors don't run hospitals anymore. But you know tours of duty change. Since you were at Walter Reed, General Kiley, I think we've even had a third or a fourth—

General KILEY. Yes, ma'am. A fourth now, yes, ma'am.

Senator MIKULSKI. And that's the military way, so they come and they go, they come and they go, and they come and they go. So there's the loss of institutional memory, the culture the institution needs to maintain.

I believe that there needs to be military leadership at military facilities, but I think we've got to take a look at the role of civil service here and now. It also goes to the contracting out of other services, because we not only have the wounded warrior, we have the wounded waiting warrior. Now, that takes me—

Admiral ARTHUR. Yes, ma'am. May I comment, ma'am, just briefly?

Senator MIKULSKI. Yes.

Admiral ARTHUR. The CNO asked me, when I first took this job, could we have our casualties seen at Mayo Clinic or Johns Hopkins? And I said they could treat their injuries and illnesses, but the advantage of having a military hospital with military commanders and people in charge is, we understand what our mission is and whom our population is.

We never ask our patients how sick they can afford to be. And all of our people, all of our uniform people, have been to combat or at least have been exposed to the operational scenario so that they know what our patients have gone through, and I think there's great benefit to understanding the patient who has been in combat, the family needs, et cetera. So having someone other than military run our basic facilities runs the risk of not understanding who—

Senator MIKULSKI. No, no. I'm not talking about contracting it out to Hopkins or to Mayo. I'm talking about who should be there

all of the time, which is the chief executive officer (CEO) manager. No, I in no way would mean to dilute that.

But let me go on. In TRICARE you do contract it out. There is TRICARE, but you reach a point where you do contract it out. That's one of the reasons, and one of the reasons these guys and gals are wild to get a 30 percent disability, so that they can get TRICARE for life, because they fear if they go into the VA they're going to wither away, exactly for the reasons you said.

DISABILITY RATINGS

Which then takes me to this. General Kiley, of the 22,000 Purple Hearts that we have, how many of them have achieved a 30 percent or more disability?

General KILEY. Senator, I can take that question for the record. I do know that in 2006, as I understand it, the active force had about a 4 percent permanent disability, so about——

Senator MIKULSKI. Which goes to the Murray point. Thank you.

General KILEY. Yes, ma'am.

[The information follows:]

The Department of the Navy has identified 362 military personnel (326 Marine Corps/36 Navy) who have been awarded a Purple Heart and a combined disability rating of 30 percent or greater for injuries sustained while participating in Operations ENDURING FREEDOM and IRAQI FREEDOM.

Senator MIKULSKI. Admiral?

Admiral ARTHUR. All Purple Hearts are given to active duty military. I'm not sure how many have received a disability. We'll take it for the record. But there are a lot of injuries which are minor, for which a Purple Heart is awarded.

Senator MIKULSKI. Well, we don't know how minor is "minor," now. That's the whole point about this war, that "minor" might become "major," which is one of the reasons they're talking about, when you are discharged and you have been handed over to the VA, which there's a lot of flashing lights about, that there is no goodbye physical that's uniform and passed on to them.

Admiral ARTHUR. Well, we do have a joint physical that we're piloting and we've had for several years with the VA, so that we——

Senator MIKULSKI. Let me tell you why I asked about the disability. So, okay, they're at Walter Reed, and we clean it all up and everybody is jazzed, and we ought to be jazzed. Well, what I worry about is what happens after they leave Walter Reed.

Admiral ARTHUR. Yes, ma'am.

General KILEY. Yes, ma'am.

Senator MIKULSKI. And that's why I was asking for this. Now, what is the plan, and have you taken the action that——

General KILEY. The plan, to address your question, Senator, from my view is for the Army to get together very quickly——

Senator MIKULSKI. But have they? Have they? Have you met? What is your plan?

General KILEY. Well, I have not yet met, since I started working through this process here at Walter Reed——

Senator MIKULSKI. But how long have you been Surgeon General?

General KILEY. Two and one-half years.

Senator MIKULSKI. And how long have we been at war in Iraq?

General KILEY. A pretty long time. Yes, ma'am.

Senator MIKULSKI. I think it's since March 2003, isn't it?

General KILEY. Yes, ma'am.

Senator MIKULSKI. We went to war, so we have been at war there as long as World War II.

General KILEY. Yes.

Senator MIKULSKI. And you don't have a plan for these——

General KILEY. In terms of the issues of addressing what we have been talking about, which is what appears to be and to me is a disparity and a confrontational position, we have to take this on, and I——

Senator MIKULSKI. Well, that's the disability of 4 percent, but what is your plan for even the 4 percent?

General KILEY. In terms of taking care of those soldiers?

Senator MIKULSKI. Yes. What is the long-term care plan? Do you have a plan for TRICARE for them? Do you have a plan for assisted living? Do you have a plan for long-term care? Do you have a plan for family assistance? Do you have a plan to pay for the divorce lawyers? Do you have any plan at all for any of this?

General KILEY. For the 50-year plan, no, ma'am, I do not.

Senator MIKULSKI. Do you have it for the next 3-year plan?

General KILEY. Not yet. We have not addressed——

Senator MIKULSKI. Well, I find this shocking. This is a war that we have been fighting for 5 years. One hundred and fifty thousand people will now be there, if the President gets his surge way, but even now, 128,000. Five years, longer than World War II, where these men fought and bear the permanent wounds of war. That's why they are so passionate about this. They know what good care and good follow-up care means.

General KILEY. Yes, ma'am.

Senator MIKULSKI. I have heard their personal stories, and been touched and motivated and been inspired by them. How about you? Now, you said, when the problem with the Post article occurred, that it was yellow journalism and you wanted to reset our thinking. What thinking now do you want to reset? You wanted a private meeting with me. I want a public hearing. What part of that do you want to reset? You said it at the press conference.

General KILEY. Senator, I did not call the Post series by reporters Priest and——

Senator MIKULSKI. No, but you said you wanted to reset our thinking. Here is your moment in the sun. What part of that Dana Priest series do you want to reset our thinking on?

General KILEY. I don't want to reset anyone's thinking, Senator. I share the concern of——

Senator MIKULSKI. But you did when you said it. You did in your first press conference, said you wanted to reset thinking.

General KILEY. I wanted to assure the American people that, one, we were as concerned as the report was, that we wanted to work through solutions, we weren't sitting back on our heels. I clearly was not attempting to suppress or in any way mitigate the circumstances.

Senator MIKULSKI. Well, let me tell you what I'm hearing. I'm hearing from soldiers where they wanted to appeal their benefits,

but they told me I can't use their stories because they fear retaliation.

General KILEY. Yes, ma'am, and I——

Senator MIKULSKI. That people fear retaliation, you need to know that. They fear retaliation about speaking up at facilities, so you need to know that.

General KILEY. Yes, ma'am.

Senator MIKULSKI. So there is a culture here, and I think the culture has got to change.

General KILEY. And I agree.

Senator MIKULSKI. This is why we think it's a failure of leadership. But I'm going to come back to the leadership of this subcommittee, who have devoted their life to military medicine, and who I'm proud to serve with. I think we've got to look at this, the fact that here we are in the fifth year of the war in Iraq, and we don't have a plan for what happens when these men and women leave truly acute care, not only the 50-year plan, but we don't have a 3-year plan.

MILITARY MEDICINE AND VETERANS ADMINISTRATION

Now I'm going to ask, have the Surgeon Generals of military medicine met with Nicholson at the VA to talk about that continuity handoff? Have you as a group met with him?

Admiral ARTHUR. Not as a group, ma'am, but I've met with him individually and have met when Secretary Perlin was the Under Secretary for Health of the VA.

Senator MIKULSKI. And do you have a plan for doing this, for handing off the marines?

Admiral ARTHUR. Yes, ma'am.

Senator MIKULSKI. And other Navy personnel?

Admiral ARTHUR. The marines also have a plan for the marines, the Marine for Life Program and others that take care of marines even after they are discharged, active duty or reserves. The marines have been very, very forthcoming and forward-leaning in taking care of their own marine casualties.

Senator MIKULSKI. Have you met with them?

General ROUDEBUSH. Yes, I've met off line with Secretary Nicholson on at least one occasion, talking about this, as well as——

Senator MIKULSKI. Do you feel you have a plan?

General ROUDEBUSH. Ma'am, the plan that the Air Force uses is something that we call our wounded warrior plan, with the Palace HART, which actually follows our individuals through their hospitalization, through their disability processing, out into the civilian life, and continues to track them to assure that their needs are, in fact, met.

Senator MIKULSKI. Have you met with them?

General KILEY. I have not met with the Secretary on this subject. I have met with, had discussions over the last several years with Dr. Perlin and particularly with Dr. Kussman about the handoff from our facilities to the VA. I have put U.S. Army personnel into our multitrauma centers as liaisons to coordinate that. I have visited the polytrauma centers myself. I am very concerned about and think that that's the next great plan we need, which is to make sure the VA can continue to support these soldiers.

Senator MIKULSKI. I find this horrifying, after 5 years, I just find this, the lack of a continuum. But I have confidence in the leadership of this subcommittee and look forward, and now the Dole-Shalala investigation, where we can continue this. Let's start with the BRAC, look at the facilities, and then the human infrastructure and the plan.

Thank you, Mr. Chairman.

Senator INOUE. Senator Stevens.

Senator STEVENS. My comment to the Surgeon Generals would be that both of our Senators have spoken up very strongly. I particularly want to go back to what Senator Murray said, though. We have all heard, from the families of these wounded members of the military, an expression of fear if they speak up. Somehow or other that has got to be dispelled.

General KILEY. Yes, Senator, I agree.

Senator STEVENS. And I think it applies across the board. I would urge that you ask that there be just a flat statement that there is no retaliation. We welcome those comments. Those comments help us find ways to solve the problems, and I think many times they will help you.

General KILEY. Yes, Senator.

Senator STEVENS. I would hope that we find some way to dispel this and start retaliating against the people who put that fear in these people. That should not be. There should not be any fear of speaking up about the quality of care or the future plans for these people. I don't think we can emphasize that too much. That has just got to stop.

General KILEY. I agree completely, Senator, and I send surveys directly to med holdover soldiers and ask for their direct feedback to us, and we're getting that back. We've had over 1,000 surveys come back. Many of the comments are negative.

It's not about going and reprising against someone. It's about finding out what's going on out there and letting us know. I can travel every camp, post, and station, and I do. I talk to soldiers. I was in Puerto Rico talking to med holdover soldiers. They have issues. We need to get on with it, and there will be no reprisal. It's absolutely unacceptable.

Senator STEVENS. Thank you, Mr. Chairman.

Senator INOUE. Thank you very much.

Like all citizens, when I began reading the articles in the Washington Post, I began to reflect, and I thought about a moment just about 1 year ago when a group of high school students converged into my office to interview me. And the first question I asked was, I suppose, a soft one: What happy moments have you had in your life? What were the happiest moments of your life?

And my answer was a shocker for them because I said, "The 21 months I spent in the Army hospital after my injury." They couldn't understand that. In fact, they were my most enjoyable moments in my life. I had a ball in the military hospital.

But as you think about it, you realize that there was a difference in culture. The President of the United States in my time, World War II, was very popular. The people were almost 100 percent in favor of the war. Veterans were treated like gods. We would go into a restaurant and "Anything you want, fella." Times were different.

And then, well, I got hospitalized in the most unlikely place. We took over the best places in the United States. For my surgery it was Atlantic City. That's where it was. We took over Haddon Hall and Chalfont Hotels, huge hotels.

When the Miss America program was finally restored, we got the front rows. And although I don't have a leg injury, I asked the surgeon to put a cast on because I wanted to get on a wheelchair to sit up in front. And I think I'm the only Member of Congress of the United States who was kissed by Miss America at that time.

Senator MIKULSKI. And you well deserved it.

Senator INOUE. These were happy moments for me. I spent 21 months. The average GI spends 5 months in surgical, medical, and then he's an outpatient. I was not an outpatient. I was a member of the population there. We had 7 months of surgery and medical treatment and 14 months of what we called rehab.

Had a group of carpenters from the carpenters group in that town who came out to teach us how to do carpentry. I built my own desk. Plumbing. To do electrical work, so that we won't be afraid to fiddle around with wiring, electrical wiring.

We had to demonstrate that we can play sports. We had a choice. I decided not to take golf because after three rounds it was 92, and that's pretty high. I took up basketball and swimming, passed those tests.

I took a driving course because I never drove before I got in the service, and they taught me how to drive, gave me a certificate to qualify me to drive in all States, all territories, all possessions, because at that time you know States had different driving laws.

I had to play a musical instrument. Before the war I played a saxophone and a clarinet, but that was impossible, so they tried a trumpet and they said, "No, your lips are too soft for that." And so they said, "How about the piano?" I said, "You must be out of your mind," but I passed the test. Someday I'll demonstrate to you.

They even taught us how to make love. Someday I'll say so in public, not for the record here, but I can assure you it was the best lesson I ever got. I've never made a mistake since.

They taught us self-defense. They taught us how to dine, how to dress, how to dance. When you ask for a dance for the first time since your injury, how do you hold the lady? With your right? With the left? These are things you think about.

When we learned how to swim, we were all required to swim, it was not in the hospital pool. It was in the public lake, so you had to swim in the presence of normal people. You know, the average guy who is injured is reluctant to show his ugliness and scars to others. That's human nature. He has to be taught. I'll go out here anytime, it doesn't bother me. I walk around the house and the backyard with shorts on. Doesn't bother me. But I think it would bother some of those who are just coming back because they haven't been taught how to do it.

Well, the culture is different. As far as I'm concerned, you people are doing the utmost you can. And when you consider that since 2002 Walter Reed, for example, has handled over 6,000 war-injured veterans, that's a load that's suddenly thrust upon them. Out-patient load since the war has gone up from 100 to about 800 a day.

At the same time, as Barbara Mikulski, Senator Mikulski, has pointed out, you had this BRAC. When people were moving up, they wanted a permanent job. They knew that 2011 was right around the corner, so they wanted a job with some pension plan, so they were leaving. And Bethesda, because of the new orders of opening up a good, first class hospital, began recruiting. And voluntarily I know that six anesthesiologists have left, and if you don't have an anesthesiologist, you don't have surgery.

And so in the beginning I said I hope this is not a finger-pointing exercise or fault-finding, scapegoating, sacrificial lamb, because all of us have dirty hands. Some got dirtier hands than others but we all do.

So let's do our best. The soldiers deserve much better. I was horrified to see that mold and stories of rats around the place. These things didn't happen, I don't recall happening in my time.

We had great socials. I don't know if they do have great dances today, but we had some good ones. And the first woman I ever fell in love with was a nurse. You couldn't help it. They were that good.

So, with that, I'd like to thank the three gentlemen, and now may we call the nurses.

General KILEY. Thank you, Senator.

Admiral ARTHUR. Thank you.

General ROUDEBUSH. Thank you, sir.

Senator INOUE. I would like to welcome the Nurse Corps Chiefs: Major General Gale Pollock, Chief of the U.S. Army Nurse Corps; Rear Admiral Christine Bruzek-Kohler, Director of the Navy Nurse Corps; and Major General Melissa Rank, Assistant Air Force Surgeon General for Nursing Services.

As I have indicated, as a veteran the first woman I fell in love with was a nurse, and I'm still in love with them. You're doing a great job. And with that, got any words, Ted?

Senator STEVENS. No, I don't have a similar experience to talk about.

Senator INOUE. Well, well, well. May I call upon General Rank?

STATEMENT OF MAJOR GENERAL MELISSA A. RANK, ASSISTANT SURGEON GENERAL FOR NURSING SERVICES, DEPARTMENT OF THE AIR FORCE

General RANK. Mr. Chairman and distinguished members of the subcommittee, I am pleased to represent nearly 8,000 men and women of the total nursing force. It has been my privilege to lead and serve alongside my senior advisors, Brigadier General Jan Young of the Air National Guard and Colonel Ann Hamilton of the Air Force Reserve.

Air Force nursing is an operational capability, and strengthening clinical currency remains a priority. I have connected with each unit level nursing leadership for updates on their top initiatives. I can assure you that our clinical sustainment policy of 168 hours at the bedside has returned seasoned clinicians to inpatient settings to refresh skills and mentor the less experienced.

Since September 2001, more than half of the Air Force service deployments have been filled by the total nursing force. We are in demand, serving in the air, on the ground, in every time zone, theater of operations, and level of care. Just as the global war on terrorism triggered an evolution in combat medicine, the unrelenting

volume of complex trauma patients has generated an unprecedented demand for nursing resources.

In the words of deployed Reserve officer, Lieutenant Colonel Dawn Smith, "We do more than change dressings, maintain airways, stabilize blood pressure, and control bleeding. We provide the human touch. The hands I have held, the stories I have listened to, and the blank stares I have helped to find focus again, that is the essence of nursing." And that is why we are here. I couldn't describe Air Force nursing any better.

This type of nursing care rivals that of any stateside facility. We are providing phenomenal critical trauma care and maximizing survivability for patients during high volume air evacuation missions and in theater hospitals at Balad and Bagram.

To provide this operational capability, we increased production of critical care trauma nurses. Building upon the successful joint training program in San Antonio, we awarded 30 critical care and emergency nursing fellowships, and are expanding our training sites to Bethesda and St. Louis University Hospital in Missouri.

The Graduate School of Nursing at the Uniformed Services University is the primary source for training our certified registered nurse anesthetists (CRNAs) and perioperative nurse specialists. We are particularly pleased with the operational focus of their programs and the collaborative initiatives of the current leadership. We would also like to recognize the TriService Nursing Research Program which funds a number of expeditionary-focused studies conducted by Air Force nurses. Thank you for your continued support of both programs.

The national nursing shortage is posing a threat to our recruiting and retention efforts. Overall, we accessed 92 percent of our goal for fiscal year 2006, reflecting a 10-percent increase from the previous year. We attribute our success to offering higher accession bonuses and more loan repayment options. We are implementing a specific Nurse Enlisted Commissioning Program similar to the successful Army and Navy programs. We have secured 12 student starts, and anticipate exponential growth of this program over the next 5 to 10 years.

Of grave concern is our current inventory, which has dropped to 85 percent. We are evaluating the downward trend in retention rates, and are now offering a \$15,000 critical skills retention bonus to nurses completing their initial commitment. For the first time, we are also considering monetary incentives to impact retention at the 9- to 15-year point.

On a positive note, we are encouraged by gains in master clinician billets. We anticipate this will allow nurses to stay at the bedside and remain competitive for promotion to colonel. Our powerful retention tool is professional development, and we continue to invest in advanced military and professional education programs. We are moving forward with plans to relocate enlisted medical basis and specialty training to a TriService Medical Education and Training Campus at Fort Sam Houston.

We have fiercely maintained our ability to grant Community College of the Air Force degrees to Air Force students, and are exploring the feasibility of extending that benefit to our sister services. We are also investing in remarkable individuals like Staff Sergeant

Victoria Weiger, who enlisted in 2001 at the age of 17. She has deployed twice to Iraq, and refers to helping injured U.S. and coalition forces as her most rewarding military experience.

Sergeant Weiger expanded her scope of practice as an immunization technician and then as a critical care technician. She has earned an associate degree, and will be attending our Independent Duty Medical Technician Program early this summer. She aspires to commission as a Nurse Corps officer and becoming an Air Force CRNA.

Last fall, I received an e-mail and photo from one of our deployed nurses. He was holding an Iraqi baby. This e-mail said: "This child is one of our better outcomes. We see quite a few children here, and some very sad outcomes. We had three come in yesterday. One had both legs blown off near the hip, a very beautiful 8-year-old girl. I stopped by to see her. She was on continuous pain medication, and she looked like a sleeping angel. I didn't stay long because I couldn't keep the tears from welling up. No regrets about being here in Iraq. I love my work. Thanks for your support, and you take care." Signed, Captain Jose P. Jardin III.

Mr. Chairman and distinguished subcommittee members, Lieutenant Colonel Smith, Captain Jardin, and Sergeant Weiger are representative of Air Force nursing. It is imperative that we recruit and retain quality airmen, afford them the best training and equipment, and safeguard clinical platforms to operationally prepare them and their replacements. We will look after their families while they are far from home, and be prepared to care for them when they return.

We need to optimize the potential in our enlisted force with the opportunity to commission, and I must work diligently to improve Nurse Corps promotion opportunity and timing so that we can retain these airmen and capitalize on their leadership, clinical expertise, and operational experience. They are the symbol of the future of Air Force nursing.

PREPARED STATEMENT

I am extremely honored to be here today. Thank you for the considerable support you have given us this year, and thank you for inviting me to tell our Air Force story.

Senator INOUE. Thank you very much, General. Would you share with us the names and addresses of those three gallant nurses?

General RANK. I would be proud to.

Senator INOUE. We would like to send a note to them, a note of appreciation.

General RANK. Yes, sir.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL MELISSA A. RANK

Mr. Chairman and distinguished members of the committee, it is my honor to be here today representing Air Force Nursing Services. The Total Nursing Force encompasses officer and enlisted nursing personnel of Active Duty, Air National Guard, and Air Force Reserve Command components. It has been my privilege to lead and serve alongside Brigadier General Jan Young of the Air National Guard and Colonel. Anne Hamilton of the Air Force Reserve Command, my senior advisors for their respective components this past year.

The Secretary and Chief of Staff of the Air Force have set three priorities: Win the global war on terrorism, develop and care for our airmen, and modernize and recapitalize our assets. I assure you Total Nursing Force objectives align with, and directly support, these priorities.

EXPEDITIONARY NURSING

Air Force nursing is an operational capability, and Air Force Nursing Services remains in the forefront supporting the warfighter. Between January and December 2006, 12 percent of the Total Nursing Force inventory (2,187 personnel) deployed to 43 locations in 23 countries. Within the active duty component, 13 percent of our nurses and 15 percent of our medical technicians were deployed in 2006. The average deployment length was 110 days. Since September 2001, the Total Nursing Force has completed 53 percent of all Total Force deployments within the Air Force Medical Service. Total Nursing Force nurses and medical technicians are providing remarkable operational support. We are a well-trained, highly motivated capability serving in every time zone, every theater of operations, and at every level of care.

In January 2007, we activated the 455th Expeditionary Medical Group and assumed operational control of Craig Theater Hospital located at Bagram Air Field, Afghanistan. We have received impressive reports of life-saving care at the 455th. For one Afghani National admitted with multi-organ failure, classic medical-surgical nursing care saved his life. Over a 3-week period, Captain Cindee Wolf saw to his daily care and treatments. Providing frequent personal care, administering countless intravenous and oral medications, cajoling "one more bite" at mealtimes, and performing multiple range of motion exercises were just a few of the interventions nursing teams employed. Disease, compounded by poor nutrition and harsh living conditions, proved just as life threatening as an insurgent's bullet. The compassionate care of everyone assigned to the 455th Immediate Care Ward contributed to this patient's recovery and discharge home.

The 332nd Expeditionary Medical Group remains the epicenter for wounded in Iraq. Located at Balad Air Base, this Air Force theater hospital treats more than 300 trauma patients every month and provides care to another 400 sick and injured patients. Of the roughly 700 patients seen per month, about 500 (71 percent) are U.S. troops, 170 (20 percent) are Iraqi soldiers, police and civilians, and the remaining 30 (10 percent) are foreign national contract employees, insurgents, or those of unknown status.

Nursing teams are providing phenomenal emergency trauma care and maximizing favorable outcomes for patients in these high-volume theater hospital environments. U.S. casualties making it to Balad have an unprecedented survival rate of 97 percent to Landstuhl Regional Medical Center in Germany. Describing the response of medics to an influx of casualties, 332nd Chief Nurse Colone Rose Layman said, "... we had such a smooth rhythm as we worked together ... we were able to take 20 patients with multiple traumatic injuries and triage, treat, and move them ... without calling any additional staff. I stood in that empty emergency room (exactly 1 hour after the first casualty came in and simply thought, wow!)"

Our nursing care rivals that of any stateside facility. In the words of one of our experienced Air Force Reserve Command nurses, "I had the best experience in my entire 20 years as a trauma nurse [because] I saw how trauma patients should be treated—I saw the best possible care done on the worst traumas I have seen in the shortest time imaginable. I work at one of the largest trauma centers in my State and just realized we could learn a lot." What a testimony to the Air Force Medical Service!

The en route care construct has significantly decreased our footprint on the ground. Since October 2001, the Air Force Medical Service Aeromedical Evacuations System has moved nearly 40,000 patients. To put this in terms you may appreciate, this equates to evacuating the entire population of Annapolis, Maryland. In an excerpt from the Chief of Staff of the Air Force's "Portraits of Courage", General Moseley recognized our Aeromedical Evacuation flight nursing teams. Although written with the 86th Aeromedical Evacuation Squadron (AES) in mind, his comments described the mission performed by any one of our 31 Total Force Aeromedical Evacuation units. "... wounded warriors, premature babies, accident victims, retirees falling ill and other Department of Defense (DOD) beneficiaries needing medical care are routinely transported by [teams of] flight nurses and aeromedical evacuation technicians ... Our Nation asks much of her military and she provides an unsurpassed transportation of the sick and injured around the world ..."

The challenging task of facilitating Aeromedical Evacuation missions rests with our four Global or Theater Patient Movement Requirements Centers. The Theater

Patient Movement Requirements-Europe provided around-the-clock support during the Beirut, Lebanon Non-combatant Evacuation Operation. Working in concert with DOD, Department of State, U.S. European Command, and U.S. Consulates in Nicosia, Cyprus, and Frankfurt, Germany, they synchronized patient movement of evacuees. In one case, the U.S. Consulate in Nicosia contacted Theater Patient Movement Requirements-E and requested assistance moving an 84-year-old Lebanese-American. At the outbreak of hostilities, this gentleman was evacuated from Beirut and admitted to the American Heart Institute in Nicosia for treatment of his chronic cardiac and respiratory problems. Theater Patient Movement Requirements-E validated the need for en route medical care, coordinated an accepting physician at Landstuhl Regional Medical Center in Germany, and secured airlift for an Aeromedical Evacuation mission. Within 24 hours, the mission was complete and the patient was receiving care at Landstuhl Regional Medical Center.

Members of the Total Nursing Force, like Aeromedical Evacuation Technician Staff Sergeant Jason St. Peter, saved lives using their extensive medical and combat readiness training. While on a rescue mission into a high threat area of anti-coalition militia activity, SSgt. St. Peter was informed that the casualty count had quadrupled. Taking decisive action, he directed reconfiguration of the aircraft to accommodate additional patients. Upon landing, he triaged and prioritized treatment under infrared illumination provided by overhead aircraft. SSgt. St. Peter was credited with saving eight soldiers, as well as eliminating the need to bring additional rescue teams into harm's way. He was nominated for a Distinguished Flying Cross.

In the Pacific theater, crews from the 18th AES moved six critically burned sailors from Guam to Hawaii and then on to San Antonio. During the final leg of this 6,000 mile journey to Brooke Army Medical Center, the sailors received en route critical care from a team of burn specialists. This feat showcased Tri-Service interoperability, validating the joint capability of moving patients in an efficient manner and providing the greatest opportunity for survival and rehabilitative care. Notably, it was during this mission that our C-17 fleet logged its one-millionth hour.

For some, duties were performed along our Nation's border in support of Operation Jump Start. One hundred fifty-five Air National Guard nurses and medical technicians from four States were activated for 1 to 4 month rotations supporting this Homeland Security Border Control mission.

OPERATIONAL SKILLS SUSTAINMENT

The global war on terrorism demand for operational, clinically-current specialty nurses has steadily grown. In response, we have increased production of critical care and trauma nurses and returned nurses with specialty nursing experience to the deployment pool.

Encouraged by the success of our joint training pipeline in San Antonio, we awarded 30 critical care and emergency fellowships this year and expanded our joint training platforms to include the National Naval Medical Center in Bethesda and St. Louis University Hospital in Missouri. We have not stopped there. We are revising our support agreement with the University of Cincinnati Medical Center in Ohio to accommodate critical care nursing fellows.

We continue to rely on our Centers for Sustainment of Trauma and Readiness Skills (C-STARS). These advanced training platforms are embedded into major civilian trauma centers throughout the continental United States. In 2006, this invaluable clinical immersion enabled 614 doctors, nurses, and medical technicians to refresh operational currency while preparing them to deploy as Critical Care Air Transport Team (CCATT) members or clinicians in expeditionary medical support (EMEDS) facilities. Many of our chief nurses consider the Centers for Sustainment of Trauma and Readiness Skills an essential component of their clinical competency programs and the majority of the graduates tell us it is one of the best training experiences of their military career.

Strengthening operational clinical currency remains a priority. Now 11 months old, our clinical sustainment policy continues to gain momentum. The concept is simple: providing opportunities for nurses temporarily assigned in out-patient or non-clinical settings to refresh their technical skills by working a minimum of 168 hours per year at the bedside. For many of our out-patient facilities, this means affiliating with local medical centers for innovative patient care partnerships. Where available, our medical technicians are capitalizing on these partnerships. Said an airman from Kirtland Air Force Base (AFB), New Mexico, "The Veterans Affairs (VA) rotation . . . was a great way to get hands-on experience and exposure to emergency and inpatient settings."

In 2006, we gained access to eight complex medical-surgical, emergency trauma and critical care training platforms in which to sustain clinical skills for our officer

and enlisted nursing personnel. An extraordinary benefit emerging at nearly all training sites has been exposure to—and appreciation for—the unique missions of various agencies. We are encouraged by reports of how affiliations with our Federal health partners have fostered collegiality between nurses. Among these affiliations, two are with civilian organizations (Miami Valley Hospital in Dayton, Ohio and Iowa HealthCare in Des Moines, Iowa). Federal Tort Laws make securing affiliations with civilian organizations particularly challenging, so I applaud the hard work expended at the local level. Nursing personnel from the 3rd Medical Group (MDG) DOD/Veterans Affairs Joint Venture Hospital and the Alaska Native Medical Center have collaborated on continuing education and professional development programs for many years. Their partnership expanded recently to include rotations in pediatric, medical-surgical and critical care units—experiences long-sought to bolster currency at home station and in deployed settings.

In addition to sustainment, we have robust entry-level training platforms. The 882nd Training Group at Sheppard AFB, Texas graduated 1,638 Total Force Aerospace Medical Service Apprentice (AMSA) students in fiscal year 2006. AMSA students have the unique experience of training on technologically advanced simulations systems. Life-like mannequins simulate clinical patient scenarios, allowing students to learn and gain hands-on experience in a controlled environment. As they progress through training, students are challenged with increasingly complex scenarios. This training module was recognized by 2nd Air Force as a “Best Practice”.

Landstuhl Regional Medical Center became our 10th Nurse Transition Program (NTP) training site and the first NTP hosted in a joint facility. With the addition of the Landstuhl Regional Medical Center NTP, we have increased overall enrollment to 160 nurses in this Air Force Medical Service entry-level officer program.

We depend on the Uniformed Services University of the Health Sciences (USUHS) Graduate School of Nursing (GSN) to prepare many of the Family Nurse Practitioners (FNPs) and Certified Registered Nurse Anesthetists (CRNAs) needed to fill our mission requirements. Currently, 57 percent of our 49 FNPs and 52 percent of our 143 CRNAs are USUHS graduates. The GSN enrolled 46 Air Force nurses this fall in Perioperative Specialty, FNP, and CRNA programs. Overall, Air Force nurses represented 41 percent of the GSN student population. Once again, all 13 of our CRNA candidates passed the National Certification Exam before graduating this past December. We would like to acknowledge the support of faculty, and recognize Lieutenant Colonel Adrienne Hartgerink for her selection as Military Faculty Member of the Year.

We are pleased with the collaborative research endeavors available to GSN students. Air Force nurses have published their research in professional journals and presented their work at the national level. Ten of our nurses were among the GSN students contributing to a landmark study that analyzed more than 11,000 reported perioperative medication errors. The recommendations emerging from this research have significant implications for patient safety, and will lead to better outcomes for patients in all U.S. healthcare organizations. Collaborative clinical training occurred as well. The Mike O’ Callaghan Federal Hospital at Nellis AFB in Nevada and National Naval Medical Center were formally designated as Phase II Nurse Anesthesia Clinical Sites. Air Force nursing has successfully integrated training platforms at every level.

CLINICAL SUCCESSES

We are also logging significant improvements at home-station treatment facilities. The 81st MDG at Keesler AFB, Mississippi celebrated another post-Katrina milestone with the opening of a new labor, delivery, recovery and postpartum unit. The new labor and delivery unit is staffed with six OB/GYN physicians, one nurse midwife, nine military and three civilian nurses, as well as seven medical technicians. More staff will be arriving over the coming year to coincide with projected increases in prenatal caseload.

At the 23rd MDG, Moody AFB, Georgia, Major Jennifer Trinkle and a team of nurses instituted a nurse-run Active Duty Fast-Track Clinic using pre-defined care protocols. The fast-track made a measurable impact on their business plan and increased overall productivity of the facility. Exit surveys revealed patients liked the “express” experience, and nursing teams enjoyed more interaction with patients.

A Tri-Service nurse consortium, chartered at Landstuhl Regional Medical Center, addressed complex infection control issues affecting global war on terrorism casualties. Their initiatives included modifying specimen collection intervals to reduce bacterial colonization of *acinetobacter baumannii*, instituting contact precautions for all intensive care unit admissions, and switching to waterless/antibacterial bathing pro-

protocols. These efforts have the potential to become benchmark infection control practices for participating National Nosocomial Infections Surveillance System hospitals.

CARING FOR OUR OWN

The cornerstone of military capability is a fit and ready force; however, the undeniable consequence of continued exposure to polytraumatic injuries is profound risk to the health of our nursing staff. Although vast resources are available to airmen and their families prior to deployment, lessons from earlier conflicts have taught us some returning warriors—warrior medics among them—have difficulty resuming personal and professional activities. Dr. Michael Murphy, an Assistant Professor of Surgery at the Indiana University School of Medicine and OIF veteran, offered this Veteran's Day tribute: "There is . . . a group of forgotten veterans . . . who carry with them the ghosts of war that will haunt them forever . . . nursing staff (assigned to) forward surgical teams and combat support hospitals." To that end, every airman completes a Post Deployment Health Re-Assessment (PDHRA) survey at some point during their 90 to 180 day post-deployment window. At the local level, nurses are connecting those at risk with appropriate primary care or mental health providers.

We recognize caring for our own includes caring for those who care, looking after airmen and their families and educating all concerned on signs and symptoms of stress. Over the past year, we have promoted awareness and neutralized stigmas associated with seeking help by incorporating post traumatic stress and compassion fatigue discussions with nurses attending symposiums, conferences and senior leader gatherings. We are now pursuing targeted interventions to ensure we have the appropriate resources available for our nurses and medical technicians when they return to home.

PROFESSIONAL DEVELOPMENT

The goal of Nurse Corps (NC) professional development is to produce nursing leaders for the Air Force Medical Service. We accomplish this goal by creating role-specific skill-sets and competencies to enhance current job performance and prepare junior officers for success in the future. Our nursing Development Team (DT) convenes quarterly to ensure NC officers are afforded deliberate career progression. The DT competitively selects our squadron commander and chief nurse candidates, both of which represent pivotal career leadership milestones. Additionally, the DT selects, through a board process, those leaders who will most benefit from developmental education in residence. This year three outstanding NC officers were selected for senior developmental education.

Professional development also serves as a powerful retention tool. Seventy-five percent of Air Force nurses responding to our 2006 DT Assessment Tool survey stated educational opportunities positively influenced them to stay in the military. In addition to professional military education and pinnacle leadership positions, the NC supports very robust educational opportunities. Three percent of Total Force nurses are funded for advanced academic degrees and specialty training every year. For 2006, these included 69 nurses selected for the nurse practitioner programs, 21 nurses selected for clinical nurse specialists' education, and 14 nurses selected for other advanced degrees. Eighteen nurses were selected for very competitive fellowships to include emergency room/trauma/critical care, Advanced Executive Development programs, Advanced Education and Training programs, Joint Commission and Accreditation Association for Ambulatory Health Care fellowships, and numerous others. In addition to professional military education and advanced degree programs, we continued our specialty courses for operating room nursing, neonatal intensive care nursing, infection control, perinatal/OB nursing and the Health Professions and Education and Training Course. In 2006, we trained 66 Total Nursing Force flight nurses and 172 Total Nursing Force Aeromedical Evacuation technicians at our Flight School at Brooks City Base in San Antonio. This program continues to be a vital training platform for our increasing requirements for clinical Aeromedical Evacuation crews in support of global war on terrorism.

Purposeful assignment selection and rank-appropriate developmental education opportunities will ensure our nurses have the requisite skills and experience to succeed in deployed operations and future leadership roles. I want to especially thank Dean Bester of USUHS for the continued support, which makes much of our advanced education a huge success.

RECOGNITION

Air Force nurses and medical technicians were recognized for outstanding performance by various professional organizations this year. The Air Force Association

is an independent, nonprofit, civilian education organization promoting public understanding of aerospace power and the pivotal role it plays in the security of the Nation. They recently selected Air Force Medical Service Expeditionary Medics to receive the AFA Outstanding Air Force Team of the Year award for their direct support of the warfighter and our expeditionary efforts. Seven Total Force medics will accept this award on behalf of the entire Air Force Medical Service at the end of March.

Last fall, Lieutenant Colonel Leslie Claravall, 374th Medical Operations Squadron Commander at Yokota AB, Japan was honored as one of the 2006 Ten Outstanding Young Americans. Since 1938, this project has recognized 10 Americans each year who exemplify the best attributes of the Nation's young people.

In July 2006, the National Nursing Staff Development Organization presented national awards to two Air Force nurses at their annual conference. Lieutenant Colonel Lola Casby and Major Francis Desjardins won the Excellence in Educational Technology and Excellence in the Role of Professional Development Educator Awards, respectively. Lieutenant Colonel Sandy Bruce, Consultant to the Air Force Surgeon General for Nursing Education and Training, was appointed editor-in-chief of the next edition of Core Curriculum for Staff Development, and five Air Force nurses were named to the editorial board. This manual, endorsed by National Nursing Staff Development Organization, is widely accepted as the standard of practice for healthcare educators. For the first time, an Air Force nurse was named Research Consultant to the International Council of Nurses (ICN). The ICN is a federation of more than 120 national nurses' associations representing millions of nurses world-wide. Colonel John Murray was also selected as a Fulbright Visiting Scholar for research, another first for military nursing.

Our medical technicians were similarly honored for outstanding achievement. Master Sergeant Charles Cremeans, an independent duty medical technician assigned to the 786th Security Forces Squadron at Ramstein AB, Germany, was awarded the 2006 Lewis L. Seaman Enlisted Award for Outstanding Operational Support. Air Force independent duty medical technicians have won this award 3 of the past 4 years, validating their unique role in operational healthcare missions. Sponsored by the Association of Military Surgeons of the United States, this prestigious award recognizes an enlisted professional of the Army, Navy, Air Force or Coast Guard, who has demonstrated compassionate, quality patient care and service, clinical support, or healthcare management.

Technical Sergeant Shannon McBee, an Aeromedical Evacuation technician assigned to Pope AFB, North Carolina was awarded the 2006 Airlift Tanker Association's Specialized Mission Award. During the award presentation, General Duncan McNabb told the audience, "In time of war, when we are doing 900 sorties a day . . . there's one individual who stands out above all others . . ." While deployed, TSgt. McBee flew 28 missions in Iraq and Afghanistan, sometimes under fire, to provide critical nursing care to more than 300 wounded people—from special operations soldiers to children who stepped on land mines.

Some of the most rewarding recognition came in the form of spontaneous acknowledgement from our professional colleagues. During a regional nursing conference, Air Force nurses Major Prudence Anderson, Major Wendy Beal, and Captain Charlotta Leader presented Deployed Military Nursing from Ground to Air; focusing on the EMEDS concept, en route care processes and Aeromedical Evacuation missions. As they concluded their presentation, there was a moment of silence followed by a standing ovation. "It was an honor to represent military nursing . . . to be so appreciated in our community," they said.

RECRUITING AND RETENTION

Nurses remain at the top of Gallup's annual poll assessing honesty and professional ethics. However, public confidence has yet to translate into larger recruiting pools. In fact, a U.S. Department of Health and Human Services report (<http://bhpr.hrsa.gov/nursing/>) projects demand shortfalls will reach 17 percent by 2010 and 27 percent by 2015. Clearly, Air Force nursing will need to capitalize on every opportunity to recruit and retain nurses.

In fiscal year 2006, we achieved 80 percent (281) of our total recruiting goal (350). This was a significant improvement over fiscal year 2005's 69 percent. Graduates of our scholarship programs brought overall accessions up to 92 percent of goal. We attribute our success to larger financial incentives, which combined the options of accepting an accession bonus and Health Professions Loan Repayment for nursing school loans. Our fiscal year 2006 accession bonus options were \$15,000 for a 3-year commitment or \$20,000 for a 4-year commitment. We have increased the bonus for fiscal year 2007 (\$25,000/4yrs), and are optimistic this will get us even closer to

goal. Direct accessions accounted for the majority of our fiscal year 2006 recruits, but we also attracted new nurses via ROTC scholarships, Line of the Air Force (LAF) funded enlisted to BSN and Airman Enlisted Commissioning Programs.

Mirroring our Sister-Services' successful enlisted commissioning programs, we are aggressively pursuing a specific Nurse Enlisted Commissioning Program. We gained LAF support for 12 student "starts" over the next 2 years, and anticipate exponential growth of this program for the next 5–10 years.

As calendar year 2006 came to a close, the NC inventory was a gravely concerning 85 percent. We retired 166 officers and separated another 188, for a net loss of 354 experienced nurses. We know our attrition rates spike at the 4–5 year point as nurses complete their initial service commitment; and again at 7–9 years, when nurses face disparate promotion opportunity. In response, we initiated a \$15,000 critical skills retention bonus targeting nurses completing their initial commitment in the Air Force, and will be closely monitoring its impact on retention for this year group.

Compensating for our second attrition spike will be much harder, but we have made progress this year. LAF acknowledged inequities in colonel-grade billets, and validated 100 percent of the NC position descriptions submitted to the Air Force Colonel Grade Review Board. As a result, we have conservatively estimated a 45 percent gain in NC colonel-grade billets over the next year.

We are especially pleased with the increased number of validated master clinician billets at our larger hospitals and medical centers. This is significant because it will provide an avenue for some of our most clinically experienced senior nurses to remain in patient care settings without sacrificing opportunities for promotion and advancement. We are now a few steps closer to bringing NC promotion opportunity in parity with other Air Force categories constrained by the Defense Officer Personnel Management Act. These are tremendous strides for the NC, although the effect they will have upon major-grade and lieutenant Colonel-grade promotion opportunity is not yet clear.

TRANSFORMATION INITIATIVES

The Air Force Medical Service has deployed transformation initiatives this year using the principles of Air Force Smart Operations 21 (AFSO21). The primary goal of AFSO21 is to eliminate redundant processes that compete against priority missions for time, manpower, and money. In 2006, the Air Force Medical Service became the first DOD service to align with the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for surveys of our ambulatory care clinics. Our partnership with The Joint Commission continues for surveying our inpatient facilities. In the words of our senior healthcare inspector, "Our new partnership with AAAHC will allow us to significantly integrate (military) inspections and accreditation findings in our reports . . . while reducing duplication of effort . . . a great example of AFSO21 principles at work."

The 39th MDG at Incirlik AB, Turkey provided another example. They applied AFSO21 strategies to their Medical Right Start Program, an Air Force medical service wide process of enrolling beneficiaries into the local health care system upon arrival to a new duty station. They streamlined their process by relocating all points of service to a central location at their Military Treatment Facility (MTF) and scheduling all Right Start Orientation enrollment activities on a single day. They estimate annual savings of \$106,000 and 1,630 duty hours by implementing these customer-focused process improvements.

By far, the most challenging initiative has been the conversion of military positions to civilian equivalents needed to support a leaner military medical force posture. The Air Force nursing services civilian inventory includes more than 1,000 nursing personnel in advanced practice, licensed and paraprofessional roles. Nationally, the demand for nursing personnel far exceeds the supply, creating a competitive market that favors qualified candidates. In 9 months of active recruiting, we have hired 11 nurse practitioners and nurse specialists, 59 clinical nurses, and 41 paraprofessional nursing personnel (Licensed Practical Nurses (LPNs), Emergency Medical Technicians and Operating Room (OR) technicians). Although we hired 86 percent of the clinical nurses programmed for fiscal year 2006, we were significantly less successful with other civilian hires, especially LPNs and OR technicians. Through active recruiting, hiring bonuses where warranted, and use of direct hire authority, we are cautiously optimistic about reaching our fiscal year 2007 goal of accessing 211 additional civilian nursing personnel.

JOINT ENDEAVORS

Our International Health Specialty Nurses organized several important initiatives supporting the goals of Theater Security Cooperation. Among them, was a bilateral project to enhance the infection control capability of nurses serving in the Vietnam (VN) military. Facilitated by the Center of Excellence (COE) for Disaster Management and Humanitarian Assistance and funded through Presidential Emergency Plans for AIDS/HIV Relief (PEPFAR), this project builds upon previous U.S.-VN military nursing exchanges. During the first phase of this project, VN nurses will travel to Wichita Falls, Texas for didactic training at Sheppard AFB and then transition to Tripler Army Medical Center (TAMC) for clinical experience. A total of eight VN nurses will be trained; with the first two scheduled to begin in March. The second and third phases involve U.S. nurses traveling to VN to assist newly-trained VN nurses with Infection Control Program implementation at their four largest military hospitals. The University of Hawaii, College of Nursing collaborated with DOD and COE partners to develop the educational framework and gather supporting data. This project meets Theater Security Cooperation goals of capacity building, building competent coalition partner, interagencies, interoperability, access, and influence.

A joint capital venture between the 1st MDG at Langley AFB, Virginia and the Naval Medical Center Portsmouth is underway. This venture establishes a Special Care Nursery at Langley AFB that accepts transfers of moderately ill neonates from the Naval Medical Center Portsmouth, thus enabling them to preserve bed-space for more critical/ acutely ill neonates. This partnership will allow beneficiaries to continue care within the Military Health System, a benefit to both medical facilities and their patient population.

Air Force nurses actively participated in monthly System-wide Trauma Continuum of Care video teleconferences in 2006. The complexities of issues addressed were astounding, and included standardizing pressure-related baldness and skin ulceration surveillance and prevention, managing complex pain issues during en route care, standardizing burn management and resuscitation documentation, reducing mortality and morbidity associated with under/over fluid resuscitation, and reducing ventilator-associated pneumonias. This world-wide, DOD/Veterans Affairs performance improvement forum, facilitated successful outcomes and improved quality of life and functionality for recovering global war on terrorism casualties.

Twenty-four medics from the 52nd MDG, Spangdahlem AB, Germany deployed to Tamale, Northern Ghana where they joined 22 Ghanaian military medical staff for MEDFLAG 06. Operations required extensive interoperability. Participants gained experience in deploying to austere locations, interacting with host nation military and governmental organizations, observing/understanding local customs, integrating healthcare teams of multiple specialties and several units/Service components, procuring supplies and equipment, and reallocating personnel and resources to meet changing mission requirements. Everyday at sunrise, teams loaded supplies and convoyed to villages where thousands stood waiting for medical, dental and optometry care. Over 3,200 patients received care in just 4 days, and U.S. medical personnel were able to learn about, see and treat a myriad of chronic and tropical diseases rarely seen in the United States. A letter of appreciation signed by Pamela Bridgewater, U.S. Ambassador to Ghana, summed up the impact made by our medics, "In my many years of Foreign Service I can think of no other time that I was so proud to be an American than on my visit to the MEDFLAG sites in the Northern Region. . . . I (saw) first-hand the professionalism of U.S. (military) personnel and the strong ties of cooperation fostered in a short period of time. I (directly) witnessed the positive effect that the U.S. military presence had on the population of that deprived region. This is truly a case where we are winning the hearts and minds just by being who we are and doing what we do so well, helping others."

RESEARCH

Our patients have benefited from cutting edge research conducted by Air Force nurses, particularly in the realm of operational clinical readiness. Colonel Peggy McNeill, an Air Force doctoral student, is examining the performance of medical aircrew in a simulated military aircraft cabin environment. CCATTs provide intensive specialty care to nearly 10 percent of the global war on terrorism casualties transported on military cargo aircraft, and yet we have limited understanding of how in-flight stressors impact medical aircrew and affect their cognitive and physical performance on long Aeromedical Evacuation missions. Her findings will enhance patient outcomes by maximizing operational performance of medical personnel in the Aeromedical Evacuation environment.

Due to the nature of their injuries and stressors of flight, combat casualties are at high risk for having an inadequate supply of oxygen in their blood. Traditional methods of monitoring for this complication are not possible with combat casualties experiencing severe burns, amputations, decreased body temperature, or massive swelling. Research being conducted by Lieutenant Colonel Marla DeJong will provide clinicians with valuable information about the ability of specialized monitoring devices to provide more accurate patient assessment data needed to care for acutely and critically ill patients in flight.

Lieutenant Colonel Karen Weis, a graduate of Air Force-sponsored doctoral education, studied the impact of deployment on psychosocial experiences of pregnancy. Her findings indicated effective maternal identification, or pregnancy acceptance, was dependent upon the husband's presence in the first and early second trimesters of pregnancy. As a result, an evidence-based program has been developed to provide timely family support to pregnant military wives with deployed, or deploying, husbands.

Air Force nurses received generous financial support from the Tri-Service Nursing Research Program (TSNRP) to conduct the type of research just described. In addition to research studies, the TSNRP Resource Center funded the creation of an operational pocket guide for nurses. Designed as a concise reference for deployed nurses, it contains the most current evidence-based practice recommendations for operational health care. Topics range from critical care of blast victims to psychological first aid and culturally appropriate pain assessment and management.

BASE REALIGNMENT AND CLOSURE (BRAC) INTEGRATION

Air Force nurses are working alongside Sister-Service colleagues to achieve functional nursing integration. Here in the National Capital Region, Air Force critical care nurses assigned to Andrews AFB, Maryland are now augmenting staff at Walter Reed Army Medical Center. BRAC integration is affording Air Force nurses additional opportunities to maintain operational currency in complex patient care platforms, while serving the needs of critically ill and injured military heroes and their families.

In San Antonio, we are moving forward with plans to relocate enlisted medical basic and specialty training to a Tri-Service Medical Education and Training Campus (METC) at Fort Sam Houston. METC will capitalize on synergy created by co-located training programs. We have fiercely protected our Community College of the Air Force degree granting to Air Force students, and are exploring the feasibility of extending authority to our Sister Services.

The Air Force Surgeon General Consultants for nursing specialties are working with their Tri-Service counterparts to solidify scopes of practice that reflect nursing care in joint environments. The Nurse Consultants are incorporating Service-specific requirements and civilian benchmarks to establish a single scope of practice for each specialty, thereby easing transition into joint units and providing nurses with a clear understanding of their roles and responsibilities.

OUR WAY AHEAD

For the past year, I have connected with nursing leadership teams at every one of our military treatment facilities; learning more about their mission priorities, challenges, and concerns. These conversations have assured me Air Force nursing stands ready for the exciting and challenging events ahead.

Mister Chairman and distinguished members of the committee, it is my honor to be here today representing nearly 18,000 men and women that make up our Total Nursing Force. Thank you for the considerable support you have given us this year and thank you for inviting me to tell our story.

Senator INOUE. And now may I call upon Admiral Bruzek-Kohler. Admiral.

STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZЕК-KOHLER, DIRECTOR, NAVY NURSE CORPS, DEPARTMENT OF THE NAVY

Admiral BRUZЕК-KOHLER. Good morning, Chairman Inouye, Ranking Member Stevens, and distinguished members of the subcommittee. It is an honor and privilege to speak to you again about our 4,100 outstanding Active and Reserve Navy nurses and the selfless contributions they make in operational, humanitarian, and traditional missions at home and abroad. My written statement

has already been submitted for the record, and I'd like to highlight just a few of those key issues.

Amidst the Nation's nursing shortage and the continuation of what is now 5 years of our engagement in Operations Iraqi and Enduring Freedom, I am proud to say we are projected to meet our direct accession goals for the first time in 4 years. This success can be attributed to our increased recruiting efforts, attendance at a diverse range of nursing conferences, but most importantly, because we stress that every Navy nurse is a Navy recruiter.

As a result, we have recently made a request to increase our direct accession opportunities. This increase will help fortify the healthcare assets which support the deployment of additional soldiers and marines as recently requested by our Commander in Chief.

Throughout our career continuum, our Navy nurses are responsive, capable, and continually ready to provide the finest care anytime, anywhere. Our clinical sustainment policy ensures our nurses are ready to deploy at a moment's notice and provide superior clinical care from operational platforms in Iraq to humanitarian missions in Southeast Asia. In our military treatment facilities in the United States and abroad, Navy nurses are at the forefront of providing comprehensive mental and physical care to our returning heroes.

To address their needs, 13 deployment health clinics have been established across the Nation. In these clinics, a specialized team of nurses, providers, and allied health professionals ensure personnel returning from operational deployments receive health assessments and follow-up care. Naval Medical Center San Diego has created a multidisciplinary program that coordinates hospital assets and personnel, offering a wide range of medical, surgical, behavioral health, and rehabilitative care to those injured in the service of our country.

In these settings and at many of our military treatment facilities, mental health nurses and nurse practitioners help meet the psychosocial needs of our returning personnel and their families. We intend to further capitalize on these practitioners in both the inpatient and outpatient arenas, as well as in operational assignments.

Beyond our military treatment facilities, Navy nurses serve honorably and courageously with Navy and Marine Corps operational units around the globe. In 2006, Navy nurses on board the U.S.N.S. *Mercy* conducted a successful 5-month Southeast Asia humanitarian mission. Joining the Navy medicine team on this mission were medical assets from the United States Air Force and Army, from Canada, India, Malaysia, Australia, and nongovernmental organizations.

At Landstuhl Regional Medical Center, nearly 100 Reserve Nurse Corps officers work alongside their Army and Air Force colleagues, providing lifesaving care to America's selfless and courageous warriors. The mental and physical stress of providing day-to-day nursing care to our critically wounded necessitates that we acknowledge the demands of our profession and the importance of caring for our caregiver, who may so often place the needs of others over self.

Our educational programs and policies support nursing operational readiness, the warfighter, and provide opportunities for graduate level studies. These programs help sustain continued growth in clinical knowledge and expertise and improve the quality of care. Our advanced practice nurses from these programs are actively conducting research and implementing healthcare programs that directly benefit the active duty member and all our beneficiaries. On an annual basis, we shape our graduate education training program based on our healthcare and operational support requirements.

Our civil service and contract nurses are integral members of the Navy medicine team, and their support and efforts are essential in ensuring we provide quality nursing to all entrusted to our care. We recruit and retain the very best of these nurses through a number of programs and initiatives, from the superior qualification bonus to the accelerated promotion program. In the last 2 years we have made great strides in increasing our civilian nursing workforce, and continue to reassess all programs to ensure we can attract the best qualified nurses.

In the last year our Active and Reserve Navy nurses have answered the call of a grateful Nation and are proud members of the One Navy Medicine Team. By partnering with civilian and military healthcare organizations, our nurses provide the finest care worldwide and make a positive and meaningful difference in the lives of our uniform service members, their families, our retired heroes and beneficiaries.

Our future requires that we align with the mission of our armed forces while simultaneously meeting advances in professional nursing practice. The uniqueness of military nursing is our dynamic ability to seamlessly integrate critical nursing specialties into compassionate care for America's sons and daughters, our soldiers, marines, sailors, and airmen. We will continue the exemplary tradition of Navy nursing excellence by focusing on interoperability and working alongside our military and civilian colleagues.

PREPARED STATEMENT

I greatly appreciate the opportunity to share these accomplishments and issues with you, and I look forward to continued work as the Director of the Navy Nurse Corps. Thank you, sir.

Senator INOUE. Thank you very much, Admiral.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

INTRODUCTION

Good morning, Chairman Inouye, and distinguished members of the committee. I am Rear Admiral Christine Bruzek-Kohler, the 21st Director of the Navy Nurse Corps and the Chief of Staff, Bureau of Medicine and Surgery. It is an honor and privilege to speak to you again about our outstanding 4,100 Active and Reserve Navy nurses and their contributions in operational, humanitarian, and traditional missions on the home front and abroad. Over the last year, we faced numerous challenges from the continuing war in Iraq, and the global war on terrorism, to conducting overseas humanitarian missions in Southeast Asia. The performance of all Navy nurses, in particular our wartime nursing specialties of mental health, nurse anesthesia, critical care, family nurse practitioner, emergency medicine, perioperative, and medical/surgical, has been exemplary in all theaters of operations and healthcare settings. Navy nurses, with the support of our outstanding civil serv-

ice and contract nurses, answered the call of duty with outstanding dedication and provided hope and comfort to all those in need.

The primary component of success in the Navy Nurse Corps has been our ability to clearly articulate and demonstrate our military relevance. To accomplish this, our nurse leaders recently met to review our 2006 strategic goals and objectives and determine our way ahead for 2007 and beyond. The outcome of this meeting resulted in the establishment of six priorities for Navy nursing that are specifically aligned with the vision and goals of the Chief of Naval Operations and the Surgeon General. To chart our course and navigate our achievements into the future, these six priorities include: Clinical proficiency to sustain our readiness; alignment of educational programs to meet future mission requirements; shaping the Nurse Corps to meet missions of the future; development of an executive leadership model for future Nurse Corps leaders; joint partnership to create a nursing productivity model; and implementation of a robust Nurse Corps communication program. Addressing each category, I will highlight our achievements and issues of concern.

READINESS AND CLINICAL PROFICIENCY

Throughout the career continuum, Navy nurses are responsive, capable, and continually ready to provide the finest care, "Anytime, Anywhere." Our clinical sustainment policy ensures our nurses are ready to deploy at a moment's notice and provide superior clinical care from operational deployments in Iraq, to humanitarian missions in Southeast Asia. At military treatment facilities, in the operational theater, on humanitarian missions, and working in a joint environment, Navy nurses are clinically agile and trained to mission requirements. Working with our sister services, we continue to define scopes of nursing practice and competencies to ease integration and cross-utilization within the military healthcare system.

At our military treatment facilities at home and abroad, Navy nurses are at the forefront of providing comprehensive mental and physical care to our returning heroes. To fully address their needs, 13 Deployment Health Clinics have been established across the country. Here, a specialized team of nurses, medical providers and allied health professionals ensure all personnel returning from operational deployments receive timely and thorough medical screenings and follow-up care. For those wounded warriors returning from overseas, Naval Medical Center (NMC) San Diego offers a multidisciplinary program of care via the Comprehensive Combat Casualty Care Center. This service offers a wide range of medical, surgical, behavioral health and rehabilitative care to those wounded in the service of our country.

Nurses in a variety of settings within the Navy are at the forefront of providing behavioral health, case management, and community health nursing. Our mental health nurses and practitioners are working with deployed personnel pre- and post-deployment in a variety of settings to ensure their behavioral needs are fully addressed. We are in the process of recognizing the advanced skills of the mental health nurse practitioners and anticipate utilizing their expertise as advance practice nurses in the near future. As healthcare systems experts, our Nurse Corps case managers liaise between civilian, Department of Veterans Affairs, and our military treatment facilities to ensure our wounded warriors have complete and rapid access to all their physical and behavioral health needs. Additional rehabilitative support comes from the Navy-Marine Corps Relief Society, whose visiting nurses partner with our Navy nurses in order to provide greater stateside services through the newly formed Visiting Nurse Combat Casualty Assistance Program.

For our sailors, marines and all our beneficiaries, Navy nursing is proud to provide the best family-centered care. Throughout our medical treatment facilities, nurse led mother-baby initiatives continue to improve quality of life and bring deployed family members closer together. Naval Hospital Camp Lejeune, North Carolina opened a newly renovated mother-baby unit serving both Marine Corps Air Station Cherry Point and Marine Corps Base, Camp Lejeune. The 18 new labor and delivery suites greatly expand access to care and provide special features such as a Level II nursery for newborns who require close monitoring and lactation consultation for maternal support. Innovative family-centered nursing practice at the Mother-Infant Care Center at the National Naval Medical Center (NNMC) resulted in this unit being named the "Best Nursing Team" by *Advance for Nurses Magazine*. At the NNMC and Naval Hospital Camp Pendleton, deployed family members are afforded the opportunity to participate in the labor and delivery of their newborns via video and telephone conferencing. Whether at home or abroad, our family-centered care is the foundation of support to all our service members.

Beyond our medical treatment facilities, Navy nurses continue to serve with pride in a variety of operational and humanitarian theaters. During the past year, Navy nurses from both active and reserve components were deployed throughout the

world as members of joint military, humanitarian and multi-national missions. Our nurses served with pride in Navy and Marine Corps operational units around the globe: Kuwait, Iraq, Djibouti, Afghanistan, Bahrain, Qatar, Canada, Germany, Honduras, Peru, Indonesia, Philippines, Pakistan, Thailand, South Korea, East and West Timor, Vietnam, Bangladesh, Republic of Georgia and Guantanamo Bay, Cuba. Nursing care services for both operational and humanitarian missions were delivered by surgical teams, U.S. Marine Corps Surgical Companies, Shock Trauma Platoons, the Forward Resuscitative Surgical Systems, and the Enroute Care System Teams for casualty evacuation. In addition, care was provided in expeditionary medical facilities, on Navy hospital ships, aircraft carriers, amphibious ships, and at our military treatment facilities. At Landstuhl Regional Medical Center, almost 100 Nurse Corps Reserve officers are working side-by-side with their Army and Air Force colleagues giving direct care to our returning casualties.

Providing care to the citizens of the world, our humanitarian missions reflect America's generosity and compassion. These efforts greatly enhance America's image as an ambassador of goodwill. In 2006, Navy nurses on board the hospital ship USNS *Mercy*, concluded a 5 month Southeast Asia humanitarian mission. In conjunction with the Navy medicine team, our medical personnel partnered with the U.S. Air Force, U.S. Army, the nations of Canada, India, Malaysia, and Australia and with non-governmental organizations. Together, the agencies and partnering countries delivered emergency/trauma, critical care, post-anesthesia care, pediatric and medical surgical services in a mutually supportive environment.

The mental and physical stress of day to day nursing care provided to our critically wounded uniformed personnel necessitates that we acknowledge the demands of our profession and the importance of balance and care for the caregiver. To address these demands, efforts involving mental health support out-reach teams, psychological injury first aid training, and collaborative healthcare peer support services are made available to all of our nurses. In addition, our nurses are encouraged to take advantage of all family support services and command sponsored morale, welfare and relief opportunities.

EDUCATION PROGRAMS AND POLICIES

Our education programs and policies support nursing operational readiness, the warfighter, and provide opportunities for graduate level advance practice to improve quality of care at home and abroad. At our medical treatment facilities, our nurses are provided the very best clinical training environments to sustain and improve their clinical skills. To hone these clinical skills for operational deployment, we have numerous initiatives and programs to ensure their clinical abilities in the field are of the highest level. To guarantee continued growth in clinical knowledge and expertise, our graduate education program provides masters and doctoral level training for our Navy nurses. Our advance practice nurses from these programs are actively conducting research and implementing healthcare programs that directly benefit the warfighter and all our beneficiaries.

Ensuring our nurses' clinical skills are of the highest caliber, we continue to utilize, reassess and seek out the best clinical training programs. Our robust Nurse Internship Programs at NNMCC, in Bethesda, Maryland; and NMC Portsmouth, Virginia; and NMC San Diego, California, continue to provide professional guidance and mentorship to our new Navy and civilian nurses. We have initiated a pilot perinatal training program to ensure continued quality care and patient safety for our nurses going to overseas facilities. This program will provide our junior nurses the skills they need to work in the labor and delivery environment. We have implemented a new component for nurses developing critical care skills through the use of web-based training. This program is based on the American Association of Critical Care Nurses Essentials for Critical Care and coupled with bedside training, provides the most up-to-date clinical training for our critical care nurses. Certification in wound care provides our nurses with the state-of-the-art skills to care for our trauma patients returning from combat.

In addition to training within our facilities, our nurses are actively collaborating with our sister services to promote continuously improved quality clinical care. To maintain clinical proficiency, our nurses at U.S. Naval Hospitals in Naples and Rota have a collaborative staff sharing agreement with the Landstuhl Regional Medical Center. At Landstuhl, our nurses are able to enhance and maintain their clinical skills in emergency room, neonatal, mother/baby and critical care. Supporting joint training opportunities, NMC Portsmouth, in collaboration with Langley Air Force Base created a 10-week Neonatal Intensive Care Course that provides training to staff in anticipation of opening a new level II nursery at Langley. This joint project will expand the ability to care for pre-term infants in the Tidewater, Virginia area.

In addition, the Navy and Air Force formed a partnership involving the critical care course at the NNMCC. This training accompanied by follow on clinical rotations enabled the Air Force Nurses to attain critical care skills while simultaneously supporting the medical mission.

Advance practice nurses at our facilities continue to improve quality of care through implementation of national healthcare protocols as well as sound nursing research findings. Several quality and patient safety protocols from the Institute of Healthcare Improvements were adopted for use in our military treatment facilities. A sampling of current Nurse Corps clinical research underway includes: Affects of Total Parenteral Fluid on the Nutritional Status of Premature Neonates, Efficacy of a Nurse Run Outpatient Behavioral Therapy Program, Extra-Amniotic Balloon Insertion Comparison Study, and Affects of Healthcare Industry Representatives in the Operating Room.

Beyond the military treatment facility, our nurses receive specialized clinical training to enhance their critical wartime nursing skills to provide immediate care in any operational setting. Navy nurses have maximized available training opportunities through the Navy Trauma Training Course at the Los Angeles County/University of Southern California Medical Center; Joint Combat Casualty Care Course in San Antonio, Texas; and Military Contingency Medicine/Bushmaster Course at the Uniformed Services University Graduate School of Nursing in Bethesda, Maryland. Operational training has been integrated into the Navy Nurse Corps Anesthesia Program and every nurse is deployment ready on the day of graduation. Other operational medical training programs Navy nurses take part in include the: Enroute Care Course, at Fort Rucker, Alabama, Field Medical Service Officer Course, at Camp Lejeune, North Carolina, and Advance Burn Life Support course provided by the Defense Medical Readiness Institute. Collaborating with our civilian medical communities, our nurses at NMC San Diego, California, maintain an agreement with Scripps Medical Center for trauma training in their emergency room.

Navy nurses continue to support joint training opportunities in a variety of environments that provide the foundation for combined operational medicine. In Operation Northern Lights, Navy nurses helped support the Army's field exercise at Fort McCoy, Wisconsin, by jointly operating a 30-bed field hospital under simulated wartime conditions. In preparation for future operational and humanitarian missions, Navy nurses on board the hospital ship USNS *Comfort*, participated in an international medical mass casualty drill in Halifax, Nova Scotia, involving Canadian forces and the British Royal Navy. Supporting the concept of interoperability, Navy nurses in the Reserve Component have worked seamlessly with the Defense Medical Readiness Training Institute, sponsoring and teaching three major professional trauma programs. The programs conducted on-site at San Antonio, Texas included: Advanced Burn Life Support, Joint Combat Casualty Care Course, and Pre-Hospital Trauma Life Support. Furthermore, these were exported to several regional training sites to maximize participation. Working with our civilian and military counterparts provides Navy nurses important clinical training and mutual operational support opportunities.

The experiences gained in the operational environment have enabled Navy nurses to be at the forefront of implementing the latest operational medicine training programs. At Navy Medicine Manpower, Personnel, Training, and Education Command, our nurses are part of a team working on the Expeditionary Medicine Web-Based Training Project. This web-base training will support clinical operational training and include combat-related medical skill and knowledge. To provide realistic casualty training to our forces at sea and land, Expeditionary Strike Group Five home-based in San Diego introduced a medical simulation mannequin called "SimMan." Critical care nurses with the strike group have used this device to train key personnel on essential life-saving medical techniques and assessments. Navy nurses have been instrumental in the development of the Combat Lifesaver Trainers course at the Field Medical Service School. This program teaches select corpsmen how to train marines in life-saving skills that bridge the gap between basic first aid and the corpsmen.

In addition, nursing research is actively being carried out to support warfighter readiness. A sampling of these studies include: Affects of Redeployment on Military Medical Personnel, Smokeless Tobacco Use Among Female Marines and Sailors Returning from Deployment, Coping Intervention for Children of Deployed Parents, Describing Chronic Disease Conditions in the Crews of Small Ships, Assessment of the Navy Shipshape Weight Management Program, Developing a Care for the Caregiver Mental Health Promotion Model, and Perceived Barriers Toward Emergency Contraception in Female Soldiers Deployed in Support of Operation Iraqi Freedom.

Working with the civilian community, Navy nurses have provided integral disaster, readiness training and nursing education support. At Naval Health Care Clin-

ics New England, our nurses participate and provide essential emergency response training with the local community. In the National Capital Area, NNMC nurses played an essential role in coordinating and collaborating with the community in the area-wide mass casualty drill. Given the current shortage of nursing school faculty across our country, we continue to provide clinical nursing experiences at our military treatment facilities while functioning as clinical nurse preceptors, educators and adjunct professors in support of schools of nursing throughout the country.

Our Navy Nurse Corps graduate education programs continue to enable Navy medicine to improve the quality of care for our sailors, marines, and their families. On an annual basis, we shape our graduate education training plan based on our health care and operational support requirements. We select our most talented nurse leaders to attend accredited universities around the country to attain their masters and doctorate degrees, which has also proven to be an invaluable retention tool. In addition, a plethora of continuing education courses and specialized training opportunities are available to further enhance solid clinical skills.

The Tri-Service Nursing Research Program (TSNRP) has played an integral role in contributing to successful patient outcomes, quality care, and support for the warfighter. Since its inception in 1992, TSNRP has supported over 300 research studies in basic and applied science and involved more than 700 military nurses as principal and associate investigators. A sample of Navy Nurse Corps studies includes: Clinical Knowledge Development of Nurses in an Operational Environment; Factors Associated with the Onset of Depression in Navy Recruits; Interventions to Maximize Nursing Competencies for Combat Casualty Care; and Research to Practice in the Military Health Care System. Overall, approximately one quarter of the TSNRP studies have been conducted by Navy nurse researchers.

There have been numerous publications attesting to the expertise of our Navy nurses, noted in the American Journal of Nursing, Archives of Psychiatric Nursing, American Journal of Public Health, Military Medicine, Association of Operating Room Nurses Journal, Dimensions of Critical Care Nursing, Critical Care Nursing Clinics of North America, American Association of Nurse Anesthesia, and American Journal of Critical Care. In addition, Navy nurses have been invited to present innovative practice and research findings at the Sigma Theta Tau Nursing Honor Society's regional conferences, Annual Meeting of the Association of Military Surgeons of the United States, American Association of Nurse Anesthetists, American Academy of Ambulatory Care Nursing Convention, American Academy of Nurse Practitioner's Conference, and Naval Reserve Association.

It is this personal dedication to the highest clinical proficiency and continuing education that makes us proud members of the military healthcare system. Our advance practice nurses are an integral part of the Navy medicine team. Continued professional development focused on operational medicine and evidence-based health care are key to our support of the warfighter as we provide the finest care to our uniformed service members and beneficiaries.

FORCE SHAPING

Maintaining the right force structure is essential to meeting Navy medicine's overall mission by validating nursing specialty requirements, and utilizing the talent and clinical expertise of our uniformed and civilian nurses. We are focused on our operational missions, and wartime specialties: nurse anesthesia, family nurse practitioner, critical care, emergency, mental health, medical-surgical and perioperative nursing. Through force shaping, we are creating the optimum structure for the present and the future.

Navy Nurse Corps recruiting has often struggled in competing with civilian institutions and other government agencies for America's finest nurses. However, for the first time in 4 years we are projected to meet our direct accession goal. This can be attributed to the tireless efforts of Navy Nurse Corps recruiters, recent increases in our Nurse Accession Bonus, and the Health Professions Loan Repayment Program for recruiting. In addition, our pipeline programs continue to be immensely successful and are the primary recruitment source for future Nurse Corps officers. Our pipeline programs include the Nurse Candidate Program, Medical Enlisted Commissioning Program, Naval Reserve Officer Training Corps Program, and Seaman to Admiral Program. These pipeline programs are our lifeline to ensure a steady supply of trained and qualified Nurse Corps officers in the future and are critical in assisting us to maintain desired manning levels. To this end, the Seaman to Admiral Program has been increased in order to expand our enlisted personnel's opportunity to become Navy nurses. Overall, I am very proud of our recruiting efforts, but our retention of Nurse Corps officers is still of great concern.

Retention poses a greater challenge with only 67 percent of active duty Nurse Corps officers deciding to remain on active duty after their first obligated decision point. At the end of calendar year 2006, our manning end strength decreased to 91 percent in the active component, with a deficit of 286 Navy nurses. Within our wartime specialties, shortfalls have been identified in the nurse anesthesia and family nurse practitioner communities.

To counter these deficiencies, a number of programs and initiatives have been implemented. The Health Professions Loan Repayment Program has been extremely successful and the applicants exceeded available positions for the last 2 years in a row for both retention and recruiting. The Certified Registered Nurse Anesthesia specialty pay was increased to assist in retaining this critical wartime specialty. Our Nurse Corps recruiters, to enhance recruitment and promote diversity, expanded their presence at a variety of national nursing conferences: Association of Operating Room Nurses, Association of Critical Care Nurses, Emergency Nursing Association, National Black Nurses Association, National Association of Hispanic Nurses, and National Student Nurses Association. Nurse Corps officers are serving as mentors of our students in the Nurse Candidate and Naval Reserve Officer Training Corps Programs to provide professional growth while enhancing retention. We have also established specific identification codes to identify our advanced practice Nurse Corps officers with expertise as adult, critical care, and emergency room nurse practitioners. This provides military treatment facilities key data to recognize the professional abilities of these advanced practice nurses and to utilize their expertise in the role of primary care nurse practitioners. These identification codes further assist Navy medicine to accurately identify and utilize nurse practitioners in expanded operational assignments. Last year, we proposed a Critical Skills Retention Bonus for officers who entered service in fiscal year 2004 and fiscal year 2005. We did not meet direct accession goals for these 2 fiscal years. The retention bonus is specifically targeted to improve retention of Nurse Corps officers who entered active service during these 2 fiscal years. In addition, I have personally written to many of the Deans of Nursing throughout the country outlining the benefits of a Navy career. Navy Nurse Corps officers are highly encouraged to utilize every opportunity to recruit new nurses and take on the career enhancing assignment as nurse recruiters. We will continue to closely monitor our end strength throughout the year, evaluate newly initiated programs, and explore other options to retain our nurses.

In the Navy Nurse Corps reserve component, recruitment and retention continues to be of great concern. We continue to have difficulties recruiting and retaining our critical wartime specialties. To address this, fiscal year 2007 Nurse Accession Bonuses remain focused on critical wartime specialties. The Nurse Accession Bonus for the reserves has been beneficial in recruiting the professional nurse with less than 1 year of experience. To attract civilian perioperative nurses, we have opened our perioperative training programs in Jacksonville, Florida, and Camp Pendleton, California, to include reserve nurses. As a pipeline program, our Hospital Corpsman to Bachelor of Science in Nursing Program continues to be successful. With our increased rate of mobilizations to Landstuhl and Kuwait, and contributory support to our medical treatment facilities, it is imperative that we meet our nursing specialty requirements and explore all options to support our recruitment and retention efforts.

Civil Service and contract nurses are integral members of the Navy medicine team and their support and efforts are essential in ensuring we provide quality nursing to all entrusted to our care. We recruit and retain the very best of these nurses through a number of programs and initiatives. The Direct Hire Authority from the National Defense Authorization Act of 2003 gives commands the flexibility to offer nursing positions directly to interested candidates. The Superior Qualifications Bonus gives commands the option to offer a higher basic pay rate based on exceptional experience and/or education. A recruitment bonus based on a percentage of their base pay and a relocation allowance may also be utilized. Other recruitment and retention tools available include Special Salary Rates, Retention Allowance, Student Loan Repayment Program, Tuition Assistance, payment for licenses/credentials, and the Accelerated Promotion Program. For those new to the nursing profession, we have expanded the Nurse Internship Program at our major naval medical centers, to include civilian nurses. In the last 2 years, we have made great strides in increasing our civilian nursing workforce and continue to reassess all programs to ensure we attract and retain the very best for the Navy medicine team.

Our success in meeting the mission in all care environments requires that we continuously reassess our measures of effectiveness, adjust personnel assignments, and revise training plans. We continue to closely monitor the national nursing market environment to ensure Navy nursing recruiting and retention efforts remain competitive.

LEADERSHIP DEVELOPMENT

Leadership development begins the day our nurses take the commissioning oath as Navy officers and is continuously refined throughout an individual's career with increased scope of responsibilities, upward mobility, and pivotal leadership roles within the field of nursing and healthcare in general. Our Navy nurses are proven strategic leaders in the field of education, research, clinical performance, and health care executive management. To help prepare them for these roles, a variety of leadership courses are offered: Navy Corporate Business Course, Service War Colleges, Military Healthcare System Capstone Symposium, Interagency Institute for Federal Healthcare Executives, Wharton's Nurse Executive Fellows Program, Basic and Advanced Medical Department Officers Course, and the Joint Operations Medical Managers Course. To ensure we continue a legacy of nursing excellence, it is critical that we identify those leadership characteristics and associated knowledge, skills and abilities that are directly linked to successful executives in Navy medicine. A Nurse Corps study (Palarca, 2007), in conjunction with Baylor University, has identified the key leadership competencies and associated knowledge, skills, and abilities specific to mid-level and senior executive Nurse Corps officers. The competencies identified for mid-level Nurse Corps officers include: management; leadership; professional and personal development; deployment readiness and interoperability; communications; and regulatory guidelines. The competencies identified for senior executive Nurse Corps officers include: business management; executive leadership; professional development; global awareness and interoperability; communications; and personnel management. This information will provide the basis for ongoing leadership development of our mid-grade through senior executive officers as they advance in executive medicine.

To meet today's challenges, nurse leaders must be visionary, innovative and actively engaged across joint service and other agencies to maximize our medical capabilities. Nurse Corps officers continue to reach new heights of clinical and operational leadership fulfilling roles as: Regional Director, TRICARE West Region; Chief of Staff, Bureau of Medicine and Surgery; Commanding Officer, USNS *Comfort*; First Surgical Company Commander, Iraq; Officer in Charge, Camp Doha, Kuwait; Commanding Officer, Coronado Battalion U.S. Naval Sea Cadet Corps; President, National Student Nurses Association; and commanding and executive officers of military treatment facilities around the world. Navy Nurse Corps officers have been recognized in a variety of media wide publications: New York Times Nurse of the Year Runner-Up, Washington Post Nurse of the Week, and Best Nursing Team of 2006 by Advance for Nurses Magazine. Within the reserve component, our dedicated Navy nurses are in key leadership positions in their units, when recalled to active duty, as well as in their civilian organizations, professional associations and local communities. Examples of key leadership positions include Deputy Commander, Navy Medicine National Capitol Area; Deputy Director for Navy Personnel, Landstuhl Regional Medical Center; commanding officers of Operational Health Support Units; CEOs of healthcare companies; administrators of hospitals; directors for nursing services; and faculty positions in colleges of nursing. Navy nursing remains committed to creating an environment which enhances leadership opportunities for tomorrow's future senior healthcare executives.

PRODUCTIVITY

Increasing healthcare costs, coupled with balancing higher patient acuities with available nursing resources, requires accurate and efficient management of our manpower assets. To address this we are taking steps to maximize our nursing human resources. In San Diego, California, a nurse-managed Pediatric Sedation Center was established for those procedures that normally required the main operating room. This initiative reduced main operating room utilization and provided a more pleasant environment for those families requiring the service of the Pediatric Sedation Center. In Quantico, Virginia, the nurse-run Wound Clinic instituted several nurse-focused standard operating procedures to address ailments that would otherwise require physician intervention. In Camp Lejeune, North Carolina, the branch medical clinic sends nursing personnel directly to the School of Infantry to address healthcare issues on-site versus requiring medical clinic visits. In Portsmouth, Virginia, nurses from the local reserve unit have performed over 84,000 man hours of operational and clinical support over the last 27 months. This constituted a cost savings of over \$4 million to NMC Portsmouth.

To maximize the identification of nursing productivity, a Tri-Service Patient Acuity Scheduling System Working group has been formed. The purpose of the group is to develop business strategies for inpatient and outpatient acuity assessment and scheduling; and to develop a military healthcare system information technology to

transform and standardize the methodology for capturing, reporting, and communicating patient acuity, staff scheduling, and productivity across the services. The Navy Nurse Corps, with our sister uniformed services, continues to seek out the most effective productivity models to maximize our healthcare resources.

COMMUNICATION

Communicating through a comprehensive plan ensures all reserve and active Nurse Corps officers receive the most accurate, timely, and official information. A team of 24 active and reserve Nurse Corps officers coordinated and created a comprehensive set of Nurse Corps communication modalities: Nurse Corps web-page, weekly newsletter, monthly video-teleconferencing, Nurse Corps news update, Nurse Corps email database, bi-monthly senior Nurse Corps officers update, and semi-annual all Nurse Corps Admiral's Call. The aggressive implementation and the coordination of these modalities resulted in a greater awareness of the many beneficial programs we have for Nurse Corps officers. For example, our successful Health Professions Loan Repayment Program had a significant increase in the number of applicants this past year because of our ability to "get the message out" efficiently and expeditiously. By streamlining the communication process, synchronizing the methodology of delivery, and tapping into the latest technology we have seamlessly connected the Navy Nurse Corps around the world.

Beyond the Navy Nurse Corps, we continue to actively communicate with our uniformed and civilian counterparts. At the monthly Federal Nursing Service Council meeting, the nursing leadership of the Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs and the American Red Cross meet to discuss the challenges facing our respective organizations. Furthermore, the Nurse Corps Chiefs of the other uniformed services and I meet regularly to address our common military nursing issues and opportunities to partner jointly on resolutions. Joint operations, cooperation, and communication are the foundation for future success in providing the highest quality of care for all our beneficiaries.

CLOSING REMARKS

In the last year, our active and reserve Navy nurses have answered the call of a grateful Nation and are proud members of the One Navy Medicine Team. By partnering with civilian and military health care teams, our nurses provide the finest care worldwide and make a positive and meaningful difference in the lives of our uniformed service members, their families, our retired heroes, and beneficiaries. The basis of our future requires that we align with the mission of our armed forces while adapting to the advances in professional nursing practice. The uniqueness of military nursing is our dynamic ability to seamlessly integrate the critical nursing specialties into the healthcare needs of soldiers and marines on the field, and our sailors at sea. We continue the exemplary tradition of Navy Nursing Excellence by focusing on interoperability and working side-by-side with our military and civilian colleagues.

I appreciate the opportunity of sharing the accomplishments and issues that face Navy nursing. I look forward to continuing our work together during my tenure as Director of the Navy Nurse Corps.

Senator INOUE. And now may I call upon General Pollock.

STATEMENT OF MAJOR GENERAL GALE S. POLLOCK, DEPUTY SURGEON GENERAL, U.S. ARMY, AND CHIEF, ARMY NURSE CORPS, DEPARTMENT OF THE ARMY

General POLLOCK. Aloha, Mr. Chairman, and distinguished members of the subcommittee. It is again my great honor and privilege to speak before you today on behalf of the nearly 10,000 officers of the Army Nurse Corps. It is your continued, unwavering support that has enabled Army nurses to provide the highest quality care for our soldiers and their family members.

Our vision of advancing professional nursing and maintaining leadership in research, education, and the innovative delivery of healthcare is at the forefront of all we do. Army nurses serve in clinical and leadership roles in medical treatment facilities in the United States and abroad, in combat divisions, forward surgical

teams, combat stress teams, civil affairs teams, combat support hospitals, and coalition headquarters.

We have transitioned the Army community health nurse to the Army public health nurse, a role that is necessary as we face future threats within our homeland and theaters of operation. These nurses now support combat theaters of operations in civil affairs and the rebuilding of healthcare infrastructure.

Our transition to the psychiatric nurse practitioner role makes these nurses critical to the support of our soldiers in theater as well as and their families following deployment. In addition, these psychiatric nursing specialists either lead or support programs related to post-traumatic stress management and the reintegration of soldiers and families.

Our family nurse practitioners are filling critical roles during deployments, proving themselves as significant force multipliers. Their performance has validated their interchangeability as primary care and trauma providers.

We have also moved forward with the registered nurse first assist perioperative subspecialty. Incorporating the registered nurse first assist into our structure enhances our ability to recruit and retain perioperative nurses, and sustains our clinical experience base while offering nurses an expanded role within the perioperative clinical nursing specialty.

Combat operations provided many lessons learned, particularly the need for early trauma training for all of the AMEDD team. The trauma nursing core course sponsored by the Emergency Nurses Association continues to be the standard for training for new Army nurses, and serves as a refresher during predeployment training for all nurses. We also provide the advanced burn life support course in the captains career course.

From the beginning of combat operations in Iraq, Army nurses transported severely wounded patients by air within theater. Although they performed superbly, most had little or no training in aviation medicine or enroute care. Therefore, we developed the joint enroute care course to provide concise, realistic, and relevant trauma transport team training to all AMEDD personnel.

Always one of our successes, the U.S. Army graduate program in anesthesia nursing once again ranked second in the Nation. However, I remain concerned about the nursing shortage which is affecting not just anesthesia nursing but all of our advanced nursing specialties.

Starting in January 2006, new graduates assigned to Tripler Army Medical Center completed a Nurse Internship Program. They were assigned to a home room nursing unit, and over the next 6 months were scheduled for rotations that exposed them to medicine, surgery, critical care, emergency rooms and trauma, psychiatry, pediatrics, and labor and delivery.

The Tri-Service Nursing Research Program which you established in 1992 is a truly successful program. Army nurse researchers, in collaboration with their Navy and Air Force colleagues, are actively involved in the Tri-Service Nursing Research Program's Center of Excellence in Evidence-Based Nursing Practice. I hope that the current lack of funding will be corrected.

While the AMEDD team continues to provide quality health care, its members work to advance healthcare delivery systems in countries around the world. The Army nurses assigned in Afghanistan spearheaded an initiative to teach local Afghan doctors and nurses state-of-the-art techniques in providing perioperative surgical and nursing care. Nurse practitioners at the 121 Combat Support Hospital in Korea support Korean advanced practice nursing students by providing observational experiences to students as part of their clinical rotations. We remain an extremely busy corps, participating in joint military nursing endeavor programs in Vietnam, Kuwait, and the Kingdom of Saudi Arabia.

A competitive civilian market and current operational demands cause all of the challenges that we face to exacerbate the shortage of nurses and nursing educators. Currently I have a deficit of 254 officers, primarily in the company grades and in critical specialties such as anesthesia, critical care, perioperative, and OB/GYN nursing. We are constantly monitoring the status of our recruiting and retention efforts.

A recent review of personnel records by the Department of the Army indicated that the Army Nurse Corps has the highest attrition rate of any officer branch in the Army. Ongoing research indicates that Army nurses leave the service primarily because of the length of deployment and the absence of specialty pay.

For Reserve component nurses, my primary concern is the imbalance of professionally educated officers in the company grades. So many of them are prepared at the associate degree or diploma level that over the past few years only 50 percent are educationally qualified for promotion or leadership. We are grateful that the Chief of the Army Reserve is focusing recruitment incentives on those nurses educated at the baccalaureate level and funding the Specialized Training and Assistance Program for their BSN completion.

We continue adapting to the new realities of this long war, but remain firm on providing the leadership and scholarship required to advance the practice of professional nursing. We will maintain our focus on sustaining readiness, clinical competency, and sound educational preparation, with the same commitment to serve those service members who defend our Nation that the Army Nurse Corps has demonstrated for the past 106 years.

PREPARED STATEMENT

Again, thank you for the opportunity to appear before you today. I look forward to your questions.

Senator INOUE. Thank you very much, General Pollock.
[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL GALE S. POLLOCK

Mr. Chairman and distinguished members of the committee, it is again an honor and great privilege to speak before you today on behalf of the nearly 10,000 officers of the Army Nurse Corps. The Army Nurse Corps is today 106 years Army strong. It has been your continued unwavering support that has enabled Army nurses, as part of the larger Army Medical Department (AMEDD) team, to provide the highest quality care for our soldiers and their family members.

DEPLOYMENT

The Army Nurse Corps remains fully engaged in our Nation's defense and in support of its strategic goals. Our vision of advancing professional nursing and maintaining leadership in research, education, and the innovative delivery of healthcare is at the forefront of all we do. Army nurses provide expert healthcare in every setting in support of the AMEDD mission and the military health system at home and abroad. There are currently over 400 Army Nurse Corps officers from all three components deployed in support of operations in 16 countries around the world. From April 2006 to March 2007, we deployed over 560 Army nurses for a total of 204,009 man-days in a hazardous duty area. We mobilized an additional 1,616 Army Reserve Nurses in support of the total AMEDD mission, deploying 181 to Iraq and Afghanistan. They serve in clinical and leadership roles in medical treatment facilities in the United States and abroad, in combat divisions, forward surgical teams, combat stress teams, civil affairs teams, combat support hospitals (CSHs), and coalition headquarters.

Today, the 28th CSH from Fort Bragg, North Carolina; the 21st CSH from Fort Hood, Texas; and the Army Reserve's 399th CSH from Massachusetts are deployed to Iraq. The 14th CSH from Fort Benning, Georgia has just redeployed from Afghanistan. The 31st CSH from Fort Bliss, Texas arrived in theater early this year to replace the 21st CSH. While these units deploy, others are being sourced, equipped, manned, and trained to sustain the ongoing mission in support of the global war on terror.

TRANSFORMATION/ADVANCING PROFESSIONAL NURSING

The Army Nurse Corps continues the process of self-examination and transformation to maintain the competencies required to face the complexities of health care in the 21st century. Last year, I described a few of the initiatives that we have pursued and I want to provide you an update.

We have made great strides in transitioning the Army community health nurse to the Army public health nurse role—one that is necessary as we face future threats within our homeland and theaters of operation. The curriculum for the Army public health nurse has been modified to include public health officer roles and responsibilities, training in epidemiology, and the management of large population groups in the event of a pandemic or major disaster. In addition, the curriculum details the role of the Army public health nurse in combat theaters of operations to include civil affairs and the rebuilding of healthcare infrastructure. At the graduate nursing level, Army public health nurses will be directed to programs offering either a Master's in Public Health, such as the Uniformed School of Health Sciences (USUHS) or to civilian institutions offering a Public Health Nursing graduate degree.

While we have only recently transitioned to the psychiatric nurse practitioner role, with our first group of nurses attending graduate school beginning in 2006, our psychiatric clinical specialists have been critical to the support of our soldiers in theater as well as soldiers and their families following deployments. Since March of 2006, five psychiatric nurse clinical specialists have deployed in place of clinical psychologists and all have performed spectacularly. On our installations, the clinical specialists have either led or participated in programs related to post traumatic stress management and in the reintegration of soldiers and families.

Our family nurse practitioners (FNP) continue to be a valued asset of the AMEDD team. They are filling critical roles during deployments, proving themselves to be a significant force multiplier. In addition to providing outstanding primary care across our facilities, they have taken on provider roles within the Brigade Combat Teams at level II. Last year, 19 FNP's deployed in place of physician assistants. Their performance has validated their interchangeability as primary care and trauma providers. More recently, three FNP's were assigned to support special operations missions around the world.

To ensure that our nurse practitioners have the skills to transition from academia into practice, we have incorporated a post graduate preceptorship program for new graduates. We also began putting nurse practitioners through advanced trauma training programs prior to deployment ensuring they have the necessary skills to function in their advanced practice roles. In addition, we put one of our family nurse practitioners, CPT Ida Montgomery through the Army flight surgeon's course at Fort Rucker, Alabama.

We are also continuing to strategically move forward with the registered nurse first assist (RNFA) perioperative subspecialty. The RNFA expands the scope of practice of the perioperative nurse to function as first assistants to the surgeon in the operating room, optimizing the utilization of general surgeons. During times of war,

the RNFA can provide enhanced capabilities to the forward surgical team, the CSH, and be a major contributor to the successful outcomes of military surgeries during combat operations. Incorporating RNFAs into our structure also enhances our ability to recruit and retain perioperative nurses. Historically, perioperative nurses sought advanced education in roles unrelated to the perioperative arena due to a lack of advanced opportunities in that field. With the RNFA, we can preserve our clinical experience base while offering nurses an expanded role within the Perioperative Clinical Nursing Specialty. Our perioperative nursing consultant, Col. Linda Wanzer, has incorporated this training into the Perioperative Clinical Nurse Specialists program at USUHS. The current inventory of Army nurses trained as first assists is 14. There are currently three RNFA students enrolled in USUHS and three completing their internship. In the past year, five RNFA's have deployed in support of contingency operations as advanced practice Perioperative Clinical Nurse Specialists.

I am proud of the entire AMEDD team caring for the wounded warriors along the entire medical evacuation continuum. Another area in which we continue to advance professional nursing practice is in the area of case management. A world-class nurse case management model assures the seamless transition of our soldiers from the battlefield to home. There are currently 2,204 medical hold soldiers assigned to military medical treatment facilities and another 1,431 assigned to community based health care organizations. Today there are 272 nurse case managers assigned throughout the AMEDD health care system providing inpatient and outpatient care of our active duty, medical hold soldiers, retirees, and dependents. Reports from the field indicate that case managers are effectively and efficiently coordinating appropriate and quality health care for this population of ill and injured soldiers. Soldiers report high satisfaction regarding their case managers and prefer to have Army nurses manage their health care. With such demonstrated successes, we are developing and implementing strategies for the preparation of our new RN case managers to meet the special needs of our soldiers. We are also standardizing case management practices and documentation across the AMEDD and helping with the implementation of Veterans Administration and Department of Defense (DOD) clinical practice guidelines that will enhance the collaboration of medical, nursing, and other specialties as well as standardize best practices.

As the Army works to rebalance its forces, we are also working to adapt to the circumstances of this long global war on terror. We are rapidly applying lessons learned and developing training to ensure we provide the best care across the health care continuum. At the AMEDD Center and School, the Department of Nursing Science has incorporated those lessons into all courses offered to Army nurses, licensed practical nurses (LPN), and combat medics. We have had a number of other successes in both ongoing and new initiatives that I would like to share with you.

The U.S. Army Graduate Program in Anesthesia Nursing once again ranks second in the Nation. We are equally proud of the USUHS Registered Nurse Anesthesia Program. However, I remain concerned about the crisis that continued shortages of certified registered nurse anesthetists (CRNA) presents to the AMEDD. We are moving ahead and increasing enrollment in the U.S. Army Graduate Program in Anesthesia Nursing (USAGPAN), and working on issues related to their retention. The largest class in the program's history of 43 Army students will start in June 2007. To accommodate this class and assure sustained throughput, four new civilian faculty members were added to the didactic phase of the course at the AMEDD Center and School. Each of the clinical locations now have a military director and civilian deputy director in order to maintain fidelity in training when directors deploy.

Combat operations over the past 5 years have provided many lessons learned, and probably none more important than the need for early trauma training for all of the AMEDD team. Trauma rotations are now mandatory for all students in the Graduate Anesthesia Program. The Trauma Nursing Core Course (TNCC) sponsored by the Emergency Nurses Association continues to be the standard for training new Army nurses during the Officer Basic Leaders Course. In 2006, 292 entry level nurses were trained in all aspects of trauma care lead by Lt. Anthony Bohlin. The course teaches the principles of optimal care of the trauma patient and how that care is best accomplished within a systematic team framework. In addition TNCC has also become a standard part of pre-deployment training for all nurses.

With significant burn injuries being seen in both Iraq, Afghanistan, as well as during humanitarian operations last year in Pakistan, we have identified the requirement for advanced burn care training for our teams. In response, the Department of Nursing Science at the AMEDD Center and School integrated the Advanced Burn Life Support (ABLS) Course into the Captains Career Course. The course designed for physicians, nurses, physicians assistants, nurse practitioners, therapists, and paramedics provides guidelines in the assessment and management of the burn

patient during the first 24 hours post injury. The first class will take place in May 2007 for approximately 130 Army nurses of all specialties providing this advanced skill set to seasoned clinicians. The ABLS course has also been identified as a critical course for all clinicians deploying to theater.

Providing nursing care in austere environments has been the cornerstone of Army nursing. The art of field nursing has been integrated into every major course taught at the AMEDD Center and School. During fiscal year 2006, upgraded field medical equipment was purchased for the Camp Bullis training site. The result is students training on equipment identical to that which they will encounter in the theater of operations. This not only enhances their competency but also strengthens their confidence in the field technology ultimately providing better care to our ill and injured soldiers.

From the beginning of combat operations in Iraq, nurses have transported severely wounded patients by air within theater. They performed superbly, but most had little or no training in aviation medicine or enroute care. During Operation Iraqi Freedom rotations IV-VI there were 450 critical care transport missions from two hospitals in Iraq. To assure that the Army provided appropriate training to medical attendants, the U.S. Army School of Aviation Medicine Fort Rucker, Alabama developed the Joint Enroute Care Course. The purpose of the course is to provide concise, realistic, relevant enroute trauma transport team training to flight medics, registered nurses, physician assistants, and physicians. Since the program opened in June 2006, approximately 77 Army nurses have completed the training. We expect three more iterations of the course this fiscal year to train an additional 105 medical personnel. To enhance exposure to patients' requirements during medical evacuation, the Department of Nursing Science has integrated aspects of this course into programs at the AMEDD Center and School.

As reported last year, the Department of Nursing Science at the AMEDD Center and School broke ground for a new general instruction building which is scheduled to open in July 2007. The \$11.1 million, 55,000 square foot building, named in honor of Brigadier General Lillian Dunlap, 14th Chief of the Army Nurse Corps, will house all four branches of the Department of Nursing Science; the U.S. Army Practical Nurse Branch, the Operating Room Branch, the Army Nurse Professional Development Branch, and U.S. Army Graduate Program in Anesthesia Nursing Branch.

The training of enlisted medical personnel is a critical mission of the AMEDD Center and School and we continue to update and improve the educational processes and curriculum. The Surgical Technologist (68D) Program is a 19-week course preparing entry level operating room technicians. Previously, students are trained for 9 weeks at the AMEDD Center and School and were sent to 1 of 23 locations for hands-on clinical training. To improve the quality and standardize the training, the number of clinical sites has been reduced to 14 to include a newly forged partnership with the San Antonio VA Medical Center. This reorganization of the training process has markedly improved 68D training by increasing the number of dedicated faculty across fewer locations.

The Surgical Technologist Branch continues to work on the Inter-Service Training Review to conduct an analysis of Army, Air Force, and Navy commonalities in training surgical technologists. The goal in 2007 is to explore the mechanisms for certification of students with this specialty. The 68D Branch also conducted a rapid train-up program for USAR 68D's preparing for deployment and is producing a distance learning program to assist in pre-deployment training.

I remain fully committed to making sure we smoothly transition our new Army nurses into the organization and clinical practice. It is demonstrated very clearly in the professional literature and from feedback from our officers that a solid orientation and preceptorship are directly linked to, clinical skill development, job satisfaction, and ultimately retention. We continue to work towards the establishment of an enhanced new graduate internship program across the Army. In the meantime, some facilities have changed how new nurse graduates are indoctrinated by incorporating feedback from redeploying nurses and including an array of clinical experiences within the first year to maximize clinical skill acquisition. Starting in January 2007, new graduates assigned to Tripler Army Medical Center complete a nurse internship program overseen by Ms. Shelia Bunton, Lt. Patricia Wilhelm, and Lt. Mary Hardy. They are assigned to a "home room" nursing unit and over a 6-month period are scheduled for rotations that expose them to medicine, surgery, critical care, emergency/trauma, psychiatry, pediatrics, and labor and delivery. The first 12 officers will graduate from the inaugural internship in June 2007 with a much more rounded clinical skill sets.

The national nursing shortage and unprecedented nursing staff turnover have required us to examine our care delivery model and processes to continue to achieve

quality clinical outcomes. In a Bureau of Labor Statistics report dated February 2004 indicated that the production of new registered nurses is not keeping pace with nurse retirements and the aging nursing workforce. Total job openings which include both job growth and replacement of nurses will produce 1.1 million nursing job vacancies by the end of the decade. Based on these statistics, a group of senior Nurse Corps leaders and civilians from across the AMEDD are examining and piloting a relationship based nursing care model that focuses on patient and family centered care, Registered Nurse led teams, clearly defined nursing roles and responsibilities, education, experience, and the scope and standards of nursing practice. The initial pilot began in January of 2007 at Tripler Army Medical Center and is expected to become a model for the delivery of nursing care across the Army regardless of the team, facility, or region in which nursing care is being delivered.

Evidenced-based practice is the process by which nurses use the body of knowledge to develop best nursing practices based on clinical outcomes. Army nurse researchers, in collaboration with their Navy and Air Force colleagues, are heavily vested in the TriService Nursing Research Programs' Center of Excellence in Evidenced-Based Nursing Practice. Projects to bring research findings to the bedside are underway at Walter Reed, Brooke, Madigan, and Tripler Army Medical Centers. These projects are part of a larger effort to improve patient outcomes and reduce costs by standardizing care. They teach nurses how to critique research and incorporate the relevant findings into patient care. Nurses involved in these projects increase their knowledge, become motivated to further their education, and are becoming involved in research projects, much earlier in their careers.

Tripler Army Medical Center and Martin Army Community Hospital at Fort Benning, Georgia were selected as test sites by the DOD Patient Safety Center to establish rapid response teams (RRT). The purpose of the teams is to provide critical care nursing and respiratory therapy teams to assess patients exhibiting early clinical symptoms of decline. These teams provide expert resources to novices nurse to assist in assessment and intervention for at risk or high acuity patients. The pilot programs are clearly demonstrating that the RRT's are highly successful in preventing patient complication with early expert intervention, providing nursing staff support and training new and less experienced nursing staff.

Each year, the U.S. Pharmacopodia's (USP) Center for the Advancement of Patient Safety conducts an in-depth analysis of medication errors using data captured from MEDMARX. This year, the U.S. Pharmacopodia has collaborated with the Uniformed Services University of the Health Sciences and the Association of Perioperative Registered Nurses on the data analysis and report. This marks the first time USP has worked with partners on the report, and the collaboration has produced multi-dimensional analysis. The analysis and data collected will help hospitals nationwide and throughout the Department of Defense reduce and prevent medication errors and related costs due to patient injury, further hospitalization and treatment.

LEADERSHIP IN RESEARCH

The TriService Nursing Research Program (TSNRP), established in 1992, provided military nurse researchers funding to advance research based health care improvements for the war fighters and their beneficiaries (S.R. 107-732). TSNRP actively supports research that expands the state of nursing science for military clinical practice and proficiency, nurse corps readiness, retention of military nurses, mental health issues, and translation of evidence into practice.

TSNRP is a truly successful program. Through its state of the art grant funding and management processes, TSNRP has funded over 300 research studies in basic and applied science and involved more than 700 military nurses as principal and associate investigators, consultants, and data managers. TSNRP funded study findings have been presented at hundreds of national and international conferences and are published in over 70 peer-reviewed journals. Army Nurse Corps studies focus on the continuum of military health care needs from pre-and post-deployment health to nursing specific practices necessary to best care for the warrior in theatre. The Army nurse research portfolio includes a study by Col. Richard Ricciardi that evaluated the metabolic cost and the consequences of wearing body armor, finding that wearing body armor significantly increases workload. His findings have implication for the amount and type of work commanders can expect soldiers to perform and put additional emphasis on the importance of soldiers maintaining a normal body weight and physical fitness as part of overall readiness.

Col. Stacey Young-McCaughan is assessing the prevalence, severity, and characteristics of pain and sleep disturbance to determine how they impact physical and

psychological outcomes in soldiers with extremity trauma sustained during service in Operation Enduring Freedom (OEF) and OIF.

Our improvements in battlefield medical and trauma care, has resulted in unforeseen advances in treatment for both military and civilian populations. These advancements largely come from dedicated research teams co-located with deployed combat hospitals. These teams have been deployed since at least WWI and continue to be along side our providers today. We are at a phase in the war in Iraq that we can collect data, conduct comprehensive and detailed analysis, and develop focused improvement that will result in practice change while still in theater. Lt. Veronica Thurmond PhD, a nurse researcher, is part of the 6-person deployed combat casualty research team (DC2RT) located in Baghdad Iraq with the 28th CSH. This dedicated research and analysis team is operating under Multi-National Coalition Iraq (MNC-I) DOD Assurances of Compliance for the Protections of Human Subjects and complies with all research regulatory and ethical guidelines. The researchers collaborate with subject matter experts in the United States on all aspects of their research.

I would like to highlight some of the ongoing areas of research the team is focused on which will ultimately result in practice changes that save lives. These areas include: Registry of emergency airways at combat hospitals, burn outcomes at the CSH, damage control vascular surgery, effects of blast-concussive injuries, acinetobacter skin colonization among deployed soldiers, survey of tourniquet use, and outcomes of patients receiving blood transfusions in a combat environment. There are also numerous studies in various stages of development.

Army nurse researchers and our doctoral students continue to focus their efforts on military relevant issues. They are conducting a number of studies that foster excellence and improve the nursing care we provide. They are researching issues including recruit health; clinical knowledge development; the provision of care for the traumatically injured; objectively measuring nursing workload; and the impact of deployments on service members and their families. For example, LTC(P) Lisa Latendresse at USUHS is working to identify the variables predictive of phantom limb pain in combat casualties with lower extremity amputations.

The U.S. Graduate Program in Anesthesia Nursing has had a very active research/scholarship program year in 2006. Most of the research involves investigation of interactions of herbal medications with anesthesia and hypothermia. Eleven research projects were presented at the American Association of Nurse Anesthetists (AANA) convention; five posters were presented at American Surgeons of the United States (AMSUS); five research studies were presented at Phyllis J. Verhonick Conference; and three at State conventions. One student group received the AANA Program Director's Outstanding Student Research Award. Lt. Thomas Ceremuga received the Army Nurse of the Year Award, and Dr. Norma Garrett received the AANA Researcher of the Year Award. The faculty and students have over \$1,000,000 in external funding from TriService Research Nursing Program, AANA, and Air Force Medical Evaluation Support. Six student projects have been approved for funding in 2007. Thirteen research articles and three chapters written by students and faculty were accepted in 2006 and are in press.

We acknowledge and appreciate the faculty and staff of the USUHS Graduate School of Nursing for all they do to prepare advanced practice nurses to serve America's Army. They train advanced practice nurses in a multidisciplinary military-unique curriculum that is especially relevant given the current operational environment. Our students are actively engaged in research and the dissemination of nursing knowledge through the publication of journal articles, scientific posters, and national presentations. In the past year alone there have been over 21 research articles, publications, abstracts, manuscripts, and national presentations by faculty and students at USUHS.

COLLABORATION/INNOVATIVE DELIVERY

The AMEDD team collaborating with government and non-government organizations around the world has helped streamline care where it was otherwise fragmented and introduced innovations in the delivery of care. I would like to share with you some examples of these innovations and collaborative partnerships.

The 21st CSH nurses have seamlessly supported the transition of medical care to over 4,000 detainees from Abu Ghraib to Camp Cropper and have continued to improve the medical care of that population. Efforts like those of 1st Lt. Michelle Racicot demonstrate how Army nurses continue to improve health care on the ground in Iraq. She designed a data base for over 10,000 tuberculosis patients to track when laboratory testing and medication refills were required. Her efforts improved the quality of care and follow-up while reducing the spread of this infectious

disease in the detainee population. Similarly, Cpt. Nicole Candy and 1st. Lt. Sharon Owen developed an outpatient wound care clinic that manages up to 45 patients a day with complex wound care needs. The program has drastically reduced wound infection rates and freed up inpatient beds.

While the AMEDD team continues to provide quality health care, its members work to advance health care delivery systems in the countries around the world. Between April 2006 and January 2007, the 14th CSH initiated a formal program in Bagram, Afghanistan to train nearly 50 Afghan military and civilian nurses. In Salerno, Afghanistan, Lt. Bruce Schoneboom, Maj. Elizabeth Vinson, and Maj. Tanya Sanders worked with the Khowst Provincial Teaching Program. These Army nurses spearheaded an initiative to teach local Afghan doctors and nurses state of the art techniques in providing perioperative surgical and nursing care. They were instrumental in teaching over 15 Afghan providers and were involved in the care of over 600 local nationals. They trained providers in conscious sedation, burn and wound care, airway management, postoperative management, and sterile technique. At the end their rotation, the 14th CSH opened the Khowst Afghan-American Comprehensive Surgical Clinic designed to serve the local Afghan community.

Army nurses around the world continue to work collaboratively through practice and educational partnerships. In Korea, the 121st CSH shares a collegial and enriching partnership by providing continuing nursing education. Nurse practitioners at the 121st CSH support Korean Advanced Practice Nursing (APN) student from Yonsei University by providing observational experiences to students as part of their clinical practicum. This opportunity allows Korean nurses to see APNs functioning within that role. In return, the partnership with Yonsei University provides Army nurses with continuing education activities and supports professional practice partnerships.

Last year I mentioned the Vietnam Military Subject Matter Expert Exchange that was started in December 2005. We continue working with that country to help establish structures and processes to enhance military nursing in Vietnam. To date this has included trips by Army nurses and subject matter experts to Hanoi as part of a health care systems assessment, as well as a visit by a Vietnamese Delegation to Tripler Army Medical Center, the University of Hawaii, the AMEDD Center and School, and Brooke Army Medical Center. I am firmly committed to partnerships that advance health care delivery and professional nursing practice in emerging nations.

Army nurses continue making contributions toward building sustainable medical infrastructure throughout the world. Earlier this year, Lt. Charlotte Scott was dispatched to Kuwait as part of an informatics team to advise the Kuwaiti military and civilian health care systems on medical information technology capabilities. Also this year the Kingdom of Saudi Arabia requested a group of medical and nursing advisors from the AMEDD to enhance capabilities of military medical treatment facilities within the Kingdom. The team included a nurse executive, Col. Diana Ruzicka, a perioperative nurse, Lt. Lawrence Crozier, and a medical surgical nurse, Lt. Gerdell Phyll, to make a comprehensive assessment of the system and make recommendations for sustainable improvements.

Despite a sustained upswing in enrollments in baccalaureate nursing programs, the need for nurses continues to outpace the number of new graduates. Baccalaureate programs continue to turn away tens of thousands of qualified applicants each year, many due to faculty shortages. We remain committed to partnering with the civilian sector to address this and other issues contributing to the worldwide shortage of professional nurses. We are currently researching ways to encourage our retired officers to consider faculty positions as viable second career choices.

RECRUITING AND RETENTION

The future of the Army Nurse Corps depends on our ability to attract and retain the right mix of talented professionals to care for our soldiers and their families. In addition to the shortage of nurses and nurse educators, competitive market conditions and current operational demands continue to be a challenge as we work to ensure we have the proper manning to accomplish our mission. With a current deficit of 254 officers, primarily in the company grades and in critical specialties, such as anesthesia, critical care, perioperative, and OB/GYN nursing, we are continuously monitoring the status of our recruiting and retention efforts.

We access officers for the Active Component through a variety of programs, including the Reserve Officers' Training Corps (ROTC), the Army Medical Department Enlisted (AMEDD) Commissioning Program, the Army Nurse Candidate Program, and direct accession recruiting, with ROTC optimally being our primary accession source. We reported to you last year that since 1999, we have accessed an average

of 16 percent fewer officers than required. That proved to be true last fiscal year as well, despite rate increases to the Nurse Accession Bonus, increased funding for the AMEDD Enlisted Commissioning Program, and a substantial commitment of personnel resources to the recruiting effort. However, there are positive trends on the horizon. For the first time in several years, the majority of our new lieutenants came from ROTC and so far this year, we are seeing a 62 percent increase in accessions as compared to this same time last year. These are trends we hope will continue. We thank the U.S. Army Cadet Command and the U.S. Army Recruiting Command for their focused efforts at providing nurses for the Army Nurse Corps.

Retention also remains under close scrutiny and we are constantly working to refine our retention strategy. A recent review of personnel records by the Department of the Army indicated that the Army Nurse Corps had the highest attrition rate of any officer branch in the Army. Ongoing research indicates that Army nurses leave the service primarily because of less than optimal relationships with supervisors, length of deployment, and the absence of specialty pay. Those who stay do so because of our outstanding educational opportunities and retirement benefits, as well as the satisfaction that comes with working with soldiers and their families.

I remain very concerned about our certified registered nurse anesthetists (CRNAs). Our inventory is currently at 66 percent—down from 70.8 percent at the end of the last fiscal year. While the U.S. Army's Graduate Program in Anesthesia Nursing, our primary training program, is rated as the second best in the Nation, we have not been filling all of our available training seats for several years now. Additionally, many of these outstanding officers are opting for retirement at the 20 year point. The restructuring of the incentive special pay program for CRNAs in 2005, as well as the 180-day deployment rotation policy have helped stem the tide in the mid-career ranks and this coming June, we will start one of the largest classes in the history of the program. However, there is still much work to be done to ensure there are sufficient CRNAs to meet mission requirements in the future. We continue to work closely with the Surgeon General's staff to closely evaluate and adjust rates and policies where needed to retain our CRNAs.

For Reserve Component nurses, the issue is primarily the imbalance of professionally educated officers in the company grades—so many of them are prepared at the associate degree or diploma level that over the past few years, only 50 percent are educationally qualified for promotion to major. This creates a concern for the future force structure of the senior ranks of the Reserve Component in the years to come. For this reason, we are grateful that the Chief, Army Reserve is focusing recruitment incentives on those nurses educated at the baccalaureate level and funding the Specialized Training and Assistance Program for BSN completion (BSN-STRAP) for both new accessions and existing Army Reserve nurses without a BSN. These strategies will assist in providing well-educated professional nurses for the Army Reserve in the years ahead.

As we continue to face a significant registered nurse shortage, it is essential that I address the civilian nursing workforce. We also face significant challenges in recruiting and retaining civilian nurses, particularly in critical care, perioperative, and OB/GYN specialties. This results in an increased reliance on expensive and resource exhausting contract support. We must stabilize our civilian workforce and reduce the reliance on contract nursing that impinges our ability to provide consistent quality care and develop our junior Army nurses. To address this issue, last year the AMEDD approved recruitment and retention initiatives at Walter Reed Army Medical Center and Charles R. Darnell Army Medical Center, Fort Hood, Texas. These two pilot projects provided financial support for advertising, salary increases, and recruitment financial incentives. At Fort Hood, Texas the initiative was very successful in recruiting, training, and retaining obstetrical nurses that were very much in demand.

The AMEDD also recently approved the limited application of a student loan repayment program for current and new civilian nurse recruits with an outstanding response. Over 70 civilian nurses opted into the loan repayment program with an associated 3 year service obligation. The program has been so successful that the AMEDD will continue the education loan repayment program, and seek a program to support civilian nurses seeking advanced degrees. We must continue such initiatives in the future if we are to maintain a quality nursing work force.

We are also challenged in recruiting and retaining civilian nurses as a result of personnel regulations that date as far back as 1977. These regulations constrain our ability to hire in a competitive nursing employment market. We must have the same flexibilities as the Department of Veterans Affairs to recruit nurses, especially new graduates. Recently, I have assembled a strategic work group of civilian nurses and senior Army nurse leaders to look at these issues and help us solve some of the long term problems impacting recruitment and retention of our civilian work force.

One promise of the National Security Personnel System (NSPS) is to attract and retain talented and motivated employees. I remain optimistic that NSPS will address the issues that make civil service a disincentive for new and practicing nurses. We have worked with the Navy and Air Force to standardize duty titles throughout the system. This will ease local marketing and facilitate the development of tiers for advanced practice nurses, similar to those for physicians and dentists. However, the delay in implementation of NSPS because of legal challenges by unions renews our concerns.

More than ever, the Army Nurse Corps is focused on providing service members and their families the absolute highest quality care they need and deserve. We continue adapting to the new realities of this long war, but remain firm on providing the leadership and scholarship required to advance the practice of professional nursing. We will maintain our focus on sustaining readiness, clinical competency, and sound educational preparation with the same commitment to serve those service members who defend our Nation that we have demonstrated for the past 106 years. I appreciate this opportunity to highlight our accomplishments and discuss the issues we face. Thank you for your support of the Army Nurse Corps.

Senator INOUE. May I call on Senator Stevens?

Senator STEVENS. I have to apologize. I have to leave, but I will make one request. I would like to have the three of you submit to us suggestions for changes in the law to give additional incentives to people to join and stay with the nursing corps of our armed services. I think they have been under extreme strain, and we ought to understand that, and we ought to offer great incentives to people to join and stay.

Thank you.

General POLLOCK. Thank you, sir. We will work that for you and get that to you quickly.

Senator INOUE. I concur with the Senator, because we are competing with the general public, and if we don't do and provide incentives, we're not going to meet the demands.

You are at 92 percent now?

General RANK. Yes.

Senator INOUE. And the Navy?

Admiral BRUZEK-KOHLER. Ninety percent, sir.

Senator INOUE. Ninety percent? And the Army?

General POLLOCK. Sir, it really depends on the specialties that we address. Across the corporate nurse corps, I would estimate 90 to 92. In some of our specialties we are at 59 percent.

[The information follows:]

Suggestions for changes in the law to give additional incentives to people to join and stay in the Nurse Corps of our Armed Services:

Support Office of Personnel Management Act Relief for Nurse Corps and Biomedical Sciences Corps. Disparate promotion opportunity and timing is currently the greatest challenge in retaining Nurse Corps officers. In a recent survey, lack of promotion opportunity was the most common influence mentioned by the 381 responders in their decision to separate from the military. Promotion opportunity for Nurse Corps officers is and has consistently been 10-15 percent lower than other Air Force officers. Promotion timing for Nurse Corps officers lags consistently two to three years behind all other Air Force officers.

Continue to support: Nurse Accession Bonus; Critical Skills Retention Bonuses and Incentive Special Pays; Uniformed Services University of the Health Sciences & Graduate School of Nursing; Board Certification Pay; Scholarship Programs; Health Professions Loan Repayment Program; and Tri-Service Nursing Research Program.

Clarify legislative language (Title 10, United States Code Section 2107) to allow candidates over the age of 31 years to be eligible for financial assistance. Recently nine candidates over the age of 31 years were disapproved for the Airman Enlisted Commissioning Program based on interpretation of Title 10, United States Code, Section 2107.

Senator INOUE. Senator Mikulski.
 Senator MIKULSKI. Thank you, Mr. Chairman.

NURSES AND THE CONTINUUM OF CARE

I'm so glad to see you once again, and I thank you for working with my staff to crack this issue of retention and recruitment, because it's the linchpin of delivering care. But in the warmest and most grateful way, I would just like I think just talk about the role that nurses have been playing from, as you say in your testimony, from battlefield to home, and the very intense ops tempo, the nature of the injuries, et cetera.

I'll come back, because I know we're all well aware that without recruitment and retention this isn't going to work, but as you know, we're focusing so much now on outpatient care. General Pollock, I'd like to start with the testimony on page 8 in which you raise some very important issues, and then have our other leadership respond.

You talk about the AMEDD team caring for the wounded warriors, and the medical evacuation continuum, et cetera. You also talk about this continuum of care and nurses as case managers. Could you share with us, what is the role of nursing both in outpatient care, or is there any in rehabilitation, for the three services?

And then I'm going to get to my point two. One of the issues that came up in the Walter Reed series and we're hearing everywhere is the so-called case manager. Now, you all are nurses. I'm a professionally trained social worker. The question is, do we have enough? Who are these so-called case managers?

Because here when I see nurse case managers, I breathe a sigh of relief, because you know the medicine but you look at the whole person, including these 19-year-old spouses or maybe the 50-year-old mother. So could you, one, just talk with us about the role in the continuum of care, in addition to the acute care continuum that has been both brilliant and stunning and all—we can't say enough good things.

General Pollock, can we start with you? And then what would it take for you to be able to continue to do this?

General POLLOCK. Yes. There's a couple of pieces that I would like to answer for you—

Senator MIKULSKI. I know there's not—

General POLLOCK [continuing]. So I'll focus on your question of case management.

Senator MIKULSKI. You see where I'm trying to get to?

General POLLOCK. Yes, yes.

Senator MIKULSKI. Which is what is the role of the nurses, but we really need to have good case managers if we're going to oversee the continuum of care back home.

General POLLOCK. Ma'am, I think this is a second- and third-order effect of the transition from inpatient care that Senator Inouye spoke of, that we provided during Vietnam, that no longer exists. Now, 90 percent of the healthcare that we provide is done in the ambulatory setting.

And in the past, when it was done as an inpatient, the nurse was the coordinator, the communicator, the teacher, the educator—the

coercer, as Senator Inouye has talked, the story about how he learned to light a cigarette again, and start to understand that he could care for himself. We do all of those things, but when we made the national transition to ambulatory care, no one thought of the importance of having nurses actively engaged to ensure that continuity of care.

And, as a result, in the Army we were significantly downsized. "Well, if you're not going to do inpatient care, then we don't need you." That has been a major challenge for us, because although we know we need to do care management, case management in the outpatient arena, our first priority was to use the nurses to ensure that people survived that very traumatic event so that they would eventually need outpatient care.

Unfortunately, particularly at Walter Reed, I don't have enough case managers. Now, the case managers that they have been using, there were three social workers and the rest were retired enlisted soldiers who they believed understood how to care for a soldier, which they did, but they didn't understand healthcare and the need to bring all those pieces together to assure that the patients would have the highest quality outcome.

Senator MIKULSKI. Well, with the indulgence of the Chair, when they use the term "social worker," you know, that can range from just a term to those of us who have MSWs. And I'm not saying an MSW should do this, but I come with a body of knowledge, a particularly trained skill set, and a code of ethics. That's the triad which we stood on, regardless of how we practice, including here.

But my question was, are these bachelor of arts people? Are these trained social workers, because they would at least know how to work—

General POLLOCK. The social workers, ma'am, I was up at Walter Reed last week meeting with the case managers, meeting with the staff, to help them to endure the negativity of the press, because it's been very, very difficult for the staff. They're working very, very hard, and to see on the front page of the paper every day and to hear on the news every night that the Nation is now thinking that what they do has no value, that they're not doing a good job, this has been devastating for the personnel of the Army Medical Department. So I wanted to spend time with them and reassure them—

Senator MIKULSKI. And we want to reassure them, too, that the fault is not at the mid-level hands-on, it's where was the leadership?

General POLLOCK. So that's why I know, ma'am, that three of those, that group that had been in the case management bucket, three were social workers who were MSM-prepared and were certified, and the rest of them were retirees that they thought would be adequate to manage the issues, not realizing how complex it was.

CASE MANAGEMENT

Senator MIKULSKI. Do you believe that as we look ahead to the new world order, both for Army, the marines, the caregivers, there will be Air Force involved, that we should reclaim the heritage of nurses as case managers—

General POLLOCK. Absolutely.

Senator MIKULSKI [continuing]. Particularly the move from acute care to maybe outpatient, et cetera, and then also ensuing, and that this is a need?

General POLLOCK. Oh, absolutely, it's a need, and it's one that nurses are particularly skilled for. What I would really like to see is for the Nation to understand that once someone has a diagnosis of any chronic condition, they then receive a nurse case manager to ensure that all of the pieces that need to come together so they can live at their highest quality of functioning is addressed.

Senator MIKULSKI. Admiral?

Admiral BRUZKE-KOHLER. Thank you, Senator Mikulski.

In the Navy we have 106, approximately 106 active duty and civil servant nurses who are presently engaged in case management. Case management is a catch-all, in my opinion—

Senator MIKULSKI. Yes.

Admiral BRUZKE-KOHLER [continuing]. Of following the care of a category or categories of patients. In my opinion, when we moved care into the outpatient arena, there was a period of time when nurses were trying to determine exactly what their role was in the ambulatory care setting. Many thought they were clinic managers, many thought they were receptionists, some thought they were appointment clerks, but in reality they were case managers.

Senator MIKULSKI. In reality they were nurses.

Admiral BRUZKE-KOHLER. And they were nurses.

Senator MIKULSKI. Nurse is an identity.

Admiral BRUZKE-KOHLER. Yes.

Senator MIKULSKI. I mean, it is an identity.

Admiral BRUZKE-KOHLER. And their role in an ambulatory setting as a case manager is different than the role of case manager that you refer to, in today's world, in a wartime scenario. So while case management is fielded by nurses, by active duty and civil servant nurses, it's more of a multidisciplinary team.

As I mentioned in my oral testimony, San Diego has created a multidisciplinary team because it's not just about nursing care. Clearly it's about the rehabilitative care, the mental healthcare, and the continuum of assets that we have to pull together to make certain that the care of the patient is holistic and appropriate. Nurses are leading these teams in many cases. And if they are not the team leader, they are still filling a significant role as a member on the team.

Do we have enough? I don't think you ever have enough nursing care, and I don't think we ever have enough nurses. Clearly, as we have shown, we are not achieving our end strength goals. But case management is, in my opinion, one of the most important services a professional nurse offers our wounded servicemembers as they return home from war.

Senator MIKULSKI. Well, I think I'm going to share with the subcommittee leadership, we want again the ideas for recruitment and retention, because whatever job the nurse does, you need the nurse. The length of deployment issue, if we could—I know Senator Stevens has talked about financial incentives, but the length of deployment and who makes those decisions and what would be your recommendations.

And the other, what I thought was so interesting was that for those that are already nurses, you noted were either the so-called hospital trained and then the associate of arts, but your point was, if they could get—and correct me if I’m wrong, General Pollock and others—that if they could have the ability while they are within military nursing to then move to the next level of education, that this in and of itself would be both recruitment but you would also be not recruiting a per capita slot.

You’re recruiting someone who is trained, absorbs the culture, which is different than working for a doc-in-a-box. I mean, it’s what we said about why people want to be in military medicine. So is this where you see an opportunity for both your next level leadership as well as keeping good people, that they could go from an associate of arts degree to a bachelor’s degree, or a bachelor’s degree to get specialized training? Did I understand the testimony right, or am I off base?

General POLLOCK. Yes, some of it, and some of it is—

Senator MIKULSKI. Yes, I am off base, and yes, I’m right? That’s okay.

General POLLOCK. For our Reserve component, we are working very hard to provide more opportunities for them to make their transition, because they are the only officers among the three militaries who are allowed to access without a baccalaureate degree. So it’s very important, because that education is required for officers in our military, it’s very important that they complete that education. So the funding for them to complete that education as part of their military experience would be fabulous, because then the big reason that people use for not completing their education is, they can’t afford to stop working and caring for their families.

The piece that you raised, though, ma’am, about case management for us, and we talked for a moment about the transition that we made to ambulatory care in the Nation, with this being a long war, with the threats that these terrorists pose to our homeland, this is not going to be just an issue for military nursing or military healthcare. We are going to need a plan for the assisted living, for the rehabilitation of our citizens, should they start to become injured.

Senator MIKULSKI. But right now we could start with our military. They are an identifiable population for which we have a moral and a legal obligation, and if we got that right, then the civilian, I think this is where we could lead civilian planning in medicine.

General POLLOCK. Thank you, and I would like to submit for the record the responses to your concerns about the length of deployment and the nurses’ concerns about that deployment.

Senator MIKULSKI. Right. Well, Mr. Chairman, I know we could continue this very excellent and instructive conversation. But I think what we want to know is, how do we keep what we’ve got and recruit the new that are as talented and dedicated as your leadership. And the other is really the role now of nursing in the continuum, to be sure that the continuum works for both the patient but for the system.

And I think you are the leadership team. I mean, nursing, by the very nature that it can coordinate the medical and the psychosocial

needs and understand that, I think is there. So as a social worker, I'm happy to be part of your multidisciplinary team. Thank you.

General POLLOCK. Thank you.

ADDITIONAL COMMITTEE QUESTIONS

Senator INOUE. Several of the members would like to submit questions, and I hope that you will respond accordingly. General Rank, Admiral Kohler, and General Pollock, in behalf of the subcommittee, I thank you very much for your participation in our hearings. I can assure you that your words will be taken very seriously.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO VICE ADMIRAL DONALD C. ARTHUR

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

NURSE CORPS: SHORTAGE IMPACTS

Question. The U.S. Bureau of Labor Statistics (BLS) has projected that by 2014, our nation will need an additional 1.2 million new and replacement nurses. In 2004, 72 percent of hospitals were experiencing a nursing shortage. The ongoing conflicts in Iraq and Afghanistan have increased the need for qualified nurses in military medical facilities. Unfortunately, the military faces the same difficulty in recruitment and retention of nurses. In addition, the average age of retirement of nurse faculty is 62.5 years and it is expected that 200 to 300 doctorally prepared faculty will be eligible for retirement each year from 2005 through 2012 just as more than 1 million replacement nurses will be needed.

Can you please elaborate on the impact that the nursing shortage has had on the Armed services? Do you feel that you are sufficiently staffed and have the adequate resources to engage in aggressive recruiting efforts?

Answer. We recognize that our recruiters have often struggled in competing with civilian institutions and other government agencies for the same group of nurses. Yet for the first time in four years, the Navy Nurse Corps is projected to meet its direct accession goal. This can be attributed to the tireless efforts of Navy Nurse Corps recruiters, recent increases in our Nurse Accession Bonus and the Health Professions Loan Repayment Program.

Additionally, our pipeline programs continue to be quite successful and serve as the primary recruitment source for future Nurse Corps officers. The Nurse Candidate Program, Medical Enlisted Commissioning Program, Naval Reserve Officer Training Corps Program and Seaman to Admiral Program ensure a steady supply of trained and qualified Navy Nurses who are critical to maintaining desired manning levels.

Attentive monitoring of the national nursing market, coupled with periodic evaluation and modification of the aforementioned programs help maintain our competitiveness and viability amidst civilian recruiting initiatives for America's nursing workforce.

NURSE CORPS: SHORTAGE CHALLENGES

Question. What do you think are the major challenges compounding the nursing shortage in the Armed Services?

Answer. The continuation of our ongoing engagement in Iraq has not become a deterrent to recruiting prospective nurses to join our ranks. Instead we have found that the decision to leave active service is more related to concerns regarding the length of deployments in which our nurses support our war fighters and humanitarian missions. A six month geographic separation from family and friends is typically deemed acceptable. Concerns arise when the potential for lengthening deployments is discussed to extend beyond six months.

Other factors which contribute to the nursing shortage in the Armed Services include recruitment challenges posed by: regional areas that have few schools of nursing; and highly competitive civilian markets for the same available nursing pool.

NURSE CORPS: RECRUITING

Question. Can you please speak to the issue of faculty shortage and its implications on the ability for the Armed Services to recruit additional nurses?

Answer. Navy Nurses welcome the opportunity to assist our colleagues in academia. We have served as clinical nurse preceptors, educators and adjunct professors in support of schools of nursing throughout the country. This interface with America's colleges and universities provides a unique perspective of Navy Nursing and avails possible recruitment opportunities for our corps.

The Troops-to-Nurse Teachers program offers some salient proposals to amend the shortage of nursing faculty. We must be assured that this amendment will not become an incentive for Nurse Corps officers to leave the active component of military service. We would also recommend that the Troops-to-Nurse Teachers program be modeled after the DANTES Troop-to-Teachers program under the purview of the U.S. Department of Education.

TRAUMATIC BRAIN INJURY

Question. It is estimated that as many as 2 of every 10 combat veterans from Iraq/Afghanistan are returning with concussions of varying degrees of severity. With 1.4 million vets already having served, that would mean up to 280,000 people (and that number grows with every new soldier, sailor, marine, and airman deployed) requiring some sort of screening/treatment.

Do we currently have the capacity to screen, diagnose and treat all of these service members in the Defense and Veterans health care systems today and in the future?

Answer. Identifying, evaluating and treating service members and veterans suffering from brain injuries is of highest priority for Navy Medicine. The current criteria for sustaining brain injury was derived from sports medicine models and works well for athletes on the playing field; however, over-pressurization such as that caused by an IED correlates irregularly with signs and symptoms of classic ball-field sustained closed head injuries such as concussion. Over-pressurization may produce occult and sometimes subtle damage and service members often wrongfully believe that if they are able to "walk away from it" they are well.

The extraordinarily high rate of occurrence the press is reporting ("upwards of 20 percent of combat veterans") cannot be definitively ascertained without conducting sophisticated neuropsychological testing. The most prudent approach employs a conservative, low threshold of suspicion for administering neuropsychological screening tools. This is precisely the approach in use by the National Naval Medical Center (NNMC), Bethesda Brain Injury Center.

Screening/Identification

Navy medical personnel maintain heightened awareness to possible TBI-related symptoms in service members, using increased indices of suspicion when performing medical assessments. There is not one specific tool used to evaluate service members for TBI. Each of the Services and the Veterans Administration (VA) have developed tools.

On the battlefield, Navy medical personnel use the Military Acute Concussion Evaluation (MACE), a screening tool identifying symptoms in service members involved in blast events. Mental health personnel assigned to USMC I Marine Expeditionary Force utilized the Combat Trauma Registry (CTR) to document and identify TBI-related symptoms in Marines seeking in-theater mental health care. At NNMC, all inpatients with the diagnosis of trauma from any deployment are evaluated for blast injuries using the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

DOD and Navy Medicine use the Post Deployment Health Assessment (PDHA) immediately following deployment, Post Deployment Health Re-Assessment (PDHRA) at 90 to 180 days post-deployment and the Periodic Health Assessment (PHA); a health evaluation tool completed once a year on all active and reserve Navy and Marine Corps service members screening questions for TBI will be added to these assessments.

Treatment

We do not know if we have sufficient capacity to fully evaluate, diagnose and treat an unknown but increasing number of service members returning who may have varying degrees of concussion. It is anticipated that the need for services to OIF/OEF patients will continue to increase significantly due to troop surges. As a result, the increased screening for TBI in the field and at Landstuhl Regional Medical Center and the necessary follow up care for TBI patients will require new resources.

In addition to the screening tools mentioned in the previous section, the Navy continues its collaboration with the VA to share resources in joint ventures to improve the immediate and long term care of our wounded warriors. A training program for providers in screening and identifying concussion injuries is currently being developed. Education of family members in identifying behavioral changes of returning spouses from OIF/OEF and the seeking of medical attention has been in place at the Navy Family Service Centers for the last two years. Additionally, command family briefs and command ombudsmen assist in the education of family members.

Over the past two years NNMC has developed special expertise in blast injuries and has created the Traumatic Stress and Brain Injury Program to identify, assess, and treat patients with traumatic brain injuries.

As the Global War on Terror continues we anticipate a prevalence of TBI that relates to the number of personnel directly exposed to blast. At NNMC, neuropsychological services are heavily involved in the evaluation and treatment of OIF/OEF patients with TBI. They routinely screen all returning OIF/OEF casualties arriving for any medical reason. Due to this need, psychological and neuropsychological testing and cognitive rehabilitation services have been severely limited/eliminated to other beneficiaries. They have identified additional personnel requirements to continue to evaluate and treat the majority of casualties returning with TBI, including psychiatrists, psychologists, recreational therapists, case managers with expertise in brain injury, social worker/substance abuse counselors and marriage and family therapist at a cost of over \$3,000,000 annually.

We continue to learn a great deal as we care for OIF/OEF casualties. This new expertise will serve as a foundation for future requirements. With appropriate resources, NNMC's programs being developed at other Naval Medical Treatment Facilities and the VA's hospitals will expand capacity to serve the emerging number of patients and offer a broader range of services.

QUESTIONS SUBMITTED BY SENATOR PETE V. DOMENICI

TRAUMATIC BRAIN INJURY (TBI)

Question. I am very worried about the number of our men and women who are suffering traumatic head and brain injuries on the battlefield. I am also very worried about those servicemembers who may not suffer actual physical brain or functional impairment but who nonetheless are suffering because of the stress and psychological effects of the war.

Traumatic brain injury (TBI) and post traumatic stress disorder (PTSD) are often times very difficult to identify and diagnose. These injuries may manifest themselves months after troops have returned home from battle or have recovered from other injuries. They can also be amongst the most difficult injuries to treat, frequently requiring months or years of rehabilitation and therapy.

Some doctors are calling TBI the "signature injury" of the Iraq campaign. Body armor is helping many soldiers survive bomb and rocket attacks, but they are suffering brain injury and brain damage as a result of the blasts. What is being done to screen, identify, and treat servicemembers who may be suffering from TBI?

Answer. Navy medical personnel maintain heightened awareness to possible TBI-related symptoms in servicemembers using increased indices of suspicion when performing medical assessments. Unit medical personnel use the Military Acute Concussion Evaluation (MACE) developed by the Defense Veterans Brain Injury Center (DVBIC). MACE is a battlefield screening tool used to identify symptoms in servicemembers involved in blast events. Additionally, mental health personnel assigned to USMC I MEF use the Combat Trauma Registry (CTR) to document presenting symptoms. This registry includes neuropsychological screening questions to identify TBI-related symptoms in Marines seeking in-theater mental health care.

Post-deployment screening occurs immediately following deployment using the Post Deployment Health Assessment (PDHA), and again at 90 to 180 days using the Post Deployment Health Re-Assessment (PDHRA). The PDHRA includes a question regarding exposure to blast incident or motor vehicle accident. DOD (Health Affairs) plans additional TBI-related screening questions to the PDHA, the PDHRA, and the Periodic Health Assessment (PHA).

All casualties evacuated to the National Naval Medical Center (NNMC), Bethesda receive neuropsychological screening with appropriate treatment and follow-up for later-onset symptoms. Abnormal TBI screens receive 3-month follow-up, and referral to appropriate level of treatment as needed. A dedicated NNMC database tracks all casualty treatment/follow-up. The Physical Evaluation Board (PEB) process and VA OIF/OEF Coordinators also track patients to ensure continuity of care.

POST TRAUMATIC STRESS DISORDER (PTSD) IDENTIFICATION AND TREATMENT

Question. This war is going to create a high number of patients who need mental health care because of the stress of battle and the traumatizing, often life-threatening events they are witnessing. What is being done to help identify those servicemembers who may suffer from PTSD or otherwise need assistance dealing with their combat-related experiences? Once identified, what help is being provided to these servicemembers?

Answer. Prevention is at the forefront of the continuum that includes early identification and intervention of PTSD. Closely aligned with warfighters while in garrison, providers teach Marines and their leaders on signs of combat stress and how to prevent it. Navy Medicine has also established a Deployment Health Directorate and identified a Combat/Operational Stress Control Consultant to coordinate prevention and treatment efforts.

Sailors and Marines receive Post Deployment Health Assessment (PDHA) immediately following deployment and Post Deployment Health Re-Assessment 90–180 days later. Additionally, Navy Medicine has established 13 Deployment Health Centers (DHCs)—non-stigmatizing portals for identification and care. Through February 2007, DHCs conducted more than 4,000 encounters (in excess of 3,700 primary care and 420 mental health visits).

When intervention is necessary the PIES (Proximity, Immediacy, Expectancy, Simplicity) principle is used as treatment by embedded mental health personnel in deployed units (USMC OSCAR teams and Carrier Group Clinical Psychologists). The Navy uses best practice guidelines for mental health treatment such as the VA/DOD jointly developed clinical practice guidelines. Moreover, the Navy has partnered with other services to establish a Center for Deployment Psychology, providing education and training on treatment of PTSD and other combat stress disorders. Extensive in-theater research efforts are also underway to identify mental health needs, guide development of appropriate prevention and treatment programs, and ensure adequate in-theater mental health support.

TRANSITION OF CASES OF SERVICEMEMBERS SUFFERING FROM PTSD/TBI TO VA FACILITIES AND CIVILIAN LIFE

Question. What is being done to help servicemembers suffering from PTSD and TBI as they transfer from Service-run programs to Veteran Affairs facilities and civilian life?

Answer. Patient information for the hospitalized service member is coordinated with the assistance of the case manager or discharge planner when they transfer from a service-run program to VA or to civilian life. Providers may change as the patient transitions through the continuum of care; it is expected that transfer of the case history will be seamless.

The National Naval Medical Center (NNMC) has a system to review each individual trauma patient during a meeting called Trauma Rounds. This is a bi-weekly multi-disciplinary team care meeting in which inpatient care is revisited, patient progress is reviewed, and the plan for discharge is implemented. Case management is an integral component of the inpatient Trauma Rounds.

Each patient at NNMC is assessed prior to discharge for indicators of TBI or PTSD. When patients are discharged, case managers are sensitive to TBI and PTSD issues and monitor patients through the continuum of care, referring to appropriate resources when needed.

Navy Medicine and the VA carefully coordinate the transfer of cases from one to the other. Key components of this coordination effort include regular case-specific management VTCs between facilities, ongoing medical tracking/case management, deployment of Veteran Health Administration (VHA) Liaison staff at major Military Treatment Facilities (MTFs) (NNMC Bethesda, NH Camp Pendleton, NMC San Diego), detailing of active duty providers to select polytrauma VHA facilities, and administrative coordination between a Navy MTF and the treating VA facility.

In addition, there are multiple administrative programs to assist the patient and family as the individual transitions from Department of the Navy system Service to the Veterans Administration or civilian life. These include: Marines for Life-Injured Support Program, Military Severely Injured Joint Operations Center, SIMS Pilot Program, Military One Source, Fleet Liaisons, Marine Corps Extension Program, Military Severely Injured Support, Navy Safe Harbor, Fleet and Family Services, Chaplain Corps, Navy and Marine Corps Relief Society, Wounded Warrior programs, and Navy Safe Harbor.

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL JAMES G. ROUDEBUSH

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

MEDICAL READINESS

Question. The U.S. Bureau of Labor Statistics (BLS) has projected that by 2014, our nation will need an additional 1.2 million new and replacement nurses. In 2004, 72 percent of hospitals were experiencing a nursing shortage. The ongoing conflicts in Iraq and Afghanistan have increased the need for qualified nurses in military medical facilities. Unfortunately, the military faces the same difficulty in recruitment and retention of nurses. In addition, the average age of retirement of nurse faculty is 62.5 years and it is expected that 200 to 300 doctorally prepared faculty will be eligible for retirement each year from 2005 through 2012 just as more than 1 million replacement nurses will be needed.

Can you please elaborate on the impact that the nursing shortage has had on the Armed Services? Do you feel you are sufficiently staffed and have the adequate resources to engage in aggressive recruitment efforts?

Answer. Currently the national nursing shortage is not impacting the Air Force Nurse Corps' ability to meet deployment requirements to include supplementing Army taskings. The shortage is impacting the home station business plans due to military registered nurse recruiting and retention shortfalls. Significant increases in contract dollars are being used to backfill vacant military positions or to shift workload to the TRICARE Managed Care Support Contract network. Additionally, early evidence indicates limited success in efforts to fill military-to-civilian conversions (privatization) of registered nurse positions; however, the number of conversions in fiscal years 2006 and 2007 are limited. The larger numbers in fiscal years 2008 to 2013 will be extremely challenging to fill. We will evaluate hiring and retention success in every execution year.

Based on recent successes in recruiting for fiscal year 2006 (92 percent of goal), we feel confident that our monetary incentive package has proven successful in achieving adequate manpower. However, field-level nurse recruiters have been cut for fiscal years 2007 and 2008 so it is unclear what impact this will have on recruiting effectiveness. Additionally, we are aggressively working to diversify accessions sources by expanding the enlisted Bachelors of Science in Nursing program from 7-10 per year up to 50 per year.

Question. What do you think are the major challenges compounding the nursing shortage in the Armed Services?

Answer. Three major challenges stand out as compounding the nursing shortage with the Air Force Medical Services: (1) Recruiting (active and civilian workforce), (2) retention, and (3) deployment operational tempo for a few specialties. These challenges are all compounding the nursing shortage in the Air Force Nurse Corps.

As the market for nurses becomes more competitive it is imperative for the Air Force to keep up with financial incentives to recruit a qualified workforce. In fiscal year 2006, we achieved 92 percent of our accessions goal. This was a significant improvement over fiscal year 2005's 69 percent. We attribute our success to larger financial incentives, which combined the options of accepting a nurse accession bonus and Health Professions Loan Repayment for nursing school loans. We also attracted new nurses with Reserve Office Training Corps scholarships. Our fiscal year 2006 accession bonus options were \$15,000 for a 3-year commitment or \$20,000 for a 4-year commitment. In collaboration with our sister services we have increased the bonus for fiscal year 2007 (\$25,000/4 years).

Air Force salaries are relatively competitive starting in the Major rank category; however, for novice nurses the military salary falls short. Our nurse accession bonus for fiscal year 2006 proved to be successful in filling the salary gap.

	Military Annual Pay	RN National Average 2004
1 Lt	\$29,631.60	\$57,784.00
2 Lt	38,876.40	57,784.00
Capt	52,704.00	57,784.00
Maj	70,588.80	57,784.00
Lt Col	83,617.20	¹ 77,140.00
Col	100,742.40	¹ 77,140.00

¹ Mean annual salary for Medical and Health Services Managers (i.e. Director, Nursing Services, Chief Nurse, etc.) Bureau of Labor Statistics, May 2005.

Additionally, we are aggressively working to diversify accessions sources by expanding the enlisted Bachelors of Science in Nursing program. After we resolve internal Air Force issues, we look forward to increasing the students from 7–10 per year up to 50 per year.

Retention is currently the greatest challenge compounding the Air Force nursing shortage. Disparate promotion opportunity and timing are also great challenges of retention. In a recent survey, lower promotion opportunity was the most common influence mentioned by the 381 responders in their decision to separate from the military. Promotion opportunity for Nurse Corps officers has consistently been 10–15 percent lower than other Air Force officers. Promotion timing for Nurse Corps officers lags consistently two to three years behind all other Air Force Defense Officer Personnel Management Act (DOPMA)-constrained corps. This disparity has a 15–20 year history. Recently, we are experiencing improvements in opportunity and will continue to work with the Line of the Air Force to bring Nursing Corps promotion opportunity and timing in line with other officers.

As Calendar Year 2006 came to a close, the Nursing Corps inventory was a grave-ly concerning 85 percent. We retired 166 officers and another 188 separated, for a net loss of 354 experienced nurses. Loss rates are increasing at the 4–5 year point and 9–12 year point. In response, we initiated a \$15,000 critical skills retention bonus targeting nurses completing their initial commitment in the Air Force (4–5 year point), and will be closely monitoring its impact on retention for this year group. For the second attrition peak (9–12 years) disparate promotion and timing opportunity has the greatest impact. We are working aggressively to resolve this problem through the submission of a Unified Legislation and Budgeting request for DOPMA relief in an effort to improve Nursing Corps promotion opportunity and timing.

In addition to recruiting and retaining our active force we are facing the challenging initiative of converting military positions to civilian equivalents and hiring into those equivalents. Nationally, the demand for nursing personnel far exceeds the supply, creating a competitive market that favors qualified candidates. Through active recruiting, hiring bonuses where warranted, and use of direct hire authority, we hired 86 percent of the clinical nurses programmed for fiscal year 2006.

Lastly, deployments for our critically manned specialties compound the nursing shortage. Of note, since September 2001, the Total Force Nurses have comprised 53 percent of all Air Force medical Total Force deployments. Out of necessity we have had to prolong deployments for “high demand low density” specialties, (critical care). Deployments for this group are now 179 days, or 59 days longer than other deployed nurses. We have increased our training platforms to increase our numbers of nurses skilled in these specialties. Additionally, we continue to incentivize our specialty nurses with incentive specialty pay programs.

Question. Can you please speak to the issue of faculty shortage and its implications on the ability for the armed services to recruit additional nurses?

Answer. According to the latest projections from the U.S. Bureau of Labor Statistics published in the November 2005, Monthly Labor Review, more than 1.2 million new and replacement nurses will be needed by 2014. Government analysts project that more than 703,000 new registered nursing positions will be created through 2014, which will account for two-fifths of all new jobs in the health care sector.

The American Association of Colleges of Nursing (AACN) has cited the shortage of nursing school faculty as a major contributing factor in the nursing shortage. It's estimated that for 2006 approximately 42,000 qualified applicants were turned away from baccalaureate and graduate nursing programs due to insufficient number of faculty, limited clinical sites/clinical preceptors/classroom space and budget constraints.

According to an article published in the March/April 2002 issue of Nursing Outlook, the average age of nurse faculty at retirement is 62.5 years. With the average age of doctorally-prepared faculty currently 53.5 years, a wave of retirements is expected within the next ten years. In fact, the authors project that between 200 and 300 doctorally-prepared faculty will be eligible for retirement each year from 2003 through 2012, and between 220–280 master's-prepared nurse faculty will be eligible for retirement between 2012 and 2018.

According to the 2006 salary survey by The Nurse Practitioner, the average salary of a master's prepared nurse practitioner is \$72,480. By contrast, AACN recently reported that master's prepared associate professors earned an annual average salary of \$58,249.

In 2005, 49 percent of hospital Chief Executive Officers reported having more difficulty recruiting registered nurses than in 2004.

The information above was obtained from the American Association of Colleges of Nursing Fact Sheet.

The end results of the nursing faculty shortage on recruitment of nurses for the armed forces are directly related to supply and demand. The number of nursing faculty retiring will decrease the number of students graduating from schools. The law of supply and demand would indicate that as the supply shrinks, there will be greater civilian competition for new nurses.

QUESTIONS SUBMITTED BY SENATOR PETE V. DOMENICI

MEDICAL READINESS

Question. I am very worried about the number of our men and women who are suffering traumatic head and brain injuries on the battlefield. I am also very worried about those service members who may not suffer actual physical brain or functional impairment but who nonetheless are suffering because of the stress and psychological effects of the war.

Traumatic brain injury (TBI) and post traumatic stress disorder (PTSD) are often times very difficult to identify and diagnose. These injuries may manifest themselves months after troops have returned home from battle or have recovered from other injuries. They can also be amongst the most difficult to treat, frequently requiring months or years of rehabilitation and therapy.

Some doctors are calling TBI the "signature injury" of the Iraq campaign. Body armor is helping many soldiers survive bomb and rocket attacks, but they are suffering brain injury and brain damage as a result of the blasts. What is being done to screen, identify, and treat service members who may be suffering from TBI?

Answer. We recognize that, while severe Traumatic Brain Injury (TBI) is readily identified, mild TBI (mTBI) can be difficult to identify. At our level II and III theater facilities we have implemented the Joint Theater Trauma System (JTTS) Clinical Practice Guideline (CPG) for in-theater management of mild traumatic brain injury (concussion). Any Service member involved in an explosion/blast, fall, or blow to the head and/or motor vehicle incident is considered to have potentially suffered a concussion and will undergo a TBI screening questionnaire. If a patient has a positive screen they undergo further evaluation using the Military Acute Concussion Evaluation which was developed in conjunction with Defense and Veterans Brain Injury Center Program.

Treatment of TBI begins at the point of injury with level I Self-Aid/Buddy Care and continues in theater to our level III theater hospitals according to the JTTS CPG for TBI. Those unable to return to duty are returned to a Continental United States level V Military Treatment Facility by aeromedical evacuation. Patients requiring specialized rehabilitation for traumatic brain injury, spinal cord injury, blind rehabilitation and post traumatic stress disorder are typically sent to one of the four Veterans Administration Polytrauma Centers for continued care using the aeromedical evacuation system. Individual case managers work with these patients and their families in arranging this specialized care.

All returning deployed Service members are screened for mTBI using the DOD Post Deployment Health Assessment. Additionally, at three to six months after returning home the Service member undergoes a second evaluation, the Post Deployment Health Reassessment. Additional TBI screening questions are being added to these screening tools to better assess unrecognized TBI injuries.

Question. This war is going to create a high number of patients who need mental health care because of the stress of battle and the traumatizing, often life-threatening events they are witnessing. What is being done to help identify those service members who may suffer from PTSD or otherwise need assistance dealing with their combat-related experiences? Once identified, what help is being provided to these service members?

Answer. We screen all members returning from deployments administering the DOD Post Deployment Health Assessment (PDHA). Any problems identified are fully assessed and any treatment required is done. All members undergo a second evaluation, the Post Deployment Health Reassessment (PDHRA), three to six months after returning home from deployment. To date, roughly seven percent of deployed Air Force personnel are diagnosed with new mental health concerns (depression, marital problems, anxiety, difficulties sleeping, etc.); PTSD has been diagnosed in 0.3 percent of our deployed personnel.

The Air Force deploys mental health providers to offer in-theatre assistance to Service members to head off combat-related problems. At home, we have trained one hundred AF mental health providers in specialized PTSD training to allow them to effectively treat combat-related PTSD. GWOT monies have been used to hire 32 ad-

ditional mental health professionals to bolster Military Treatment Facility mental health care services available at our high operational tempo bases.

Question. What is being done to help service members suffering from PTSD and TBI as they transfer from Service-run Programs to Veteran Affairs facilities and civilian life?

Answer. The Air Force places all combat wounded and ill casualty patients into the Palace HART (Helping Airmen Recover Together) Program. Each patient is assigned a Family Liaison Officer (FLO) to assist during their recovery. Family liaison officers assist transitioning service members to coordinate follow-up appointments, facilitate record transfers, and aid service members and their families to obtain any services they may require. The program continues to assist service members and families until the member returns to duty or the fifth year anniversary of separation from service.

Patients requiring specialized rehabilitation for traumatic brain injury, spinal cord injury, blind rehabilitation and post traumatic stress disorder are usually sent to one of the four Veterans Administration (VA) Polytrauma Centers for continued care. In some cases, Active Duty members receive rehabilitation in the VA and are transitioned back to the Military Treatment Facility (MTF) system if they have recovered sufficiently.

Air Force mental health providers and other physicians understand the importance of establishing continuity of care as they transition from Service-Run Programs to Veteran Affairs facilities and civilian life. The Defense and Veterans Brain Injury Center (DVBIC) program is a model of interaction between the DOD and the VA system for those Airmen who sustain Traumatic Brain Injuries. Regular teleconferences are held between DVBIC physicians at VA Polytrauma Centers, case managers, and the referring MTFs to coordinate preparation for transition.

QUESTIONS SUBMITTED TO MAJOR GENERAL MELISSA A. RANK

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUE

AIR FORCE NURSES

Question. General Rank, the combat casualty care in the Global war on Terror demonstrates a remarkable synergy between the Army and the Air Force. The ability of the Army medical care to save more lives on the battlefield, coupled with the ability of the Air Force to transport patients to higher levels of care in the United States is a true success story.

How has the higher acuity level of patients requiring inter-theater transportation changed the structure and the training requirements of the Air Force Nurse Corps?

Answer. The Global War on Terror (GWOT) demand for operational, clinically-current specialty nurses have steadily grown. In response, we have increased production of critical care and trauma nurses and returned nurses with specialty nursing experience to the deployment pool.

Encouraged by the success of our joint training pipeline in San Antonio, Texas, we awarded 30 critical care and emergency fellowships this year and expanded our joint training platforms to include the National Naval Medical Center in Bethesda, Maryland and St. Louis University Hospital in Missouri. We have not stopped there. We are revising our support agreement with the University of Cincinnati Medical Center in Ohio to accommodate critical care nursing fellows.

We continue to rely on our Centers for Sustainment of Trauma and Readiness Skills (C-STARS). These advanced training platforms are embedded into major civilian trauma centers throughout the continental United States. In 2006, this invaluable clinical immersion enabled 614 doctors, nurses, and medical technicians to refresh operational currency while preparing them to deploy as Critical Care Air Transport Team members or clinicians in expeditionary medical support facilities.

Strengthening operational clinical currency remains a priority. Now 11 months old, our clinical sustainment policy continues to gain momentum. The concept is simple: providing opportunities for nurses temporarily assigned in out-patient or non-clinical settings to refresh their technical skills by working a minimum of 168 hours per year at the bedside. For many of our outpatient facilities, this means affiliating with local medical centers for innovative patient care partnerships.

In 2006, we gained access to eight complex medical-surgical, emergency trauma and critical care training platforms in which to sustain clinical skills for our officer and enlisted nursing personnel. An extraordinary benefit emerging at nearly all training sites has been exposure to—and appreciation for—the unique missions of various agencies. We are encouraged by reports of how affiliations with our federal

health partners have fostered collegiality between nurses. Among these affiliations, two are with civilian organizations (Miami Valley Hospital in Dayton, Ohio and Iowa HealthCare in Des Moines, Iowa). Federal tort laws make securing affiliations with civilian organizations particularly challenging, so I applaud the hard work expended at the local level. Nursing personnel from the 3rd Medical Group DOD/VA Joint Venture Hospital and the Alaska Native Medical Center have collaborated on continuing education and professional development programs for many years. Their partnership expanded recently to include rotations in pediatric, medical-surgical and critical care units—experiences long-sought to bolster currency at home station and in deployed settings.

In addition to sustainment, we have robust entry-level training platforms. The 882nd Training Group at Sheppard AFB, Texas graduated 1,638 Total Force Aerospace Medical Service Apprentice (AMSA) students in fiscal year 2006. AMSA students have the unique experience of training on technologically advanced simulations systems. Life-like mannequins simulate clinical patient scenarios, allowing students to learn and gain hands-on experience in a controlled environment. As they progress through training, students are challenged with increasingly complex scenarios.

Landstuhl Regional Medical Center, Germany (LRMC) became our 10th Nurse Transition Program (NTP) training site and the first NTP hosted in a joint facility. With the addition of the LRMC NTP, we have increased overall enrollment to 160 nurses in this AFMS entry-level officer program.

Additionally, we deliberately laid in higher grade positions into selected Unit Type Codes (UTCs) or deployment requirements driving a demand for increased rank for those deployment taskings. In the military, rank equates to experience level. This action puts more experienced nurses in our deployed locations where they teach, mentor and guide our more junior nurse corps officers.

In addition to laying in increased grade, we reevaluated our substitution designation for UTC requirements. For example, between fiscal years 2003 to 2006, of the 78 requirements for mental health nursing, 15 of these were filled by clinical nurses or clinical psychologists. In retrospect, we realize a requirement for mental health nurses is best met with mental health nurses and now we are not allowing this substitution.

Lastly, in fiscal year 2007 we deployed the first Air Force Joint Theater Trauma System Program Manager. This individual has accomplished much to include authoring clinical practice guidelines, conducting advanced research, and refining the trauma registry.

AIR FORCE NURSES

Question. General Rank, is there a potential way to utilize our retired military nurses to benefit recruiting nurses into the military?

Answer. All nurses are recruiters. We have emphasized this in the Air Force Nurse Corps for some time. We would hope that retired military nurses use every opportunity to encourage nurses to serve in the military.

Question. General Rank, would you consider filling critical shortages in deployments from other services?

Answer. Air Force Nursing Services is an operational capability. We consider all appropriate deployment scenarios. At this time, we are able to meet the demand for nurse and technician deployment taskings within the Total Nursing Force (Air National Guard, Reserve and Active Duty components). We will continue to support Army “in lieu of” taskings with personnel assigned to corresponding Air Expeditionary Force (AEF) windows. However, we make every effort to honor the AEF construct rather than pull from upcoming “buckets” to support “in lieu of” missions.

Question. General Rank, in fiscal year 2008, the Air Force is planning to convert 123 Nurse Corps positions to civilian positions. Please comment on the status of these conversions, the process used for determining them and the anticipated impact on the nurse corps for converting nurse billets.

Answer. Military essential positions were identified first, along with the critical operational readiness requirements analysis. The Nurse Corps recommended conversions in the outpatient and maternal child arenas as loss of either platform does not negatively affect the active duty nurses’ opportunity for practicing war readiness skills.

For the 2008 to 2013 conversions, a make vs. buy with market availability analysis was performed on billets available for conversion. This analysis compared the “fully burdened cost” of an Active Duty authorization in a given specialty with the “fully burdened cost” of a General Schedule civilian or contractor. Where a General Schedule civilian or contractor was less expensive than Active Duty, consideration

was given to the market availability of that person/skill set. The outcome from this analysis identified the number of authorizations by Air Force specialty code to convert to civilian or contractor. The analysis included four levels of risk: Not constrained, minimally constrained, moderately constrained and highly constrained. Recommended conversions came from only the “not constrained” and “minimally constrained” risk categories.

The current Air Force Nursing Services civilian inventory includes more than 1,000 nursing personnel in advanced practice, licensed and paraprofessional roles. Nationally, the demand for nursing personnel far exceeds the supply, creating a competitive market that favors qualified candidates. In nine months of active recruiting, we have hired 11 nurse practitioners and nurse specialists, 59 clinical nurses, and 41 paraprofessional nursing personnel (Licensed Practical Nurses (LPNs), Emergency Medical Technicians and Operating Room (OR) technicians). Although we hired 86 percent of the clinical nurses programmed for fiscal year 2006, we were significantly less successful with other civilian hires, especially LPNs and OR technicians. Through active recruiting, hiring bonuses where warranted, and use of direct hire authority, we are cautiously optimistic about reaching our fiscal year 2007 goal of accessing 211 additional civilian nursing personnel.

Question. General Rank, the Quadrennial Defense Review recommends aligning medical support with emerging joint force employment concepts. What is your vision for joint medical training?

Answer. We support the warfighter in fully-integrated Joint environments. Ideally, we train as we fight because Joint Interoperability promotes mission success. Joint Medical Training Platforms are not new. We currently have them at the Uniformed Services University of the Health Sciences (USUHS) and the Graduate School of Nursing (GSN). We depend on USUHS and GSN to prepare many of the Family Nurse Practitioners (FNPs) and Certified Registered Nurse Anesthetists (CRNAs) needed to fill our mission requirements. Currently, 57 percent of our 49 FNPs and 52 percent of our 143 CRNAs are USUHS graduates. The GSN enrolled 46 Air Force nurses this fall in Perioperative Specialty, FNP, and CRNA programs. Overall, Air Force nurses represented 41 percent of the GSN student population.

Additionally, in San Antonio, Texas we are moving forward with plans to relocate enlisted medical basic and specialty training to a Tri-Service Medical Education and Training Campus (METC) at Fort Sam Houston, Texas. METC will capitalize on synergy created by co-located training programs. We have fiercely protected our Community College of the Air Force degree granting to Air Force students, and are exploring the feasibility of extending that authority to our Sister Services.

Currently, enlisted joint training includes neurology, allergy, immunization, biomedical equipment technician (BMET), and dental courses. Training is available for both Air Force and Army at the U.S. Army Critical Care Education Fellowship and the U.S. Air Force Flight School. We are pursuing training affiliations with both federal and civilian medical centers to sustain operational currency as mentioned earlier. We anticipate the BMET and radiology courses as the first courses to move to METC in the fourth quarter of fiscal year 2009.

QUESTIONS SUBMITTED TO REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUE

HUMANITARIAN MISSIONS EFFECT ON NAVY NURSE CORPS

Question. Admiral Bruzek-Kohler, the Navy continues to support humanitarian missions throughout the world, and most recently deployed the U.S.S. *Mercy* to Asia. How does participation in humanitarian mission affect the Navy Nurse Corps in terms of its ability to meet both the inpatient demands and deployment requirements? How does the Navy Nurse Corps measure the effectiveness of this mission?

Answer. Regional TRICARE contracts continue the provision of healthcare to all beneficiaries when active forces are deployed to meet essential missions. A plan that includes targeted reserve component support and proactive case management has also allowed our nurses the opportunity to support both humanitarian missions and deployment requirements with minimal disruption to our inpatient care services.

The provision of care to citizens of the world can positively affect their perceptions of America via our humanitarian missions is important to our Corps. Our nurses are emotionally engaged and professionally rewarded by these missions. Discussions with our nurses indicate that this experience or the prospect of an experience in a humanitarian mission would influence their decision to stay in the military.

Qualitative methods to capture and measure our effectiveness in these humanitarian missions encompassed the development of a rating scale that evaluated the following: interoperability, host nation support and access and medical operations (which included right personnel and skill mix).

A variety of opinion polls done in the regions visited by our hospital ships indicate that health diplomacy is a very powerful tool against the war on terrorism and the Navy Nurse Corps has become a vital commodity in accomplishing this mission.

ADVANCED JOINT NURSING EDUCATION

Question. Admiral Bruzek-Kohler, this Committee urged the establishment of a Graduate School of Nursing (GSN) at the Uniformed Services University (USU) for a number of years and we were gratified by its establishment in 1993. Recent investments have allowed the University to break ground on a new building. Admiral, can you tell us how advanced joint nursing education contributes to the recruitment and retention of military nurses? What do you see as the future of the Graduate School of Nursing?

Answer. Joint training opportunities, such as those afforded by the Graduate School of Nursing (GSN) at the Uniformed Services University, provide our nurses with the unique opportunity to see first hand how closely our mission aligns with those of our sister services. An educational milieu in which the similarities as well as the differences of other services are incorporated into learning objectives fosters collaborative rapport, longstanding professional respect and enhances retention.

The Navy Nurse Corps utilizes the Graduate School of Nursing for our duty under instruction selectees in the following programs: Peri-Operative Clinical Nurse Specialist, Family Nurse Practitioner, Certified Registered Nurse Anesthetist and Doctorate in Nursing. The Uniformed Services University provides excellent advanced degrees with a military focus that are not typically provided in civilian programs. These programs have all been quite helpful in bolstering our retention.

In the future, the Navy Nurse Corps' Peri-operative Clinical Nurse Specialists will be participating in the GSN's new First Assist Program. While our nurses are not utilized in this exact role, the training received will be of great value, providing our nurses with advanced clinical skills and leadership and management tools which are integral to the role of a Clinical Nurse Specialist.

We are also exploring the feasibility of moving the Navy Nurse Corps Anesthesia Program (in its entirety) to the GSN and would welcome the GSN's offering of a Masters Degree in Nursing via distance education/online learning.

IMPACT OF DEPLOYMENTS ON RETENTION OF NAVY NURSES

Question. Admiral Bruzek-Kohler, how have deployments impacted the retention of Navy nurses?

Answer. The continuation of our ongoing engagement in Iraq has not become a deterrent to retaining nurses in our Corps. Instead we have found a greater concern in relation to the length of the deployments in which our nurses support our war fighters and humanitarian missions. A six month geographic separation from family and friends is typically deemed preferable. But when discussions ensue regarding lengthening deployments from six months to one year, greater concerns arise. Thus we are cognizant of keeping our deployments at close to six months when operationally feasible.

MILITARY-TO-CIVILIAN CONVERSIONS EFFECT ON NAVY NURSE CORPS

Question. Admiral Bruzek-Kohler, I am concerned about the Navy's continued conversion of military to civilians given the issues we face about patient care and continued recruiting and retention challenges. How do these conversions affect the Navy Nurse Corps and what specialties and/or locations have been problematic?

Answer. Indeed, the degree of flexibility in meeting both forward deployment requirements as well as humanitarian assistance missions will be tested by the military to civilian conversions as both of these missions have not been incorporated into our operational requirement algorithms.

Currently all Navy Military Treatment Facilities are staffed at 90 percent or above with Military Nurses. These manning levels include nurses who are currently deployed to Iraq and Afghanistan, causing staffing adjustments at some facilities during deployments. Our treatment facilities are experiencing challenges in recruiting civilian registered nurses in some nursing specialty areas (particularly in: emergency care, labor and delivery and pediatrics).

Recruitment and retention initiatives for both military and civilian nurses have been implemented to assuage the nursing shortages experienced at our Military Treatment Facilities. These incentives include accession bonuses, Health Profes-

sional Loan Repayments, and submission of a Critical Skills Retention Bonus for junior nurses.

NAVY NURSES IN OUTPATIENT CARE

Question. Admiral Bruzek-Kohler, could you describe the involvement of Navy nurses in the outpatient care of sailors and Marines who are returning from deployment?

Answer. In our Deployment Health Clinics, a specialized team of nurses, providers and allied health professionals ensure personnel returning from operational deployments receive health assessments and follow-up care.

Naval Medical Center San Diego offers a multidisciplinary program of care via the Comprehensive Combat Casualty Care Center. This service offers a wide range of medical, surgical, behavioral health and rehabilitative care to those wounded in the service of our country.

In Quantico, Virginia, the nurse-run Wound Clinic instituted several nurse-focused standard operating procedures to address ailments that would otherwise require physician intervention. In Camp Lejeune, North Carolina, the branch medical clinic sends nursing personnel directly to the School of Infantry to address healthcare issues on-site versus requiring medical clinic visits. In Portsmouth, Virginia, nurses from the local reserve unit have performed over 84,000 man hours of operational and clinical support over the last 27 months.

Throughout our military treatment facilities, Navy Nurses proudly serve alongside their civilian (Government Service and contract) colleagues as nurse case managers to our active duty service members.

SUBCOMMITTEE RECESS

Senator INOUE. And with that, this subcommittee will stand in recess until March 14, at which time we will receive testimony from the Department of the Army.

[Whereupon, at 12:30 p.m., Wednesday, March 7, the subcommittee was recessed, to reconvene at 10:30 a.m., Wednesday, March 14.]