DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2009

WEDNESDAY, APRIL 16, 2008

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

The subcommittee met at 9:41 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Feinstein, Mikulski, Murray, and Stevens.

DEPARTMENT OF DEFENSE

MEDICAL HEALTH PROGRAMS

STATEMENT OF LIEUTENANT GENERAL ERIC B. SCHOOMAKER, SURGEON GENERAL, UNITED STATES ARMY AND COMMANDER, UNITED STATES ARMY MEDICAL COMMAND

OPENING STATEMENT OF SENATOR DANIEL K. INOUYE

Senator INOUYE. I'd like to welcome all of the witnesses as we review the DOD medical services and programs. There will be two panels. First we'll hear from the Service Surgeon General, General Eric Schoomaker, Admiral Adam Robinson, Jr., and Lieutenant General James G. Roudebush.

Then we'll hear from our Chiefs of the Nurse Corps, General Gale Pollock, Admiral Christine Bruzek-Kohler, and Major General Melissa Rank.

While many of our witnesses are now experts at these hearings, I'd like to welcome the General, and Admiral Robinson to our subcommittee for the first time. I look forward to working with all of you to ensure the future of our military medical programs and personnel.

Over the past few years, decisions by leaders of the Department forced the military healthcare system to take actions which are of grave concern to many of us in this subcommittee.

For example, in 2006, DOD instituted the efficiency wedge, cutting essential funding from our military treatment facilities. These funding decreases were taken from the budget before the service could even identify potential savings, raising numerous concerns over the proper way to budget for our military health system, especially during a war.

To help alleviate this shortfall, Congress provided relief to the services in fiscal year 2007 and 2008, and directed that the Depart-

ment of Defense reverse this trend in future years. And we are encouraged to hear that the Department of Defense is making a concerted effort to restore these funding shortfalls in the next fiscal year.

A military to civilian conversion was another alarming directive established by DOD. As we saw in the so-called "efficiency wedge," adjustments were forced upon the services without the necessary research into short-term and long-term feasibility and affordability. Since DOD had no plans to reverse this course, Congress directed it to halt implementation.

I'm aware of the difficulties this presents to the service medical accounts, and the service military personnel accounts, and so I look forward to working with all of you to address these issues during our deliberations on the fiscal year 2009 DOD appropriations bill.

For the third year in a row, the Department is requesting the authority to increase fees for retired military in order to decrease the exponential growth in military healthcare costs. While I recognize the Department's dilemma, the approach must not cause undue financial burden on our military retirees.

To compound the problem, DOD's fiscal year 2009 budget request assumes that $1.2 billion requests—comes out in savings associated with this authority, which will likely be rejected, once again, by this Congress.

These are some of the challenges, I think, we will face in the coming year. We continue to hold this valuable hearing with service Surgeons General and the Chiefs of the Nurse Corps as an opportunity to raise and address these and many other issues.

And so I look forward to your statements and note that your full statements, all of them, will be made part of the record, and it is now my pleasure to call upon the senior member of this subcommittee, my vice chairman, Senator Stevens.

STATEMENT OF SENATOR TED STEVENS

Senator STEVENS. Thank you very much, Mr. Chairman, again, my apologies for being late.

I welcome General Schoomaker and Admiral Robinson, and of course, I'm happy to see General Roudebush here again. I would ask that my statement along with a statement from Senator Cochran be placed in the record, in view of the fact that I've already delayed this hearing.

Senator INOUYE. Without objection, so ordered.

[The statements follow:]

PREPARED STATEMENT OF SENATOR TED STEVENS

Thank you, Mr. Chairman.

I also want to welcome the Surgeons General and the Chiefs of the Nurse Corps today, who are here to testify on the current state of the military medical health system and the medical readiness of our armed forces.

General Schoomaker and Admiral Robinson, I welcome both of you in your first appearance before this subcommittee. We look forward to working with you in the future on the tough medical issues that face our military and their families.

General Roudebush, it is nice to see you here again.

This past year has shown great progress in addressing the health needs of our soldiers, sailors, marines and airmen, whether it be mental and psychological counseling after deployments, or more enhanced prosthetics that gets our servicemembers back into the fight. I experienced a prime example of how joint our

medical health care system can be, when the Air Force stepped up at Elmendorf Hospital and provided quality care for the returning Army brigade at Fort Richardson this past November. To my knowledge, it is the only Air Force hospital taking care of an Army brigade.

It is amazing how the medical corps of each service are always willing to step up and deliver the highest quality of care to those who are constantly putting their lives on the line, no matter what uniform they wear.

There will be many more challenges that will face the future of military healthcare, and I look forward to working with all of you in the future to ensure that we continue to make progress. Thank you for your testimony.

PREPARED STATEMENT OF SENATOR THAD COCHRAN

Mr. Chairman, I am pleased to join the members of the committee in welcoming our witnesses this morning.

I think it is important to note that while each of the service secretaries and chiefs testified before this committee on separate occasions over the last few weeks, the medical leadership of all the services join us today as a group, representing the truly joint effort that they have undertaken to care for our military members, veterans, family members. The efforts of the men and women you represent, from the battlefield, to the hospitals and clinics, have been nothing short of heroic.

I look forward to discussing medical care for our forces and to hearing how this year's request ensures the necessary resources are provided so our servicemembers and their families receive the best care possible.

Senator INOUYE. And now may I call upon one who is looked upon by the medical Services as the angel, Senator Mikulski.

Senator STEVENS. Angel?

STATEMENT OF SENATOR BARBARA A. MIKULSKI

Senator MIKULSKI. I don't know—even Senator Stevens was taken aback.

Thank you very much, Mr. Chairman. I just want to welcome both the Surgeons General, as well as the head of the military Nurse Corps here.

I want our military to know that many of our colleagues are over on the White House lawn welcoming the Pope. They're in search of a miracle, and I'm here in search of one, too.

But, we look forward to your testimony today, to talk about the momentum and achievements that we've made to move beyond the initial Walter Reed scandal, to look at the shortages of healthcare providers in the military, because the ops tempo is placing great stress on physicians, nurses and other allied healthcare, and also the clear relationship between the military and the Veterans Administration (VA)—essentially the implementation of the Dole-Shalala report, and how we're moving forward on that.

The rest of my comments will be reserved for, actually, in my questions, and I'll just submit the rest of my statement into the record.

Thank you very much, Mr. Chairman.

Senator INOUYE. I thank you.

[The statement follows:]

PREPARED STATEMENT OF SENATOR BARBARA A. MIKULSKI

Our military health care system must be reformed to focus on people. It is not enough to have the right number of doctors, if there are not enough nurses and not enough case managers or other allied professionals to support both the wounded warrior and the military health care workers that care for the wounded warrior.

Technology won't solve these problems. Meaningful health care reform must address the underlying organizational problem to ensure we have a system that

serves. We must recruit and retain first-rate health care professionals. We must break down the stovepipes between the DOD military health system and the VA long-term care system to ensure our wounded warriors a fast and effective transition between systems.

Over 30,000 troops have been wounded in Iraq and Afghanistan. Our troops shouldn't be wounded twice. We know that acute care for our injured troops has been astounding. We have historic rates of survival and we owe a debt of gratitude to our military medical professionals. While we have saved their lives, we are failing to give them their life back. I have visited Walter Reed and met with outpatients. I'm so proud of their service and sacrifice for our Nation, and so embarrassed by the treatment they have received.

I'm grateful to the Dole-Shalala commission for their excellent report. Their report should be the baseline for reforming our military health system. To ensure our military health system serves our wounded warriors and their families, supports their recovery and return, and simplifies the delivery of care and disabilities.

We need our Surgeons General and the heads of our Military Nurse Corps to fight hard to achieve this reform. To fight hard to break down stove pipes between DOD and the VA, to recruit and retain first-rate doctors, nurses, case managers, and other allied health professionals that support them, to ensure a fast and effective path from DOD to VA systems, and to think out of the box on solutions to address the nursing shortage.

Our soldiers have earned the best care and benefits we can provide. They should not have to fight another war to get the care they need.

Senator INOUYE. And now our first witness, Lieutenant General Eric B. Schoomaker, Surgeon General of the United States Army.

General.

General SCHOOMAKER. Thank you, sir. Chairman Inouye, Senator Stevens, Senator Mikulski, and other distinguished members of the subcommittee, thank you for providing me this opportunity to discuss Army medicine, and the Defense Health Program. I truly appreciate the opportunity to talk to you today about the important work that's being performed by the dedicated men and women, both military and civilian, of the United States Army Medical Department, who personify the AMEDD value of selfless service.

Sir, as you mentioned in your opening comments, this is about taking care of people, this is about taking care of soldiers and their families and members of the uniformed services as a whole, and so let me start by talking about how we, in the AMEDD, are working to promote best practices in care, and addressing some of the concerns about rising costs.

In the Army Medical Department, we promote clinical best practices by aligning our business practices with incentives for clinicians for our administrators and commanders. We simply don't fund commanders with what they received last year with an added factor for inflation which rarely, in past years, has covered the true medical inflation, anyway.

We also don't pay, simply, for productivity, we are not just about building widgets of care—we focus on quality and best value for the efforts of our caregivers. At the end of the day, that's what our patients and that's what my own family really wants, they want to remain healthy, and they want to be better for their encounters with our healthcare system. And we address that through the emerging science of evidence-based medicine, and focusing on clinical outcomes. We want to be assured that we're just not building widgets of healthcare, that don't relate, ultimately, to improvement in the health and well-being of our people, and ultimately I think this is what they deserve.

We've used a system in Army medicine of outcomes-based incentives for almost 4 years now. It was implemented across the entire medical command last year after the initial trial of several years in the Southeast Regional Medical Command where I was privileged to command. I believe very strongly in this approach, it promotes our focus on adding value to people's lives through our efforts in health promotion and healthcare delivery, and frankly what this has resulted in the Army, in the last 3 to 4 years, has been a measurable improvement in the health of our population, and the delivery of more healthcare services, every year, since 2003.

As Army medicine and the military health system move forward, I have three principal areas of concern that will require attention over the course of the next year, and probably the next decade.

These concerns relate to, first of all, our people. I think as you've so aptly pointed out, sir, the people are the centerpiece of the Army, and they're the centerpiece of Army medicine.

Second, we're focused upon—I'm focused upon the care that we deliver, and our distributed system of clinics and hospitals, what we call "the direct care system," the uniformed healthcare system.

And finally, I'm concerned about our aging facility infrastructure.

Let me begin with our people—the professionalism, the commitment and the selfless service of the men and women in Army medicine really, deeply impresses me, whether they're on the active side in the Reserve component, or civilians. And frankly, throughout this 5 or 6 years of conflict, without the Reserve components, we could not have survived. I've been in hospitals, and in commands in which as many as one-half or two-thirds of our hospitals have been staffed by Reserve component, mobilized nurses and physicians, administrators who are back-filling their deployed counterparts.

Nothing is more important to our success than a dedicated—our dedicated workforce. I've charted our Deputy Surgeons General, Major General Gale Pollock, whom you'll hear from in a few minutes. Also, dual-hatted as our Chief of the Army Nurse Corps, and our new Deputy Surgeon General I brought with me today, David Rubenstein, Major General David Rubenstein, to develop a comprehensive human capital strategy for the Army Medical Department that's going to carry us through the next decade, and make us truly the employer of choice for healthcare professionals.

An effective human capital strategy is going to be a primary focus of mine for the duration of my command. Recruiting and retaining quality professionals cannot be solved by a one-size-fits-all mentality. Rather, we need to address our workforce with as much flexibility and innovation, and tailored solutions as possible, specific to corps, specific to individuals, specific to career development.

Your expansion of our direct hire authority for healthcare professionals in last year's appropriations bill was a clear indicator to me of your willingness to support innovative solutions in solving our workforce challenges. And as our human capital strategy matures, I will stay closely connected to you and your staff to identify and clarify any emerging needs or requirements.

Second, I'd like to emphasize the importance of the direct care system, in our ability to maintain an all-volunteer force. One of the

major lessons that has been reinforced throughout the global war on terror (GWOT) over the last several years, is that the direct care system is the foundation for caring for wounded, ill, and injured soldiers, sailors, airmen, marine, Coast Guardsman.

All of our successes on the battlefield, through the evacuation system, and in our military medical facilities, derives from this direct care system that we have. This is where we educate, where we train, where we develop the critical skills that we use to protect the warfighter and save lives. Frankly, the success of combatants on the battlefield to survive wounds is a direct relationship—direct reflection—of what skills are being taught and maintained in our direct care system, every day.

As a foundation of military medicine, the direct care system needs to be fully funded, and fully prepared to react and respond to national needs, particularly in this era of persistent conflict. The Senate—and this subcommittee in particular—has been very supportive of our direct care system, and I thank you for recognizing the importance of our mission, and providing the funding that we need.

Last year, in addition to funding the direct care system in the base budget, you provided additional supplemental funding for operations and maintenance, for procurement, for research and development and I thank you for providing these additional funds. Please continue this strong support of Army facilities and our system of care, and for the entire joint medical direct care system.

My last concern is that we maintain a medical facility infrastructure that provides consistent, world-class healing environments. We need environments that improve clinical outcomes, patient and staff safety, that recruit and retain staff, and I think those of you who are familiar with some of our newer facilities know that instantly, it sends the message to staff and patients alike, that we as a nation, are invested in their care and in their development.

The quality of our facilities, whether it's medical treatment, research and development, or support functions, is a tangible demonstration of our commitment to our most valuable assets—our military family, and our military health systems staff.

In closing, I want to assure the Senate that the Army Medical Department's highest priority is caring for our wounded ill and injured warriors and their families—I'm proud of Army—of the Army Medical Department's efforts for the past 232 years, and especially over the last 12 months. I'm convinced that, in coordination with the Department of Defense, the Department of Veterans Affairs, we've turned the corner on events over the last year.

I greatly value the support of this subcommittee, and I look forward to working with you closely over the next year. Thank you for holding this hearing today, and thank you for your continued support of the Army Medical Department and warriors that we are most honored to serve.

Thank you, sir.

Senator INOUYE. I thank you very much, General.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL ERIC B. SCHOOMAKER

Chairman Inouye, Senator Stevens, and distinguished members of the subcommittee, thank you for providing me this opportunity to discuss Army medicine and the Defense Health Program. I have testified before congressional committees three times this year about the Army Medical Action Plan and the Army's care and support for our wounded, ill, and injured warriors. It is the most important thing we do and we are committed to getting it right and providing a level of care and support to our warriors and families that is equal to the quality of their service. However, it is not the only thing we do in Army medicine. In fact, the care we provide for our wounded, ill, and injured warriors currently amounts to about 9 percent of the outpatient health care managed by Army medicine. I appreciate this opportunity to talk with you today about some of the other very important work being performed by the dedicated men and women—military and civilian—of the U.S. Army Medical Department (AMEDD) who personify the AMEDD value "selfless service."

As The Surgeon General and Commander of the U.S. Army Medical Command (MEDCOM), I oversee a $9.7 billion international healthcare organization staffed by 58,000 dedicated soldiers, civilians, and contractors. We are experts in medical research and development, medical logistics, training and doctrine, health promotion and preventive medicine, dental care, and veterinary care in addition to delivering an industry-leading health care benefit to 3.5 million beneficiaries around the world.

The MEDCOM has three enduring missions codified on our new Balanced Scorecard:

—Promote, sustain, and enhance soldier health;
—Train, develop, and equip a medical force that supports full spectrum operations; and
—Deliver leading-edge health services to our warriors and military family to optimize outcomes.

In January of this year I traveled to Iraq with a congressional delegation to see first-hand the incredible performance of Army soldiers and medics. I was reminded again of the parallels between how the joint force fights and how the joint medical force protects health and delivers healing. I have had many opportunities over the last year to meet wounded, ill and injured soldiers, sailors, airmen and marines returning from deployments across the globe. On one occasion, I spoke at length with a young Air Force Non-Commissioned Officer—an Air Force Tactical Air Controller in support of ground operations in Afghanistan who had been injured in an IED explosion. His use of Effects Based Operations to deliver precision lethal force on the battlefield and in the battle space was parallels the use of precision diagnostics and therapeutics by the joint medical force to protect health and to deliver healing. We strive to provide the right care by the right medic—preventive medicine technician, dentist, veterinarian, community health nurse, combat medic, physician, operating room or critical care nurse, etc.—at the right place and right time across the continuum of care.

Effects Based Operations are conducted by joint forces in the following manner:

—Through the fusion of intelligence, surveillance, and reconnaissance;
—Through the coordinated efforts of Civil Military, Psychological, and Special Operations capabilities to include the combined efforts of Coalition & host-nation forces;
—Through precision fires from appropriate weapon systems with coordinated mortar, artillery, and aerial fires in an effort to reduce collateral damage to noncombatants and the surrounding environment;
—By going beyond the military dimension—it also involves nation building through humanitarian assistance operations which are worked in close coordination with Non-Governmental Organizations (NGOs) and Other Government Agencies (OGAs). I should note here that Army, Navy and Air Force medicine play an increasing role in this aspect of the U.S. military's Effects Based Operations through our contributions to humanitarian assistance and nation-building.

The Army Medical Department and the joint military force do the exact same thing as the warfighters but for a different effect—our effect is focused on the human being and the individual's health. The parallel to our warfighting colleagues is apparent and the consequences of success in this venture are equally important and critical for the Nation's defense.

The Joint Theater Trauma System (JTTS) coordinated by the Institute for Surgical Research of the U.S. Army Medical Research and Materiel Command (USAMRMC) at Fort Sam Houston, Texas, provides a systematic approach to coordinate trauma care to minimize morbidity and mortality for theater injuries. JTTS in-

tegrates processes to record trauma data at all levels of care, which are then analyzed to improve processes, conduct research and development related to trauma care, and to track and analyze data to determine the long-term effects of the treatment that we provide.

The Trauma Medical Director and Trauma Nurse Coordinators from each service are intimately involved in this process and I can't stress enough how critical it is that we have an accurate and comprehensive Electronic Health Record accessible at every point of care—this is our fusion of intelligence from the battlefield all the way to home station.

We also help shape the outcomes before the soldiers ever deploy through our Health Promotion and Preventive Medicine efforts. We continue to improve on our outcomes by leveraging science and lessons learned through Research & Development and then turning that information into actionable items such as the Rapid Fielding Initiative for protective and medical equipment, improved combat casualty care training, and comprehensive and far-reaching soldier and leader training.

We make use of all of our capabilities, much as the warfighter does. We use the Joint Medical Force—our Combat Support Hospitals & Expeditionary Medical Support, our Critical Care Air Transport teams, Landstuhl Regional Medical Center, and a timely, safe medical evacuation process to get them to each point of care. We fully integrate trauma care and rehabilitation with far forward surgical capability, the use of the JTTS, establishing specialty trauma facilities and rehabilitation centers of excellence, and treating our patients with a holistic approach that we refer to as the Comprehensive Care Plan.

It is important to understand that the fusion of information about the mechanisms of injury, the successes or vulnerabilities of protective efforts, the results of the wounds and clinical outcome can be integrated with operational and intelligence data to build better protection systems for our warriors—from vehicle platform modifications to better personal protective equipment such as body armor. We call this program Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) and it is comprised of multiple elements of data flow and analysis. The JTAPIC Program is a partnership among the intelligence, operational, materiel, and medical communities with a common goal to collect, integrate, and analyze injury and operational data in order to improve our understanding of our vulnerabilities to threats and to enable the development of improved tactics, techniques, and procedures and materiel solutions that will prevent or mitigate blast-related injuries. One way this is accomplished is through an established, near-real time process for collecting and analyzing blast-related combat incident data across the many diverse communities and providing feedback to the Combatant Commanders. Another example of JTAPIC's success is the process established in conjunction with Project Manager Soldier Equipment for collecting and analyzing damaged personal protective equipment (PPE), such as body armor and combat helmets. JTAPIC partners, to include the JTTS, the Armed Forces Medical Examiner, the Naval Health Research Center, and the National Ground Intelligence Center, conduct a thorough analysis of all injuries and evaluate the operational situation associated with the individual damaged PPE. This analysis is then provided to the PPE developers who conduct a complete analysis of the PPE. This coordination and analysis has led to enhancements to the Enhanced Small Arms Protective Inserts, Enhanced Side Ballistic Inserts and the Improved Outer Tactical Vests to better protect our soldiers.

These efforts have resulted in unprecedented survival rates from increasingly severe injuries sustained in battle. Despite the rising Injury Severity Scores, which exceed any experienced by our civilian trauma colleagues in U.S. trauma centers, the percentage of soldiers that survive traumatic injuries in battle has continued to increase. Again, this is due to the fusion of knowledge across the spectrum of care that results in better equipment, especially personal protective equipment like body armor; better battlefield tactics, techniques, and procedures; changes in doctrine that reflect these new practices; and enhanced training for not only our combat medics but the first responder—typically non-medical personnel who are at the scene of the injury.

One of our most recent examples involves the collection of data on wounding—survivable and lethal. Careful analysis of the information yielded recommendations for improvements to personal protective equipment for soldiers. This is a combined effort of the JTTS and their partners coordinated by the Institute of Surgical Research. Another combined effort being managed by USAMRMC is the DOD Blast Injury Research Program directed by Congress in the 2006 National Defense Authorization Act. The Program takes full advantage of the body of knowledge and expertise that resides both within and outside of the DOD to coordinate medical research that will lead to improvements in the prevention, mitigation or treatment of blast related injuries. The term "blast injury" includes the entire spectrum of inju-

ries that can result from exposure to an explosive device. Most of these injuries, such as penetrating and blunt impact injuries, are not unique to blast. Others, such as blast lung injury are unique to blast exposure.

The chitosan field dressing, the Improved First Aid Kit, the Combat Application Tourniquet, and the Warrior Aid and Litter Kit are a sampling of some of the advances made in recent years through the combined work of providers, researchers, materiel developers, and others. These protective devices, treatment devices, and improvements in tactics, techniques and procedures for initial triage and treatment through tactical evacuation, damage control, resuscitation, and resuscitative surgery, strategic evacuation are all illustrative of the results of this application of "Effects Based Operations" to a medical environment. These advances directly benefit our soldiers engaged in ground combat operations.

The concept of Effects Based Operations extends to our work in healthcare in our garrison treatment facilities as well. There are many substantial benefits from focusing on the clinical outcome of the many processes involved in delivering care and in harnessing the power of information using the Electronic Health Record. In the AMEDD, we promote these clinical best practices by aligning our business practices with incentives for our clinicians, administrators and commanders. We don't simply fund our commanders with what they received last year with an added factor for inflation. This would not cover the real escalation in costs and would lead to bankruptcy. We also don't just pay for productivity. Although this remains a key element in maximizing the resources of a hospital or clinic to care for the community and its patients, quality is never sacrificed. Like the Army and the joint warfighting force, we aren't just interested in throwing a lot of ordnance down-range. We—like the Army—want to know how many targets were struck and toward what positive effect. At the end of the day, that is what our patients and what my own family wants: they want to remain healthy and they want to be better for their encounters with us, which is best addressed through an Evidence Based Medicine approach. Ultimately, this is what they deserve.

We have used a system of outcomes-based incentives for almost 4 years now—it was implemented across the entire MEDCOM last year after an initial trial for several years in the Southeast Regional Medical Command. I believe strongly in this approach. It promotes our focus on adding value to peoples' lives through our efforts as a health promotion and healthcare delivery community. Last year alone we internally realigned $112 million to our high performing health care facilities. Our efforts have resulted in the Army being the only service to increase access to healthcare by delivering more services every year since 2003.

A robust, sustainable healthcare benefit remains a critical issue for maintaining an all volunteer Army in an era of persistent conflict. Increased health care demand combined with the current rate of medical cost growth is increasing pressure on the defense budget and internal efficiencies are insufficient to stem the rising costs. Healthcare entitlements should be reviewed to ensure the future of our high quality medical system and to sustain it for years to come.

I've talked a lot about joint medicine and our collaborative efforts on the battlefield, and I strongly believe it represents future success for our fixed facilities as well. In the National Capital Region (NCR), Walter Reed Army Medical Center will close and merge with the National Naval Medical Center to form the Walter Reed National Military Medical Center. The DOD stood up the Joint Task Force Capital Medicine to oversee the merging of these two facilities and the provision of synchronized medical care across the NCR. The process starts this fiscal year and is on track to end in mid-fiscal year 2011. Transition plans include construction and shifting of services with the goal of retaining current level of tertiary care throughout.

San Antonio is the next location that will likely see a lot of joint movement with establishing the Defense Medical Education Training Center and combining the capabilities of the Air Force's Wilford Hall Medical Center and the Brooke Army Medical Center into a jointly-staffed Army Medical Center. I see potential for great value in these consolidations as long as we work collaboratively and cooperatively in the best interests of all beneficiaries. We have proven that joint medicine can work on the battlefield, and at jointly-staffed Landstuhl Regional Medical Center. I have no doubt that Army medicine will continue to lead DOD medicine as we reinvent ourselves to define and pursue the distinction of being world-class through joint and collaborative ventures with our sister services.

As Army medicine and the Military Health System (MHS) move forward together, I have three major concerns that will require the attention of the Surgeons General, the MHS leadership, and our line leadership. The continued assistance of the Congress will also be helpful. These concerns relate to the role of the direct care system,

the aging infrastructure of our medical facilities, and the importance of recruiting and retaining quality health care professionals.

One of the major lessons reinforced over the last year is that the direct care system is the foundation for caring for our wounded, ill, and injured service members. All of our successes on the battlefield, through the evacuation system, and in our military medical facilities spring forth from the direct care system. This is where we educate, train, and develop the critical skills that we use to protect the warfighter and save lives. As the foundation of military medicine, the direct care system needs to be fully funded and fully prepared to react and respond to national needs, particularly in this era of persistent conflict. As proud as we are of our TRICARE partners and our improved relationship with the Department of Veterans Affairs, we must recognize that the direct care system is integral to every aspect of our mission—promoting, sustaining, and enhancing soldier health; training, developing, and equipping a medical force that supports full spectrum operations; and delivering leading edge health services to optimize outcomes. Congress—and this Committee in particular—has been very supportive of the direct care system. Thank you for recognizing the importance of our mission and providing the funding that we need. Last year, in addition to funding the direct care system in the base budget, you provided additional supplemental funding for operations and maintenance, procurement, and research and development—thank you for providing these additional funds. We are ensuring this money is used as you intended to enhance the care we provide soldiers and their families. Please continue your strong support of the direct care system.

The Army requires a medical facility infrastructure that provides consistent, world-class healing environments that improve clinical outcomes, patient and staff safety, staff recruitment and retention, and operational efficiencies. The quality of our facilities—whether medical treatment, research and development, or support functions—is a tangible demonstration of our commitment to our most valuable assets—our military family and our MHS staff. Not only are these facilities the bedrock of our direct care mission, they are also the source of our Generating Force that we deploy to perform our operational mission. The fiscal year 2009 Defense Medical MILCON request addresses critical investments in DOD biomedical research capabilities, specifically at the U.S. Army Medical Research Institutes of Infectious Disease and Chemical Defense, and other urgent health care construction requirements for an Army at war. To support mission success, our current operating environment needs appropriate platforms that support continued delivery of the best health care, both preventive and acute care, to our warfighters, their families and to all other authorized beneficiaries. I respectfully request the continued support of DOD medical construction requirements that will deliver treatment and research facilities that are the pride of the department.

My third concern is the challenge of recruiting and retaining quality health care professionals during this time of persistent conflict with multiple deployments. The two areas of greatest concern to me in the Active Component are the recruitment of medical and dental students into our Health Professions Scholarship Program (HPSP) and the shortage of nurses. The HPSP is the major source of our future force of physicians and dentists. For the last 3 years we have been unable to meet our targets despite focused efforts. The recent authorization of a $20,000 accession bonus for HPSP students will provide another incentive to attract individuals and hopefully meet our targets. In the face of a national nursing shortage, the Army Nurse Corps is short over 200 nurses. We have increased the nurse accession bonus to the statutory maximum of $30,000 for a 4-year service obligation. The Army Reserve and National Guard have also encountered difficulty meeting mission for the direct recruitment of physicians, dentists, and nurses. We have increased the statutory cap of the Reserve Component (RC) Health Professions Special Pay to $25,000 per year and have increased the monthly stipend paid to our participants in the Specialized Training Assistance Program to $1,605 per month and will raise it again in July 2008 to $1,905 per month. As you know, financial compensation is only one factor in recruiting and retaining employees. We are looking at a variety of ways to make a career in Army medicine more attractive. A 90-day mobilization policy has been in effect for RC physicians, dentists and nurse anesthetists since 2003; this policy has had a positive impact on the recruiting and retention of RC healthcare professionals. In October 2007, U.S. Army Recruiting Command activated a medical recruiting brigade to focus exclusively on recruiting health care professionals. It is still too early to assess the effectiveness of that new organization, but I am confident that we will see some progress over the next year.

The men and women of Army medicine—whether Active Component, Reserve Component, or civilian—impress me every day with their professionalism, their commitment, and their selfless service. Nothing is more important to our success then

our dedicated workforce. I have established Major General Gale Pollock as my Deputy Surgeon General for Force Management so that she can focus her incredible talent and energy on a Human Capital Strategy for the AMEDD that will make us an "employer of choice" for healthcare professionals interested in serving their country as either soldiers or civil servants. Your expansion of Direct Hire Authority for health care professionals in last year's appropriations bill was a clear indicator to me of your willingness to support innovative solutions to our workforce challenges. As this strategy matures, I will stay closely connected to you and your staff to identify and clarify any emerging needs or requirements.

In closing, I want to assure the Congress that the Army Medical Department's highest priority is caring for our wounded, ill, and injured warriors and their families. I am proud of the Army Medical Department's efforts over the last 12 months and am convinced that in coordination with the DOD, the Department of Veterans Affairs, and the Congress, we have "turned the corner" toward establishing an integrated, overlapping system of treatment, support, and leadership that is significantly enhancing the care of our warriors and their families. I greatly value the support of this Committee and look forward to working with you closely over the next year. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the warriors that we are most honored to serve.

Senator INOUYE. May I now recognize Admiral Robinson?

STATEMENT OF VICE ADMIRAL ADAM M. ROBINSON, JR., SURGEON GENERAL, DEPARTMENT OF THE NAVY

Admiral ROBINSON. Good morning, and thank you.

Chairman Inouye, Senator Stevens, Senator Mikulski, distinguished members of the subcommittee, it is a pleasure to be before you, to share with you my vision for Navy medicine in the upcoming fiscal year.

You have been very supportive of our mission in the past, and I want to express my gratitude, on behalf of all who work for Navy medicine, and those we serve.

Navy medicine is at a particularly critical time in history as the military health system has come under increased scrutiny. Resource constraints are real, along with the increasing pressure to operate more efficiently, while compromising neither mission, nor healthcare quality. The budget for the Defense Health Program contains fiscal limits that continue to be a challenge. The demands for wounded warrior care continue to steadily increase due to military operations in Iraq and Afghanistan.

At the same time, Navy medicine must meet the requirement of a peacetime mission of family and retiree healthcare, as well as provide humanitarian assistance and disaster relief, as needed around the globe.

Our mission is Force Health Protection, and we are capable of supporting the full range of operations, from combat support for our warriors throughout the world to humanitarian assistance. As a result, it is vitally important that we maintain a ready force, and we achieve that by recruiting, training and retaining outstanding healthcare personnel and providing excellence in clinical care, graduate health education, and biomedical research, the core foundations of Navy medicine.

We must remain fully committed to readiness in two dimensions—the medical readiness of our sailors and marines, and the readiness of our Navy medicine team to provide health service support across the full range of military ops.

Navy medicine physicians, nurses, dentists, healthcare professional officers and hospital corpsmen, have steamed to assist wher-

ever they have been needed for healthcare. As a result, it has been said that Navy medicine is the heart of the U.S. Navy, as humanitarian assistance and disaster relief missions create a synergy—an opportunity for all elements of national power: diplomatic, informational, military, economic, joint, inter-agency and cooperation with non-governmental organizations.

As you know, advances in battlefield medicine have improved survivability rates, and these advances—leveraged together with Navy medicine's patient and family-centered care philosophy, provide us with the opportunities to effectively care for these returning heroes and their families.

In Navy medicine, we empower our staff to do whatever is necessary to deliver the highest quality, comprehensive, and compassionate healthcare.

For Navy medicine, the progress a patient makes from initial care to rehabilitation, and in support of the lifelong medical requirements drive the patient's care across the continuum. We learned early on that families displaced from their normal environment, and dealing with a multitude of stressors, are not as effective in supporting the patient, and his or her recovery. Our focus is to get the family back to a state of normalcy, as soon as possible, which means returning the patient and their family home to continue the healing process.

In Navy medicine, we have a comprehensive, multi-disciplinary care team which interfaces with all partners involved in the continuum of care. These partners include Navy and Marine Corps line counterparts, who work with us to decentralize care from a monolithic structure with one person in charge, to a disbursed network throughout our communities nationwide.

Moving patients closer to home requires a great deal of planning, interaction, and coordination with providers, caseworkers, and other related healthcare professionals to ensure care is a seamless continuum.

Families are considered a vital part of the care team, and we integrate their needs into the planning process. They are provided with emotional support by encouraging the sharing of experiences with other families—that's family-to-family support—and through access to mental health services.

Currently, Navy medicine is also paying particular attention to de-stigmatizing psychological health services. Beginning in 2006, Navy medicine established deployment health clinics to serve as non-stigmatizing portals of entry in high fleet, and Marine Corps concentration areas, and to augment primary care services offered at the military treatment facilities, or in garrison.

Staffed by primary care providers, and mental health teams, the centers are designed to provide care for marines and sailors who self-identify mental health concerns on the post-deployment health assessment and re-assessment. The center provides treatment for other service members, as well, we now have 17 such clinics, up from 14 last year.

Since the late 1990s, Navy medicine has been embedding mental health professionals with operational components of the Navy and the Marine Corps. Mental health assets aboard ship can help the

crew deal with the stresses associated with living in isolated and unique environments.

For the marines, we have developed OSCAR teams, operational stress control and readiness, which embed mental health professionals as organic assets in operational units. Making these mental health assets organic to the ship and the Marine Corps unit minimizes stigma, improves access to mental healthcare, and provides an opportunity to prevent combat stress situations from deteriorating into disabling conditions.

We continue to make significant strides toward meeting the needs of military personnel, their families and caregivers, with psychological health needs, and traumatic brain injury-related diagnoses. We are committed in these efforts to improve the detection of mild to moderate traumatic brain injury (TBI), especially those forms of traumatic brain injury in personnel who are exposed to blast, but do not suffer other demonstrable physical injuries.

Our goal is to continuously improve our psychological health services throughout the Navy and the Marine Corps. This effort requires seamless programmatic coordination across existing line functions, in programs such as the Marine Corps' Wounded Warrior Regiment, and Navy's Safe Harbor, while working numerous fiscal contracting and hiring issues. Your patience and persistence are deeply appreciated, as we work to achieve solutions to long-term care needs.

We have not met our recruitment and retention goals for medical and dental corps officers for the last 3 years. This situation is particularly stressful in war-time medical specialties. Currently, we have deployed 90 percent of our general surgeons, and 70 percent of our active duty psychiatrists in our inventory. From the Reserve component, 85 percent of the anesthesiologists, and 50 percent of our oral surgeons have deployed.

While we are very grateful for your efforts in support of expanded and increased accession and retention bonus—and these have made a difference—these incentives will take approximately 2 to 5 years to be reflected in our pipelines.

Additionally, the stress on the force due to multiple deployments and individual augmentations has had a significant impact on morale across the healthcare communities. Personnel shortages are underscored by Navy Medical Department scholarships going unused, and the retention rate of professionals beyond their initial tour falling well below goal.

By using experienced Navy medicine personnel to assist recruiters in identifying prospective recruits, we're developing relevant opportunities and enticements to improve retention. We are demonstrating to our people how they are valued as individuals, and how they can achieve a uniquely satisfying career in the Navy, and in Navy medicine.

Navy medicine's research efforts are dedicated to enhancing the health, safety, and performance of the Navy-Marine Corps team. It is this research that has led to the development of the state-of-the-art armor, equipment and products that have improved our survivability rates, to the highest levels compared to all previous conflicts.

In addition, our research facilities are a critical component, ready to respond to worldwide biological warfare attacks, and are making significant strides in tracking injury patterns in warfighters through the joint trauma registry. We are breaking new ground in the identification of pattern of injury resulting from exposure to blast.

Navy medicine's medical research and development laboratories are playing an instrumental role in the worldwide monitoring of new, emerging infectious diseases, and the three Navy overseas laboratories have been critical in determining the efficacy of all anti-malarial drugs used by the Department of Defense to prevent and treat disease.

PREPARED STATEMENT

Chairman Inouye, Senator Stevens, Senator Mikulski, thank you, again, for your support, and for providing me this opportunity to share with you Navy medicine's mission, what we are doing, and our plans for the upcoming year. It has been my pleasure to testify before you today, and I look forward to answering your questions.

Senator INOUYE. All right, thank you very much, Admiral.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF VICE ADMIRAL ADAM M. ROBINSON

Chairman Inouye, Ranking Member Stevens, distinguished members of the Committee, I am here to share with you my vision for Navy medicine in the upcoming fiscal year. You have been very supportive of our mission in the past, and I want to express my gratitude on behalf of all who work for Navy medicine—uniformed, civilian, contractor, volunteer personnel—who are committed to meeting and exceeding the health care needs of our beneficiaries.

Navy medicine is at a particularly critical time in history as the Military Health System has come under increased scrutiny. Resource constraints are real, along with the increasing pressure to operate more efficiently while compromising neither mission nor health care quality. The budget for the Defense Health Program contains fiscal limits that continue to be a challenge. The demands for wounded warrior care continue to steadily increase due to military operations in Iraq and Afghanistan. Furthermore, Navy medicine must meet the requirement to maintain a peacetime mission of family and retiree health care, as well as provide Humanitarian Assistance/Disaster Relief as needed around the globe.

The current rate of medical cost growth is adding increased demands on the defense budget and internal efficiencies are insufficient to stem the rising healthcare costs. Benefit adjustments should be considered to ensure the future of our high quality medical system and to sustain it for years to come.

FORCE HEALTH PROTECTION AND READINESS

Our mission is Force Health Protection. Navy medicine is capable of supporting the full range of operations from combat support for our warriors throughout the world to humanitarian assistance. As a result, is it vitally important that we maintain a fully ready force, and we achieve that by recruiting and retaining outstanding healthcare personnel and providing excellence in clinical care, graduate health education, and biomedical research, the core foundation of Navy medicine.

Navy medicine must ensure that our forces are ready to go when called upon. We must remain fully committed to readiness in two dimensions: the medical readiness of our sailors and marines, and the readiness of our Navy medicine team to provide health service support across the full range of military operations. We place great emphasis on preventing injury and illness whenever possible. We are all constantly looking at improvements to mitigate whatever adversary, ailment, illness, or malady affects our warrior and/or their family members. We provide care worldwide, making Navy medicine capable of meeting our military's challenges, which are critical to the success of our warfighters.

The Navy and Marine Corps team is working to improve a real-time, standardized process to report individual medical readiness. Navy medicine collaborates with the line to increase awareness of individual and command responsibilities for medical readiness—for it is as much an command responsibility as it is that of the individual.

HUMANITARIAN ASSISTANCE/DISASTER RELIEF MISSIONS (HA/DR)

Since 2004, the Navy Medical Department has served on the forefront of HA/DR missions which are part of the Navy's Core Elements of Maritime Power. Navy medicine physicians, nurses, dentists, ancillary healthcare professional officers, and hospital corpsmen have steamed to assist wherever there has been a need for health care. As a result, it has been said that Navy medicine is the heart of the U.S. Navy.

HA/DR Missions create a synergy and opportunity for all elements of national power—diplomatic, informational, military, economic, joint, interagency, and cooperation with non-governmental organizations (NGOs). Most recently the USNS COMFORT (TAH–20) sent a strong message of U.S. compassion, support and commitment to the Caribbean and Central and South America during last summer's mission. Military personnel, as well as officers from the U.S. Public Health Service, trained and provided HA to the people of the partner nations and helped enhance security, stability and cooperative partnerships with the countries visited. NGOs participated in this deployment and brought value, expertise and additional capacity to the mission. According to President Tony Saca of El Salvador, "This type of diplomacy really touched the heart and soul of the country and the region and is the most effective way to counter the false perception of what Cuban medical teams are doing in the region."

Last fall during the San Diego fires, the Navy engaged as an integral member of the community and provided assistance in several ways, including providing medical care to civilian evacuees. The Naval Medical Center in San Diego (NMCSD) accepted patients due to civilian hospital evacuations. In addition, NMCSD replenished medical supplies for community members who evacuated their homes without necessary medications. In addition, medical personnel from Naval Hospital Twenty-Nine Palms and aboard ships in the area were helping civilian evacuees at evacuation centers across the county.

It is important to note, that if not planned for appropriately this emerging part of our mission will prove difficult to sustain in future years. We must balance the requirements of sustaining the Global War on Terror with HA/DR requirements.

PATIENT AND FAMILY CENTERED CARE AND WOUNDED, ILL AND INJURED SERVICEMEMBERS

Navy medicine's concept of care is always patient and family centered, and we will never lose our perspective in caring for our beneficiaries. Everyone is a unique human being in need of individualized, compassionate and professionally superior care. As you have heard, advances in battlefield medicine have improved survivability rates so the majority of the wounded we are caring for today will reach our CONUS facilities. This was not the case in past conflicts. These advances, leveraged together with Navy medicine's patient and family centered care, provide us with the opportunities to effectively care for these returning heroes and their families. In Navy medicine we empower our staff to do whatever necessary to deliver the highest quality, comprehensive health care.

The Military Healthcare System is one of the most valued benefits our great Nation provides to service members and their families. Each service is committed to providing our wounded, ill and injured with the highest quality, state-of-the art medical care, from the war zone to the home front. The experience of this health care, as perceived by the patient and their family, is a key factor in determining health care quality and safety.

For Navy medicine the progress a patient makes from initial care to rehabilitation, and in the support of life-long medical requirements is the driver of where a patient is clinically located in the continuum of care and how that patient is cared for. Where a particular patient is in the continuum of care is driven by the medical care needed instead of the administrative and personnel issues or demands. Medical and administrative processes are tailored to meet the needs of the individual patient and their family—whatever they may be. For the overwhelming majority of our patients, their priority is to locate their care as close to their homes as possible. We learned early on that families displaced from their normal environment and dealing with a multitude of stressors, are not as effective in supporting the patient and his or her recovery. Our focus is to get the family back to "normal" as soon as possible,

which means returning the patient and their family home to continue the healing process.

In Navy medicine we have established a dedicated trauma service as well as a comprehensive multi-disciplinary care team which interfaces with all of the partners involved in the continuum of care. These partners include Navy and Marine line counterparts who decentralize care from a monolithic continuum with one person in charge to a dispersed network where patients and families return to their communities; once returned home they can engage with friends, families, traditions, peers and their communities in establishing their new life. To move patients closer to home requires a great deal of planning, interaction and coordination with providers, case workers and other related health care professionals to ensure care is a seamless continuum. We work together from the day of admission to help the patient and the family know we are focused on eventually moving the patient closer to home as soon as their medical needs allow. The patient's needs will dictate where they are, not the system's needs.

Our single trauma service admits all OEF/OIF patients with one physician service as the point of contact for the patient and their family. Other providers, such as orthopedic surgery, oral-maxillofacial surgery, neurosurgery and psychiatry, among others, serve as consultants all of whom work on a single communications plan. In addition to providers, other key team members of the multi-disciplinary team include the service liaisons at the military treatment facility, the Veterans Affairs health care liaison and military services coordinator.

Another key component of the care approach by Navy medicine takes into consideration family dynamics from the beginning. Families are considered as part of the care team, and we integrate their needs into the planning process. They are provided with emotional support by encouraging the sharing of experiences among other families (family-to-family support) and through access to mental health services.

Currently, Navy medicine is also paying particular attention to de-stigmatizing psychological health services, the continuity of care between episodes, and the handoff between the direct care system and the private sector. We are developing a process to continuously assess our patient and their families perspectives so that we may make improvements when and where necessary.

Beginning in 2006, Navy medicine established Deployment Health Centers (DHCs) to serve as non-stigmatizing portals of entry in high fleet and Marine Corps concentration areas and to augment primary care services offered at the military treatment facilities or in garrison. Staffed by primary care providers and mental health teams, the centers are designed to provide care for marines and sailors who self-identify mental health concerns on the Post Deployment Health Assessment and Reassessment. The centers provide treatment for other service members as well. We now have 17 such clinics, up from 14 since last year. From 2006 through January 2008, DHCs had over 46,400 visits, 28 percent of which were for mental health issues.

Delays in seeking mental health services increase the risks of developing mental illness and exacerbating physiological symptoms. These delays can have a negative impact on a servicemember's career. As a result, we remain committed to reducing stigma as a barrier to ensuring servicemembers receive full and timely treatment following their return from deployment. Of particular interest is the recognition and treatment of mental health conditions such as PTSD. At the Navy's Bureau of Medicine and Surgery we established the position for a "Combat and Operational Stress Control Consultant" (COSC). This individual, who reported on December 2006, is a combat experienced psychiatrist and preventive medicine/operational medicine specialist. Dedicated to addressing mental health stigma, training for combat stress control, and the development of non-stigmatizing care for returning deployers and support services for Navy caregivers, this individual also serves as the Director of Deployment Health. He and his staff oversee Post Deployment Reassessment (inclusive of Deployment Health Centers), Substance Abuse Prevention and Treatment, Traumatic Brain Injury diagnosis and treatment, and a newly created position for Psychological Health Outreach for Reserve Component Sailors.

As you know, in June 2007 Secretary Gates received the recommendations from the congressionally mandated Department of Defense (DOD) Mental Health Task Force. Additionally, the Department's work on identifying key gaps in our understanding and treatment of TBI gained greater visibility and both DOD and the Department of Veterans Affairs began implementing measures to fill those gaps. Positive momentum has resulted from the task force's recommendations, the Department of Defense's work on TBI, and the additional funding from Congress. This collaboration provided an opportunity for the services to better focus and expand their capabilities in identifying and treating these two conditions.

Since the late 1990s Navy medicine has been embedding mental health professionals with operational components of the Navy and the Marine Corps. Mental health assets aboard ships can help the crew deal with the stresses associated with those living isolated and unique conditions. Tight quarters, long work hours, and the fact that many of the staff may be away from home for the first time, presents a situation where the stresses of "daily" life may prove detrimental to a sailor's ability to cope so having a mental health professional who is easily accessible and going through many of the same challenges has increased operational and battle readiness aboard these platforms.

For the Marines, Navy medicine division psychiatrists stationed with marines developed OSCAR Teams (Operational Stress Control and Readiness) which embed mental health professional teams as organic assets in operational units. Making these mental health assets organic to the unit minimizes stigma and provides an opportunity to prevent combat stress situations from deteriorating into disabling conditions. There is strong support for making these programs permanent and ensuring that they are resourced with the right amount of staff and funding.

At the Navy's Bureau of Medicine and Surgery and Marine Corps headquarters, two positions for Combat and Operational Stress Consultants have been created. These individuals are dedicated to addressing mental health stigma, training for combat stress control, and the development of non-stigmatizing care for returning deployers and support services for Navy caregivers.

In addition, we are developing and strengthening training programs for line leadership and our own caregivers. The goal is for combat stress identification and coping skills to be part of the curriculum at every stage of development of a sailor and/or marine. From the Navy's A Schools, to the Marine Corps Sergeant's course, and in officer indoctrination programs, we must ensure that dealing with combat stress becomes as common as dealing with any other medical issue.

Recently Navy medicine received funding for creation of a Navy/Marine Corps Combat and Operational Stress Control (COSC) Center at Naval Medical Center San Diego (NMCSD). The concept of operations for this first-of-its-kind capability is underway, as is the selection of an executive staff to lead the Center. The primary role of this Center is to identify best COSC practices, develop combat stress training and resiliency programs specifically geared to the broad and diverse power projection platforms and Naval Type Commands, establish provider "Caring for the Caregiver" initiatives, and coordinate collaboration with other academic, clinical, and research activities. As the concept for a DOD Center of Excellence develops, we will integrate, as appropriate, the work of this center. The program also hopes to reflect recent advancements in the prevention and treatment of stress reactions, injuries, and disorders.

We continue to make significant strides towards meeting the needs of military personnel with psychological health needs and TBI-related diagnoses, their families and their caregivers. We are committed in these efforts to improve the detection of mild-to-moderate TBI, especially those forms of TBI in personnel who are exposed to blast but do not suffer other demonstrable physical injuries. Servicemembers who return from deployment and have suffered such injuries may later manifest symptoms that do not have a readily identifiable cause, with potential negative effect on their military careers and quality of life.

Our goal is to establish comprehensive and effective psychological health services throughout the Navy and Marine Corps. This effort requires seamless programmatic coordination across the existing line functions (e.g., Wounded Warrior Regiment, Safe Harbor) while working numerous fiscal, contracting, and hiring issues. Your patience and persistence are deeply appreciated as we work to achieve long-term solutions to provide the necessary care.

RECRUITMENT AND RETENTION AND GRADUATE MEDICAL EDUCATION

We have not met our recruitment and retention goals for Medical and Dental Corps officers for the last 3 years. This situation is particularly stressful in wartime medical specialties. Currently, we have deployed 90 percent of our general surgery active duty medical corps officers, a specialty that is only manned at 87 percent. For psychiatrists, who are 94 percent manned, 72 percent of the active duty inventory has deployed. From the reserve component, 85 percent of the anesthesiologists and 50 percent of oral surgeons have deployed. While we are very grateful for your efforts in support of expanded and increased accession and retention bonuses, these incentives will take approximately 2,095 years to reflect in our pipeline.

We in Navy medicine are increasing our efforts and energy in the recruitment and retention of medical personnel. We must demonstrate to our personnel how they are valued as individuals and they can achieve a uniquely satisfying career in the Navy.

We are using experienced Navy medicine personnel to assist recruiters in identifying perspective recruits and developing relevant opportunities and enticements to improve retention.

A challenge to meeting our recruitment and retention efforts is the impact of future increase in Marine Corps personnel. The Navy personnel needed in support of the increase will largely be medical officers and enlisted personnel. This situation, coupled with the stress on the force, needs to be addressed so that we can shape the force to meet the needs of the warfighter in the future.

Also, the stress on the force due to multiple deployments and individual augmentation has had a significant impact on morale across the health care continuum. Personnel shortages are underscored by Navy medical department scholarships going unused and the retention rate of professionals beyond their initial tours falling well below goal.

Graduate Medical and Health Education (GME/GHE) programs are a vital component of Navy medicine and of the Military Health System. These programs are an integral part of our training pipeline, and we are committed to sustaining these efforts to train future generations of health care providers. GME/GHE programs are required to fulfill our long-term goals and maintain the ever-changing health care needs of our beneficiaries. In addition, these programs are a critical part of our recruitment and retention efforts for new medical professionals and those involved in educating them.

RESEARCH AND DEVELOPMENT EFFORTS

Research is at the heart of nearly every major medical and pharmaceutical treatment advancement, and that is no different for Navy medicine. Our research efforts are dedicated to enhancing the health, safety, and performance of the Navy and Marine Corps team. It is this research that has led to the development of state-of-the art armor, equipment, and products that have improved our survivability rates to the lowest rates from any other conflict.

Navy medicine research and development efforts cover a wide range of disciplines including biological defense, infectious diseases, combat casualty care, dental and biomedical research, aerospace medicine, undersea medicine and environmental health.

The Naval Medical Research Center's Biological Defense Research Directorate (BDRD) is one of the few laboratories in the United States ready to detect over 20 biological warfare agents. In addition, the BDRD, located in Bethesda, MD, maintains four portable laboratories ready to deploy in 18 hours in response to worldwide biological warfare attacks.

The Naval Health Research Center (NHRC) has a significant capability to track injury patterns in warfighters through the Joint Trauma Registry and is the leader in identifying patterns of injury resulting from exposure to blast. This ongoing assessment of injury patterns provides researchers and source sponsors key information in order to base decisions on programmatic issues. These decisions are used to develop preventative and treatment technologies to mitigate the effects of blast on the warfighter.

Navy's medical research and development laboratories also play an instrumental role in the worldwide monitoring of new emerging infectious diseases, such as avian influenza, that threaten both deployed forces and the world. The three Navy overseas laboratories have also been critical in determining the efficacy of all anti-malarial drugs used by the Department of Defense to prevent and treat disease. Our personnel at those facilities, specifically Jakarta and Lima, were participants in the timely and highly visible responses to natural disasters in Indonesia (Tsunami of December 2004 and Central Java Earthquake of 2006) and Peru (Earthquake in August 2007).

Our research and development efforts are an integral part of Navy medicine's success and are aimed at providing solutions and producing results to further medical readiness for whatever lies ahead on the battlefield, at sea and at home.

Chairman Inouye, Ranking Member Stevens, distinguished members of the Committee, thank you again for providing me this opportunity to share with you Navy medicine's mission, what we are doing and our plans for the upcoming year. It has been my pleasure to testify before you today and I look forward to answering any of your questions.

Senator INOUYE. And now, General Roudebush.

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

General ROUDEBUSH. Thank you, sir.

Mr. Chairman, Senator Stevens, Senator Mikulski, distinguished members of the subcommittee, it's truly my honor and privilege to be here today to talk with you about the Air Force Medical Service. But before I make any remarks, first I must thank you for your support. The Senate, and this subcommittee in particular, have been absolutely key in helping us work through some very turbulent times, in terms of fiscal challenges, personnel challenges, facility challenges—all the while meeting a very demanding operational mission. So first, I must say, thank you.

Your Air Force is the Nation's guardian of America's force of first and last resort to guard and protect our Nation. To that end, we Air Force medics—and I use medics in a very broad sense—officer, enlisted, all-corps, total force, active Guard and Reserve, and our civilians, allies, and counterparts that come together to make up Air Force medicine.

So, when I say we Air Force medics, I mean that in the very broadest and most inclusive sense. We, Air Force medics, work directly for our line leadership in addressing our Air Force's top priorities—win today's fight, taking care of our people, and prepare for tomorrow's challenges.

The future strategic environment is complex and very uncertain. Be assured that your Air Force, and your Air Force Medical Service, are fully executing today's mission, and aggressively preparing for tomorrow's challenges. It's important to understand that every Air Force base at home station, and deployed, is an operational platform, and Air Force medicine supports warfighting capabilities at each of our bases.

It begins with our Air Force military treatment facilities providing combatant commanders a fit and healthy force, capable of withstanding the physical and mental rigors associated with combat and other military missions. Our emphasis on fitness and prevention has led to the lowest disease and nonbattle injury rate in history.

The daily delivery of healthcare in our medical treatment facilities is also essential to maintaining critical skills that guarantee our medical readiness capability, and our success. Our Air Force medics—working with our Army and our Navy counterparts, care for our families at home, we respond to our Nation's call supporting our warriors in deployed locations, and we provide humanitarian assistance and disaster response to both our friends and allies abroad, as well as our citizens at home.

To execute these broad missions, the services—the Air Force, Navy and Army—must work interoperably and interdependently. Every day, together, we earn the trust of America's all-volunteer force—airmen, soldiers, sailors, marines and their families—and we hold that trust very dear.

Today I'm here to address the health needs of our airmen and their families. The Air Force Medical Service is focused on the psychological needs of our airmen, and in reducing the effects of operational stress. We thank Congress for the fiscal year 2007 supplemental funding, which strengthened our psychological health, and

traumatic brain injury (TBI) program research, surveillance, and treatment. It has directly improved access, coordination of care, and the transition of our patients to our allies and counterparts in the VA when that's appropriate.

We're fully committed to meeting the health needs of our airmen and their families, and will continue to execute and refine these programs, again, working within the Air Force, but very closely with our Army, Navy, VA and private sector care allies and counterparts.

In meeting this demanding mission, we must recruit the best and the brightest, prepare them for the mission, and retain them to support and lead the Air Force Medical Service in the years to come. The demanding operations tempo at home and deployed requires finding a balance between these demanding duties, personal recovery and family time.

We are undertaking a number of initiatives to recapitalize and invest in our most precious resource—our people. Enhancing both professional and leadership development, ensuring predictability in deployments and offering financial incentives are all important ways we improve our overall retention, and thank you for your support in helping us do that.

In closing, Mr. Chairman, I am humbled by, and intensely proud, of the daily accomplishments of the men and women of the United States Air Force Medical Service. The superior care routinely delivered by Air Force medics is a product of preeminent medical training, groundbreaking research, and a culture of personal and professional accountability, all fostered by the Air Force's core values.

PREPARED STATEMENT

With your continued help, and the help of this subcommittee, the Air Force will continue our focus on the health of our warfighters and their families. Thank you for your enduring support, and I look forward to your questions.

Thank you, sir.

Senator INOUYE. I 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, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. The Air Force Medical Service exists and operates within the Air Force culture of accountability wherein medics work directly for the line of the Air Force. Within this framework we support the expeditionary Air Force both at home and deployed.

We align with the Air Force's top priorities: Win Today's Fight, Take Care of our People, and Prepare for Tomorrow's Challenges. We are the Nation's Guardian—America's force of first and last resort. We get there quickly and we bring everyone home. That's our pledge to our military and their families.

WIN TODAY'S FIGHT

It is important to understand that every Air Force base is an operational platform and Air Force medicine supports the war fighting capabilities at each one of our bases. Our home station military treatment facilities form the foundation from which the Air Force provides combatant commanders a fit and healthy force, capable of withstanding the physical and mental rigors associated with combat and other military missions. Our emphasis on fitness, disease prevention and surveillance has led to the lowest disease and non-battle injury rate in history.

Unmistakably, it is the daily delivery of health care which allows us to maintain critical skills that guarantee our readiness capability and success. The superior care delivered daily by Air Force medics builds the competency and currency necessary to fulfill our deployed mission. Our care is the product of preeminent medical training programs, groundbreaking research, and a culture of personal and professional accountability fostered by the Air Force's core values.

In support of our deployed forces, the Air Force Medical Service (AFMS) is central to the most effective joint casualty care and management system in military history. The effectiveness of forward stabilization followed by rapid Air Force aeromedical evacuation has been repeatedly proven. We have safely and rapidly moved more than 48,000 patients from overseas theaters to stateside hospitals during Operations ENDURING FREEDOM and IRAQI FREEDOM. Today, the average patient arrives from the battlefield to Stateside care in 3 days. This is remarkable given the severity and complexity of the wounds our forces are sustaining. It certainly contributes to the lowest died of wounds rate in history.

TOTAL FORCE INTEGRATION

Our Air Force Medical Service is a model for melding Guard, Reserve and civilians with active duty elements. Future challenges will mandate even greater interoperability, and success will be measured by our Total Force and joint performance.

A story that clearly illustrates the success of our Total Force and joint enroute care is that of Army SGT Dan Powers, a squad leader with the 118th Military Police Company. He was stabbed in the head with a knife by an insurgent on the streets of Baghdad on July 3, 2007. Within 30 minutes of the attack, he was flown via helicopter to the Air Force theater hospital at Balad Air Base, Iraq. Army neurosurgeons at the Balad Air Force theater hospital and in Washington DC reviewed his condition and determined that SGT Powers, once stabilized, needed to be transported and treated at the National Naval Medical Center, Bethesda, MD as soon as possible. The aeromedical evacuation system was activated and the miracle flight began. A C–17 aircrew from Charleston Air Force Base, SC, picked up SGT Powers with a seven-person Critical Care Air Transport Team and flew non-stop from Balad Air Base, to Andrews Air Force Base, MD. After a 13-hour flight, they landed at Andrews AFB where SGT Powers was safely rushed to the National Naval Medical Center for lifesaving surgery.

As SGT Powers stated, "the Air Force Mobility Command is the stuff they make movies out of . . . the Army, Navy, and Air Force moved the world to save one man's life."

We care for our families at home; we respond to our Nation's call supporting our warriors, and we provide humanitarian assistance to countries around the world. To execute these broad missions, the services—Air Force, Navy and Army—must work jointly, interoperatively, and interdependently. Our success depends on our partnerships with other Federal agencies, academic institutions, and industry. Our mission is vital. Everyday we must earn the trust of America's all-volunteer force—airmen, soldiers, sailors and marines, and their families. We hold that trust very dear.

TAKE CARE OF OUR PEOPLE

We are in the midst of a long war and continually assess and improve health services we provide to airmen, their families, and our joint brothers and sisters. We ensure high standards are met and sustained. Our Air Force chain of command fully understands their accountability for the health and welfare of our airmen and their families. When our warfighters are ill or injured, we provide a wrap-around system of medical care and support for them and their families—always with an eye towards rehabilitation and continued service.

Wounded Warrior Initiatives

The Air Force is in lock-step with our sister services and Federal agencies to implement the recommendations from the President's Commission on the Care for America's Returning Wounded Warriors. The AFMS will deliver on all provisions set forth in the fiscal year 2008 National Defense Authorization Act and provide our warfighters and their families help in getting through the challenges they face. I am proud today to outline some of those initiatives.

Care Management, Rehabilitation, Transition

When a service member is ill or injured, the AFMS responds rapidly through a seamless system from initial field response, to stabilization care at expeditionary surgical units and theater hospitals, to in-the-air critical care in the Aeromedical Evacuation system, and ultimately home to a military or Department of Veterans Affairs (VA) medical treatment facility (MTF). With specific regard to our airmen

who are injured or ill, Air Force commanders, Family Liaison Officers, airmen and Family Readiness Center representatives, in lock step with Federal Recovery Coordinators, and medical case managers, together ensure "eyes-on" for the airman and family throughout the care process. For injured or ill active duty airmen requiring follow-up medical care, they will receive it at their home station MTF. If no MTF is available, as is often the case for our Guard and Reserve airmen, the TRICARE network provides options for follow-on care with case managers at the major command level overseeing the care. If transition to care within the VA is the right thing for our airmen—Active, Guard, or Reserve—we work to make that transition as smooth and effective as possible. For those airmen medically separated, care is provided through the TRICARE Transitional Health Care Program and the VA health system. The Air Force Wounded Warrior Program, formerly known as Palace Hart, maintains contact and provides assistance to those wounded airmen who are separated from the Air Force for a minimum of 5 years.

The AFMS provides timely medical evaluations for continued service and fair and equitable disability ratings for those members determined not to be fit for continued service. We will implement DOD policy guidance on these matters and all final recommendations from the pilot programs to improve the disability evaluation system. We have processes in place to ensure healthcare transitions are efficient and effective. Briefings are provided on VA benefits when individuals enter the Physical Evaluation Board process. Discharged members, still under active treatment, receive provider referral and transfer of their records. A key component of seamless transfer of care is a joint initiative by the VA and DOD, called the VA Benefits Delivery at Discharge (BDD) Program. Air Force MTFs provide the BDD Program advance notice of potential new service members and their health information through electronic transfer.

The Air Force Medical Hold Program is very different from our sister services. In the Air Force, those undergoing disability evaluation stay in their units. We work closely with wing commanders to ensure that our personnel receive timely disposition. The key to success in this process is comprehensive case management. Outpatients are managed by the home unit and major command case managers. The Air Force does not use patient holding squadrons for Air Force Reserve personnel in medical hold status since the majority of reserve members live at home and utilize base and TRICARE medical services. If members are outside the commuting area for medical care, they are put on temporary duty orders and sent to military treatment facilities for consultations for as long as needed for prompt medical attention. We are teaming with our Air Force Personnel counterparts to initiate efforts to further reduce administrative time without downgrading the quality of medical care.

Psychological Health and Traumatic Brain Injury

Psychological health means much more than just the delivery of traditional mental health care. It is a broad concept that covers the entire spectrum of well-being, prevention, treatment, health maintenance and resilience training. To that end, I have made it a priority to ensure that the AFMS focuses on these psychological needs of our airmen and identifies the effects of operational stress.

Post Traumatic Stress Disorder and Traumatic Brain Injury

The incidence of Post Traumatic Stress Disorder (PTSD) is low in the Air Force, diagnosed in less than 1 percent of our deployers (at 6 months post-deployment). For every airman affected, we provide the most current, effective, and empirically validated treatment for PTSD. We have trained our behavioral health personnel to recognize and treat PTSD in accordance with the VA/DOD PTSD Clinical Practice Guidelines. Using nationally recognized civilian and military experts, we trained more than 200 psychiatrists, psychologists, and social workers to equip every behavioral health provider with the latest research, assessment modalities, and treatment techniques. We hired an additional 32 mental health professionals for the locations with the highest operational tempo to ensure we had the personnel in place to care for our airmen and their families.

We recognize that Traumatic Brain Injury may be the "signature injury" of the Iraq war and is becoming more prevalent among service members. Research in Traumatic Brain Injury (TBI) prevention, assessment, and treatment is ongoing and the Air Force is an active partner with the Defense and Veterans Brain Injury Center, the VA, the Center for Disease Control, industry and universities. To date, the Air Force has had a relatively low positive screening rate for TBI—approximately 1 percent from Operation IRAQI FREEDOM (OIF) and Operation ENDURING FREEDOM (OEF)—but maintains our clear focus on this injury because of the impact it has on each individual and family affected.

Prevention

Several years ago the AFMS shifted from a program of head-to-toe periodic physical examinations for all active duty members and moved to an annual focused process, the Preventive Health Assessment (PHA), that utilizes risk factors, exposures and health history to guide the annual assessment. Through the use of the PHA, we identify and manage personnel readiness and overall health status, to include preventive health needs.

In addition, there are separate pre- and post-deployment health assessment/reassessment processes. Before deployment, our airmen are assessed to identify any health concerns and determine who is medically ready to deploy. The Post-Deployment Health Assessments are completed at the end of their deployment and again at 6 months post-deployment. Of note, questions are embedded in the post-deployment assessments to screen for Traumatic Brain Injury. These cyclic and focused processes allow us to fully assess the airmen's overall health and fitness. This allows commanders the ability to assess the overall fitness of the force.

DEPARTMENT OF VETERANS AFFAIRS SHARING INITIATIVES

Our work with the VA toward seamless care and transition for our military members is a high priority, particularly as we treat and follow our airmen redeploying from Operations OEF/OIF.

An important lesson learned from the care of our returning warriors is the need for a seamless electronic patient health record. After assuming command and responsibility for the Bagram and Balad hospitals, the Air Force successfully deployed a joint electronic health record known as Theater Medical Information Program Block 1. This revolutionary in-theater patient record is now visible to stateside medical providers, as well as those within the battlefield. Additionally, clinicians can access these theater clinical data at every military and VA medical center worldwide using the joint Bidirectional Health Information Exchange. This serves to improve the overall delivery of healthcare home and abroad for wounded and ill service members.

We are expanding our sharing opportunities with the VA, establishing a fifth joint venture at Keesler AFB Medical Center and the Biloxi VA Medical Center in Mississippi. This new Center of Excellence will optimize and enhance the care for DOD and VA patients in the area.

Our joint venture at Elmendorf AFB, Alaska, is another Air Force/VA success story. In 2007, the 3rd Medical Group at Elmendorf increased their access by more than 200 percent for veterans in areas such as orthopedics and ophthalmology. This effort enhanced readiness training for 3rd Medical Group medics, and increased the surgery capacity by 218 percent for the 3rd Medical Group and 239 percent for the VA. Sharing our medical capabilities not only makes fiscal sense and improves access to care for our patients; it helps to sustain our medics' clinical skills currency so we remain prepared for tomorrow.

PREPARE FOR TOMORROW'S CHALLENGES

Our Medics

The demanding operations tempo at home and deployed locations also means we must take care of our Air Force medical personnel. This requires finding a balance between these extraordinarily demanding duties, time for personal recovery and growth, and time for family. We must recruit the best and brightest; prepare them for the mission and retain them to support and lead these important efforts in the months and years to come. We work closely with the Air Force Recruiting Service and the Director of Air Force Personnel to maximize the effectiveness of the Health Professions Scholarship Program (HPSP) and recruitment incentives. HPSP is our primary avenue of physician recruitment accounting for over 200 medical student graduates annually. Once we recruit the best, we need to retain them. The AFMS is undertaking a number of initiatives to recapitalize and invest in our workforce. Enhancing both professional and leadership development, ensuring predictability in deployments, and offering financial incentives, are all important ways in which we will improve our overall retention.

Graduate Medical Education

Our in-house Graduate Medical Education (GME) programs offer substantial benefits and are a cornerstone for building and sustaining our AFMS. The Air Force has 35 residencies in 18 specialties, and 100 percent of these are fully accredited compared to a national civilian average of 85 percent accreditation. This caliber of quality and commitment translates to a 95–98 percent first-time board pass rate for Air Force, Army and Navy program graduates which meets or exceeds the civilian

national average for each of our specialties. Two of our GME programs, the Emergency Medicine and the Ophthalmology Residency Programs at Wilford Hall Medical Center TX, are rated among the top in the Nation.

Centers for Sustainment of Trauma and Readiness Skills

Training our Expeditionary Airmen to be able to respond to any contingency is critically important. The Centers for Sustainment of Trauma and Readiness Skills (C–STARS) provides hands-on clinical sustainment training for our physicians, physician assistants, nurses, and medical technicians in the care of seriously injured patients. Our medics learn the latest trauma techniques and skills from leading medical teaching facilities, including the University of Maryland's R. Adams Cowley Shock Trauma Center in Baltimore, MD; the Cincinnati University Hospital Trauma Center; and the St. Louis University Trauma Center. These C–STARS sites offer an intense workload coupled with clinical experience that sharpens and refreshes our medics' trauma care. This training increases our knowledge and helps us care for the most critical injuries. We are developing plans to enhance training for our oral and plastic surgeons to better respond to facial trauma.

Medical Treatment Facility Recapitalization

Our recent experience re-emphasizes that America expects us to take care of our injured and wounded in a quality environment, in facilities that are healthy and clean. I assure you that the Air Force is meeting that expectation. All 75 Air Force medical treatment facilities are regularly inspected (both scheduled and unannounced) by two nationally recognized inspection and accreditation organizations. The Joint Commission inspects and accredits our Air Force medical centers and hospitals, while the Accreditation Association for Ambulatory Health Care inspects and accredits our outpatient clinics. These inspections focus on the critical areas of quality of patient care, patient safety, and the environment of care. All Air Force medical facilities have passed inspection and are currently fully accredited.

Telehealth

Telehealth applications are another important area of focus as we seek improvements and efficiencies in our delivery of healthcare. Telehealth moved into the forefront with the Air Force Radiology Network (RADNET) Project. This project provides Dynamic Workload Allocation by linking military radiologists via a global enterprise system. RADNET will provide access to studies across every radiology department throughout the AFMS on a continuous basis. Its goal is to maximize physician availability to address workload, regardless of location. Our partnership with the University of Pittsburgh Medical Center in this endeavor started over 6 years ago. Together we built telemedicine programs across the AFMS through the development of the Integrated Medical Information Technology System. This effort is providing teleradiology and telepathology to the AFMS. We are aggressively targeting deployment of this capability in fiscal year 2009 to all Air Force sites.

Also scheduled for fiscal year 2009 deployment is the Tele-Mental Health Project. This project will provide video teleconference units at every mental health clinic for live patient consultation. This will allow increased access to, and use of, mental health treatment to our beneficiary population. Virtual Reality equipment will also be installed at six Air Force sites as a pilot project to help treat patients with post traumatic stress disorder. This equipment will facilitate desensitization therapy in a controlled environment.

Benefit Adjustments

Increased health care demand combined with the current rate of medical cost growth is increasing pressure on the defense budget, and internal efficiencies are insufficient to stem the rising costs. Healthcare entitlements need to be reviewed to ensure the future of our high quality medical system and to sustain if for years to come.

CONCLUSION

In closing, Mister Chairman, I am intensely proud of the daily accomplishments of the men and women of the United States Air Force Medical Service. Our future strategic environment is extremely complex, dynamic and uncertain, and demands that we not rest on our success. We are committed to staying on the leading edge and anticipating the future. With your help and the help of the committee, the Air Force Medical Service will continue to improve the health of our service members and their families. We will win today's fight, and be ready for tomorrow's challenges. Thank you for your enduring support.

Senator INOUYE. Before I proceed with my questions, I believe I speak for the subcommittee in thanking all of you, and the personnel you command for the service you render us. You make us very proud of what you're doing for us.

If I may, I'd like to be a bit personal about this question. A few weeks ago, the men of my regiment got together to celebrate their 65th anniversary. And at that time one of the fellows piped up and said, "You know, we're lucky, we were in an easy war."

By "easy war" he meant that the aftermath wasn't as stressful and demanding as today's war. Take my case, for example. It took me 9 hours, from 3 o'clock in the afternoon, to midnight, to be evacuated from the combat zone to the field hospital. Today, I suppose, I'd be picked up by helicopter, and I'd be in a field hospital within 30 minutes. And that alone has made one dramatic difference.

Today when you look at photographs and go to Walter Reed, you will notice that double amputations are commonplace. In my regiment, there isn't a single surviving double amp. They either died of loss of blood, or shock, or something like that. But today, since, well, evacuation is so speedy, and the medical technology is so refined, they survive. In my day, whenever there's a huge battle, and stretchers are lined up in a tent, teams of doctors would go down the line and decide who to care for, and who will rest in peace. I was one of those selected to rest in peace, because the chaplain came by and said, "Son, God loves you." And I had to tell him, "You know, I'm not ready to see God, yet." And they changed my designation, and put me in surgery.

That brings me to my question. I note that there's a proportionately greater number of those with brain injuries, with stress problems, psychiatric problems, than I can remember in World War II. Are we making a special effort?

General SCHOOMAKER. Sir, let me, if I could start by making a comment from the standpoint of the Army.

First of all, I'd be very reluctant to compare the sacrifices and challenges facing your generation of soldiers or any generation of soldiers, sailors, airmen and marines in any war—I think those comparisons are very difficult, and probably not for people like me to make. I think we're all struck by the sacrifices and the courage that your generation demonstrated on the battlefield in defense of this country.

I would venture to say that many of the challenges that your generation of soldiers faced, and marines and others, faced, continue to face all soldiers, in all conflicts. And one of the things that I think distinguishes this conflict is that we, as an Army, and I think we as a joint force are stepping up and acknowledging, really, what have been generational challenges to all combatants.

The challenges of post-traumatic stress, which have attended every battlefield, probably, since the beginning of war, but have not been well documented, well acknowledged, and well understood—we're in an era of invention and discovery, and of appropriate training for resilience, screening for early emergence of symptoms and prevention of longstanding effects of combat exposure. In that respect, sir, I would say that we are making great headway.

There's much to be gained, and much to be learned, yet, about the overlap between post-traumatic stress symptoms that attend a

deployment, and especially in an active combat zone, and exposure to the horrors of war, and coexisting symptoms that may attend, for example, a concussive injury that is received as a consequence of blast.

The second point I would make, is the one that you've made. We have made—as Admiral Robinson and Admiral—excuse me, General Roudebush have referred to—extraordinary strides in breaking what we thought was an unbreakable limit on survival of battlefield. In Afghanistan and Iraq today, and conceivably in every conflict that we're going to face in this era of persistent conflict with an adaptive enemy that uses blast very effectively—I've said in many fora that the signature weapon of this war is blast. The signature wounds are many, but the weapon is blast.

We are encountering a constellation of injuries, and psychological challenges that are heretofore unprecedented in terms of survival. No, even civilian trauma center, sees the degree, and we know that because we bring civilian traumatologists to Landstuhl, and we take them into Baghdad. We take them into Balad, and we take them into Evensina, and we let them operate with us, and we let them observe what our soldiers and marines and sailors and airmen are exposed to. And they come away saying, "We don't see this degree of trauma." And yet, at the same time, "We don't see this survival."

And that is the consequences, as Jim Roudebush has said, of this enormous cooperation across the services, in our joint theater trauma team, and our registry and in real-time revision of our practices and our procedures and our devices that have kept soldiers from the point of injury to the VA hospitals or civilian network hospitals, or military hospitals back home, improving all along the way.

So, yes, sir—we are making great strides—it's an era of discovery.

Senator INOUYE. Well, I'm glad we've recognized that there's such a thing as stress disorder. I can still remember, because I'm old enough to—when in the ancient war, World War II, a well-known general slapped a soldier because he was afraid, and after the Vietnam war, we looked down upon those who said, "I've got stress disorder," that they were just moaning and squawking and lazy.

But, I'm glad you realized the real thing, now I hope we can do something about it, because in that ancient war, at least we knew who'd be shooting us—they were in uniform. Today, there's no one in uniform on the other side. Somebody who may be the friendliest-looking fellow, may be the most violent enemy you have.

RECRUITING AND RETENTION

So, my second question is, in light of the changes in medical service, are you having a terrible time in recruiting and retaining? Because I know the, on the outside world they're having the same thing, there are not enough nurses, there are not enough specialists—how about the Navy?

Admiral ROBINSON. Senator Inouye, we are having difficulty in recruiting and retaining in that we are in the competitive market of the entire Nation, and we have a few things that the entire Na-

tion doesn't have, and that is a volunteer force that's fighting a war. So, there are challenges that do present themselves from a medical recruitment and retention perspective.

Second, the optempo that we have and the repeated trips into war zone or repeated trips into operational environments become a stressor, not only on the individual—which probably has a direct effect in the amount of psychological stress that occurs—but additionally it has a huge effect on the families.

If you take generations of servicemembers in the past, most were unmarried. If you take our present generation of servicemembers, most are married. So, therefore, there is a new dynamic that has been introduced into the recruitment and into the retention calculus, which includes that family.

So, there are lots of factors that are making it a little bit more difficult to attract people and bring them in. But I would say that we've made significant advances in the last several years on the Navy side, by making sure that we, medical professionals, are directly involved in going to medical schools, and going to professional organizations, and actually talking about what we do, and what we need, and what people can get from service to the country. Because, as an all-volunteer force, there are a lot fewer people today in the recruitment pool than in years past, but certainly the necessity of making sure that people understand what we need, and their obligations to the country, is huge.

I think that we are slowly making turns, and I would also say that the retention and the bonus systems that you have applied for our medical officers—for our medical service Corps officers, our psychologists, our licensed clinical social workers, has made—our dentists, also, and our nurses—has made a tremendously positive impact in becoming more competitive in the job market.

So, that's a mixed answer. I think there are some trends that are hopeful, but there are also challenges, particularly with families and with some of the new dynamics of optempo that we'll have to take into account.

Senator INOUYE. General—General Roudebush—do you believe that the personnel, in the medics—I'm talking about the family—doctors and physicians and nurses—do you believe that they are appropriately recognized by the people of the United States?

To put it another way, is their morale high, or low?

General ROUDEBUSH. Sir, the morale is good. I would share the concerns of General Schoomaker and Admiral Robinson, in that as we work to recruit the best and the brightest from a rather diminishing group of willing candidates in the United States, it is more challenging to bring these individuals on.

But the things that we need to provide them, one, in terms of proper compensation, we have a special pays process and foundation that has not been changed drastically over the last 10 to 12 years. In the last year or two, we have made a lot of progress—and thank you for helping us do that—in order to move that forward, and to make the compensation more competitive.

But it goes beyond that. It goes to the working circumstances, the environment of care. As General Schoomaker pointed out, many of our facilities are aging. It is difficult, in some cir-

cumstances, to provide the quality of care that we need to because of aging infrastructure, but we are working through that.

I will tell you that what underpins the morale most firmly, however, is the services that these individuals provide. Quite often, a deployment will be—it always is—a very challenging opportunity, but it's not uncommon for it to be a life-changing opportunity. And I'll talk to physicians or nurses or technicians at Balad or Kirkuk, or Bagram, and they will tell me, "This is what I am trained to do. This is one of the most meaningful moments in my life." Being able to use their talents, use their skills, in a way that truly makes a difference—and come home and continue to do that. Because the care and the rehabilitation and the ongoing care of these men and women who go in harm's way, is a challenge. We are certainly working through that.

But, the fact is, the morale is good. But, we need to pay attention to all of those factors, in terms of operations tempo, our facilities, our compensation system, and our graduate medical education in order to remain competitive and retain these folks. There is a high demand for our military medical professionals in the private sector. These are folks who come out with skills, a demonstrated sense of purpose, and ethics, and they are incredibly valuable, and are compensated appropriately in the private sector.

So, it's a demanding environment, but sir, the bottom line is morale is good.

Senator INOUYE. Thank you very much.

Senator Stevens.

Senator STEVENS. Thank you very much.

RECRUITMENT FROM MEDICAL SCHOOLS

Admiral, you mentioned, the recruitment is fairly low, now, from medical schools. Do you have any idea what percentage of medical school graduates entered the military services?

Admiral ROBINSON. Sir, I could not tell you the number of medical school graduates that enter military service.

I can tell you, that in our HPSP—the Health Professions Scholarship Program—that we have—we have not met our goals for the last several years, as I mentioned in my opening statement, but we have increased the numbers, and we are probably at the—in the 60 to 70 percent range of making goal, and that seems to be trending upward. But total numbers of physicians coming out of medical school, coming into military services, is going to be a very, very low number. But I cannot give you that number. I will try to get it—unless someone else has it.

General ROUDEBUSH. We have looked at that, in terms of the percentage of individuals in medical school classes that are willing to consider the military, and it's less than 10 percent. It's probably more on the order of 7 or 8 percent. So, it's relatively low.

Senator STEVENS. Some time ago, I proposed that those people to receive a financial assistance from Federal taxpayers for graduate education, be compelled to provide service to some form of our Federal Government—not necessarily the medical side.

But I'm disturbed to hear that, because I think the bulk of those people that are going through graduate schools today are receiving substantial Federal assistance. And it does seem to me that there's

an obligation to serve, to deal with the great problems of those people who are in harm's way right now.

Let me ask you this, General Roudebush. I'm sure you know, and you just gave the 3rd Medical Group at Elmendorf, I believe, we have a situation there where the Air Force is caring for the 4/25th Combat Brigade, and the combat team that's come back to our State—and doing very well. Is there any other place where we're taking care of the returning veterans of one service in the hospital of another service?

General ROUDEBUSH. Oh, yes, sir. And I would begin with the wonderful care that our airmen receive at Walter Reed and Bethesda, in terms of care of their injuries, and as we transition and take care of soldiers and sailors at our facility—whether it's Elmendorf in Alaska or Wright-Patterson in Ohio, or Wilford Hall in Texas—we do see each other's soldiers, sailors, airmen and marines.

I think it's important to note that one of the key values of our military healthcare system is that we have developed centers of excellence, and I'll let General Schoomaker and Admiral Robinson talk about that. But in terms of amputee care, there is no place better than Walter Reed, or Brook Army Medical Center, in terms of head injury care, there's no place better than Bethesda Naval Hospital.

The Center of Excellence for Psychological Health and Traumatic Brain Injuries is a joint endeavor, and actually as we move toward the base realignment and closure (BRAC) implementation, these large platforms will, in fact, be joint.

I have Air Force physicians, nurses, technicians, working at Walter Reed, for example. We certainly share the platform at Brooke Army, and we work very closely with our allies in Alaska to take care of the folks there in Anchorage, as well as in Fairbanks.

So, it's a very collaborative environment that allows us to serve our servicemen of whatever service, close to their home, or in the best circumstances possible.

Senator STEVENS. Well, I would hope that there would be a better integration—particularly of knowledge of the expertise of particular areas, as you've mentioned, for dealing with some of these specific cases of people who are coming back who have a really different problem than the bulk of those who are returning. And I think that's true for those people who have been involved in units such as the Stryker units, where if they have any problems, they really have pretty severe problems. I would hope that there would be further integration.

General ROUDEBUSH. Sir, I might add that the Air Force is very proud of our ability to both be critically centered in the saving of these lives, forward, in the joint theater trauma system, but then through the aeromedical evacuation system, our critical care, our medical transport teams, to bring these severely injured servicemen and women back home to their families and definitive care, where it's best applied. Whether it's at one of our military centers of excellence, or one of our VA polytrauma centers, which are superb in treating some very, very significant and very complex injuries.

So, it really is an interdependent and interoperable system that's providing care that heretofore has never been seen.

Thank you.

Senator STEVENS. General Schoomaker, and Admiral Robinson, I'm interested in the comment that General Roudebush just made, concerning Walter Reed and Bethesda. We have a BRAC deadline for completing the integration of these facilities now, and some of us are—I'm one of them—are not too happy to see a total integration of those two facilities—what is going on out there, and will they meet the deadline?

General SCHOOMAKER. Well, first of all, sir, let me just quickly echo what General Roudebush commented about, about the jointness of care. You know, the color and type of a uniform really makes no difference when it comes time to taking care of a warrior.

Senator STEVENS. It's not that—not that. I was concerned about whether or not there was access to these various entities, without regard to uniform.

General SCHOOMAKER. Oh, yes, sir, there's—I mean if you go to Landstuhl today, it's very hard to tell a Navy corpsman from an Air Force critical care doc, from an Army nurse——

Senator STEVENS. I'm not talking about them, I'm talking about people coming in.

General SCHOOMAKER. Exactly, sir. We are mixing the joint force to care for them, and we ecumenically care for the combatant, independent of what uniform they have. And I think one of the strengths as Admiral Robinson has mentioned, is that we are a disseminated system of direct care that can provide access to all of these.

As far as the integration and co-location of facilities in the National Capital Region, integration of the National Naval Medical Center, Bethesda, and Walter Reed Army Medical Center has been ongoing, now, for a number of years. It's—full integration is very close, at this point. The Departments of Orthopedics and Rehabilitative Services, Departments of Obstetrics and Gynecology, medicine, surgery, these are all—and neurosurgery—these are all integrated programs now. We have a single chain of clinical command and directorship for Navy and Air Force—excuse me, Army services between, and the National Naval Medical Center, Bethesda, and Walter Reed, and have been working on that for a number of years. When Admiral Robinson commanded Bethesda, and I commanded Walter Reed, we worked very closely in this.

Co-location of the two facilities is what's going to be culminated in the final building of the Walter Reed National Military Medical Center, and the closing of Walter Reed, and the coalescence of the two facilities in one. But integration is ongoing, and it's very—being very aggressively pursued, and very successfully so, sir.

Senator STEVENS. And what's the use of the old Walter Reed going to be? What is the plan for that?

General SCHOOMAKER. Sir, that's not for me to say that. Under BRAC law, that's going to be turned over to other elements of the Federal Government, I understand the General Service Administration, Department of State have put a claim on that. But I don't have any notion of how it's going to be used.

Senator STEVENS. We have been looking at the conversion of medical to civilian activity as far as the treatment is concerned. Is there a plan in place for the conversion of these people over a period of time who are getting training and care, in your military medical facilities, is there a plan for, and do you follow a plan with regard to conversion over civilian treatment?

General SCHOOMAKER. Yes, sir. That's been ongoing from the beginning. Whether it's in the VA system, or whether it's in a network of private care, in partnership with our management care support contractors—all of the services—Admiral Robinson referred earlier to the Navy model of a more distributed, disseminated model that puts care closer to the home, and the home unit of the marine or the sailor. The Army uses a more centralized model, but still promotes getting the soldier and his or her family as close to home—or the parent unit—as possible, as close as possible and——

Senator STEVENS. Well, I'm taking too long. But my main concern is bringing these people—our people that have been assigned to Alaska, they're bringing back to Alaska, they're going to the Elmendorf hospital, regardless of what service they're in, and then there's a transition. Normally if they were at—in what we call the outside, the South 48—the transition would be to the VA. We don't have a VA facility.

General SCHOOMAKER. Yes, sir.

Senator STEVENS. We have to transition automatically to civilian operations for civilian care. And civilian care in our State is limited—just as you are competing for doctors, we're competing for doctors, and they're not there right now.

General SCHOOMAKER. Yes, sir.

Senator STEVENS. So, what is the plan for people in those circumstances—will they be moved back to Washington to somewhere else, if there's not a VA hospital?

General SCHOOMAKER. Exactly, sir. I mean, we try to target the care, especially for a persistent wound or injury or illness to where they can best receive that service—civilian, VA, or military direct care system, and in compliance with the needs and requirements of the family and the soldier. And that's a very, very individuated decision.

VETERANS HEALTHCARE

Senator STEVENS. Well, that worries me, because our State has the highest level of volunteers, per capita, in the country. And as they're coming back, they're going to the military hospital in Anchorage, the Air Force hospital. Some of them are going to Bassett up in Fairbanks, but not many. And once they're through that care, it looks like they're going to be shifted back outside, and their families are still in Alaska.

I would hope that somehow we would work out some kind of a VA—a concept for Alaska—so they don't have to be moved back outside to go through VA, and then moved back into Alaska when they finally transition into civilian care. Most of these are very long-term care we're talking about.

Admiral ROBINSON. Senator Stevens, one aspect that probably is also helpful in the continuum of care as a member, is transition from active duty, goes through a disability evaluation process—and

it does depend on how that process goes in percent—that member and family often are then able to obtain TRICARE benefits which would be directly usable in any of the treatment facilities in Alaska, in the sense that TRICARE would then become one of the methods that could be utilized.

It's not completely satisfactory—I understand your dilemma in Alaska—but it certainly is one of the other aspects of care of our returning warriors.

Senator STEVENS. Well, in our State that would be transition in many of the rural areas, Indian Health Service hospitals. I don't know whether you've ever worked out any arrangements with them, but I'd encourage you to do so.

Thank you very much, I've taken too much time already.

Senator INOUYE. Senator Mikulski.

Senator MIKULSKI. Thank you, Mr. Chairman, and gentlemen for the excellent testimony.

All of us recall where just a very short time ago, this room was jam-packed for a hearing on military medicine because of the press accounts on the Walter Reed scandal. We want to thank you for what you've done to clean that up, and that's going to be, really, my line of questions.

We want you to know, we're on your side. For those of us who've never worn a uniform, know that we feel that the best way to support our uniformed services, is not only in the battlefield, but with military medicine. And the opstempo that you face, the challenges of a war that's gone on for so long, the volume of injury, the new kinds of injury, and the old kinds of injury. And what we see is almost a 50-year war, in the sense of, not over there, but when we look at these men and women who've come back, some bear the permanent wounds of war, all will bear the permanent impact of war, and we need to know what that means—from stress to terrible injuries like amputation.

So, what I want to follow in my line of questions today is, what did we do in response to Walter Reed, and I'd like to refer in my questions to the Dole-Shalala report, which I think was a definitive report, and gave us benchmarks and guidelines about where to go.

I'd like to thank General Pollock, General Schoomaker, who—during the interim of change from one Surgeon General to the other, really stepped up to the plate and, I think we owe her a debt of gratitude, and we'll be talking to them about the nursing shortage later.

But here's what Dole-Shalala said, "We need to serve those who were injured, support their recovery and their rehabilitation, and simplify the complex system that frustrates soldiers and families." Their very first recommendation was, create a patient-centered recovery plan. And with that, I believe you've established something called the warrior transition units (WTUs)—that, in other words, it was not only the brilliant work done on the battlefield, at Lundsfeld and the hospital here—or even at Walter Reed itself—but it was what happened when they transitioned from acute care to outpatient care, that people began to fall between the cracks.

Could you tell us what you've done to implement Dole-Shalala, to create a patient-centered recovery plan? Where are we on the warrior transition units—do we have enough of them? Do we need

more people? Do you need more money? What do we need to do to implement Dole-Shalala?

General SCHOOMAKER. Yes, ma'am, thanks for that question—and you're absolutely right, we owe a great debt of gratitude to Major General Pollock, who stepped into the breach as the acting Surgeon General during that time, and really took the bull by the horns, as we were working at the operational level to make changes.

Probably, in a nutshell, I would say that what the Army did, almost immediately, was to stand up a program we call the Army medical action plan. And a commission chartered by the Chief of Staff of the Army, the Secretary of the Army, and overseen very, very closely by the Vice Chief of Staff of the Army, Dick Cody.

The Army medical action plan, overseen by Brigadier General Mike Tucker, who served as my Deputy Commander at the North Atlantic Regional Medical Command, and then later was elevated to an Assistant Surgeon General, the first Assistant Surgeon General for Warrior Care and Transition. The Army medical action plan began immediately to identify problems, to work closely with the Independent Review Group, chaired by former Secretaries of the Army——

Senator MIKULSKI. Please, General, I have limited time.

General SCHOOMAKER. Yes, ma'am.

Senator MIKULSKI. Tell me what we're doing for patients, rather than military bureaucracy and acknowledging the wonderful people who did it.

General SCHOOMAKER. Ma'am, the answer was intended to describe that, as Dole-Shalala stood up, we took every idea and every recommendation of Dole-Shalala on the fly, and applied that. And the Army today has created that patient-centered program that is described, is working very closely with the VA and the other services to provide the care that Dole-Shalala——

Senator MIKULSKI. But how many do you have?

General SCHOOMAKER. I have 35 warrior transition units, we currently have 11,280 soldiers, warriors in transition that have been taken out of a variety of units in the Army with wounds, illnesses or injuries—many non-battle related—and are now cared for in a patient-centered focus around a triad of care. A squad leader at the small unit leader level, a nurse case manager, and a primary care physician.

Senator MIKULSKI. General, let me go to the case managers, because in February 2007, besides the fragmented senior leadership—which obviously, from your description, has been corrected—there was a lack of integrated casework. There were no, really, primary care managers. The nurse case managers had been eliminated, in yet one other DOD reorganization plan years ago. There were no advocates, forgotten families, complaints fell on deaf ears—you know them, I don't need to give the laundry list.

Can you tell us now where we are in the case management? And do you really have enough of these warrior units—I think the military action plan is a great way for implementing the Dole-Shalala recommendations. But, where are we on the care managers? What is the ratio? The nurse case managers, with the nursing shortage? Do you have enough? Is there an ombudsman in every unit?

General SCHOOMAKER. Yes, ma'am. It's very, very closely monitored—thanks for that question—it's very closely monitored——

Senator MIKULSKI. Because it goes to your human capital needs.

General SCHOOMAKER. Yes, ma'am.

Senator MIKULSKI. These are not meant to be, "Are you doing your job?" it's how do we all do our job?

General SCHOOMAKER. Well, I think what the Walter Reed experience taught was that we had drifted over the last two decades to a model of pure inpatient and outpatient medicine, and we'd forgotten much of what Senator Inouye's generation was exposed to, which is an intermediate rehabilitation capability that had transition from one to the other. We've recreated that. And we've partnered with the VA and with the private sector, now, to have a very comprehensive handoff—we call it a comprehensive care plan—that begins almost from the point of injury, and throughout the acute phase, the recovery phase, and the rehabilitation phase, even into the VA or the private sector, we have a system of administrative leaders, of clinicians, and of nurse case managers, working in close relationship with VA coordinators, as well, to ensure that we've got this warm handoff taking place.

Senator MIKULSKI. Well, that's the plan, but let me go again. Do you have enough nurse case managers?

General SCHOOMAKER. Ma'am, we've managed—we manage that very closely, we monitor it, our ratios—our expected ratios of nurse case managers to warriors in transition is 1 to 18. We closely monitor that to ensure that we've—we are safe in all regards.

I would have to say, as the population continues—as we identify more soldiers that are better cared for in the WTUs, we bring them in and bolster the——

Senator MIKULSKI. And remember, these are not accusatory questions——

General SCHOOMAKER. No, ma'am.

Senator MIKULSKI [continuing]. These are how do we get to make sure?

General SCHOOMAKER. And there's probably no group in that triad of care right now that is more challenging to recruit than our nurse case managers.

Senator MIKULSKI. And we're going to come back to that.

Does every unit have an ombudsman?

General SCHOOMAKER. We have 29 ombudsman across the 35 units, some of them are regional in their focus, but they have access to an ombudsman in every warrior transition unit. And in the large ones, we have assigned one or two ombudsman directly.

Senator MIKULSKI. And we asked that a hotline be established, so that if you had a problem——

General SCHOOMAKER. Yes, ma'am.

Senator MIKULSKI [continuing]. You could dial 100, 1–800, Hi Army, I need help.

General SCHOOMAKER. We have a 1–800 line, I'd be happy to pass a card to you. We pass these cards out to every family member and soldier and members of the community. Any question about any aspect of anything, from pay to housing to nonmedical attendants, we've got a hotline that solves the problem. We've taken about 7,000 to 8,000 calls in the last year to this hotline.

Senator MIKULSKI. Well, I just have one other area of questioning and come back, because this is really digging into it.

Coming again back to Dole-Shalala in our own conversations, it says to restructure the disability systems, and we need to have a seamless effort between VA and DOD. One, the transition of the warfighter from military to VA, and that goes to the transition of care, and then this whole issue of reorganizing the benefit structure.

Both you and, also our other Surgeons General, how do you think that's working? The feedback I get anecdotally in my own State is that it is enormously uneven, that the real problem—one of the real problems here in implementing the recommendations from Dole-Shalala is that the connect between, I'll call it DOD medicine, and then VA—both particularly in the areas of disability benefits and handoff—can be disjointed.

General SCHOOMAKER. Ma'am, the current system of disability, the VA and DOD systems, was developed 50 to 60 years ago, in an era in which, as Admiral Robinson said, our soldiers, sailors, airmen, marines were largely single, we did not have a TRICARE healthcare benefit, and we did not have the complex wounds that we see today.

In 2008, what we're now faced with is a system of disability adjudication in the DOD that largely focuses on whether you're fit for duty or not, and then adjudicates disability based upon that single unfitting condition, even if you've got a variety of other injuries or problems, and even using the same tables of disability that the VA uses.

The VA then turns to the same soldier and says, "I will now assess disability based upon the whole person concept, and your employability and your quality of life." The military attachés to the disability adjudication for that single unfitting condition, whether or not you have access to lifetime benefits for TRICARE. And for a family who is seeking, and a soldier who is seeking disability at a threshold, 30 percent, that then gets them access to TRICARE, they see the military as being stingy for them, while the VA does not.

Until we have a single system of disability adjudication, and a national debate about what service and injury or illness in-service warrants that soldier, sailor, airman, marine, we will not resolve the flashpoint injury—the problem of the physical disability evaluation system.

Senator MIKULSKI. Well, there's an 18-month backlog in getting evaluated for VA disability. That is the subject of another hearing, General, and not your responsibility, but it is.

But it goes to what Senator Stevens raised about the Alaska soldiers. What I hear from my own—a lot of my own military that have suffered injuries, is the reason they seek a 30 percent or more disability, it's not for the money or commissary privileges, because they'll stay in TRICARE. And in TRICARE they feel that they have a medical home, and they know the rules of the game. And that medical home means they can have access to military facilities, where those academic centers of excellence or others in their own community, but they know they will have a home.

When they worry that if they go to VA, the disability ascertainment is prolonged, there's enormous stress on them, you have to go to the VA facilities. They feel that they're going into a black hole that they don't know from which they're going to emerge.

So, what they like about the military and TRICARE, is they feel it's been their one-stop shop, even as they might be transitioning to civilian life.

And, what we worry about, then, because it's really been the Walter Reed scandal, and then these excellent commission reports that was to drive, pretty strongly, that there be this, really, seamless connection between DOD, military medicine, and the transition. So my question is, do you feel—in addition to the need for a national debate, and I agree—do you feel that this is really happening? Do you feel that there is this same sense of urgency when this was all over CNN?

General SCHOOMAKER. Ma'am, I think there's a great sense of urgency, and we have a pilot program right now in the National Capital area in which we're looking at a large number of soldiers, marines, and others to see if we can't smooth out and reduce the bureaucratic hurdles and hassles associated with the physical disability system in—under current law.

But I want to say that I think we all recognize that we still have this 500-pound gorilla in the room, and that is the threshold of disability and a single adjudication of disability that access——

Senator MIKULSKI. And who would make those decision?

General SCHOOMAKER. Ma'am, that has to—that is—that is in law, and without changing the law——

Senator MIKULSKI. But who makes the recommendations to change the law?

General SCHOOMAKER. I think right now the Senior Oversight Committee that is meeting between the VA and the DOD and is in a position to help make——

Senator MIKULSKI. But we're looking for the recommendations. Do we ask that of Secretary Gates, the Secretary of the VA, do we ask for a conversation with the President, how do we get these changes?

General SCHOOMAKER. I think that at the Secretary level is probably where it needs to begin.

General ROUDEBUSH. Ma'am? I agree. I think it does get to the secretarial level and above, because what you're—you are doing is you are making a decision based on both medical and administrative pay and benefit issues that encompass the entire benefit for that individual. So I think it does rightfully accrue to the leadership positions, and I would echo General Schoomaker.

At the Senior Oversight Committee, which is co-chaired by Deputy Secretary of Defense Mr. England, and Deputy VA Secretary, Mr. Mansfield, there is a sense of very important urgency to get this right, in order to be able to do that across the entire spectrum of activities to include medical.

Senator MIKULSKI. Well, I've exceeded my time and we'll go to this.

First of all, know that I believe real progress has been made. So, I believe that real progress has been made, and we thank all who were involved in that. I think there's still much to be done, because

these military warriors—these warriors are going to be with us a long time and we have an obligation. And not only where there's been these severe injuries.

Then there's this whole impact on the families. You said they were mostly single. Well, they also had a mother. When I visited these bases, it's either the spouse or the mother that's there. We viewed them as unpaid attendants, and if we get an opportunity for a second round, we'll be talking about the family. But, I think we're looking forward to regular reports and conversations on how to implement this, and we have to ask the Secretaries about this.

And, Mr. Chairman, I think it might be the subject of another hearing, particularly also with our colleagues in VA.

Anyway, thank you very much.

Senator INOUYE. Thank you.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman.

And thank you all for being here today, for your testimony, and for the work that you do for the men and women who serve our country. It's an honor for me to follow the angel on our subcommittee, and thank her for all of her work, as well as our chairman.

We were here 1 year ago under a lot of stress and looking at a system that was literally broken. And we have made a lot of progress, not just at Walter Reed, but across the country, out in my State at Madigan and other facilities. I've been there, I've been on the ground, I know that we're making changes, but I also agree with Senator Mikulski, we still need a sense of urgency. There are big questions left remaining. It is about how we work our way through this, but also how we have the resources to do it. And it's making sure that we have the commitment from this administration and from Congress to back them up. I know the American people are there, that when we ask someone to serve our country, we have to be there to follow up with the money to take care of what we—what their needs are, and I think that's part of what the challenge is that we face.

Senator Mikulski asked a number of questions about the whole process. Let me focus on a very real concern that I still have that really still needs a sense of urgency, and that is the invisible wounds of war, the psychological needs of our soldiers when they come home. I know I've talked to soldiers and airmen and, of all of our components who feel like they're a left behind because the American people can't see their physical wounds of war.

And we still have tremendous challenges in front of us. The MHAT 5, that was recently released, illustrated the psychological stress that our deployed servicemembers are under. I was concerned because this study only focused on the active duty. We have a large Reserve component, and particularly the National Guard that has really unique concerns. They've been deployed and redeployed, and it seems to me that there are no near-term plans to discontinue the use of our Reserve component. So I wanted to ask you, do you think it's important to evaluate their overall health, as well?

General SCHOOMAKER. Yes ma'am, I think MHAT 5, the Mental Health Advisory Team 5th iteration, fifth year, really focused on

two active component brigades only because of the force mix that was in-theater at the time, Afghanistan and Iraq. In past MHATs, they've also studied Reserve component brigades.

And this is one Army, ma'am, we are as concerned about the mental health challenges for the National Guard and Reserve as we are for our active component. In fact, as is pointed out by their leadership and by their State's representatives, they frequently have to go back into parts of America, as Senator Stevens has said, where we don't have access to the direct——

Senator MURRAY. That's correct.

General SCHOOMAKER [continuing]. System, the VA system is even sometimes not readily available.

Senator MURRAY. Do you intend to do an evaluation?

General SCHOOMAKER. Yes, ma'am, we're following that very closely, we're working with the Reserve component to look at the best solutions for those soldiers as they——

Senator MURRAY. I would like to be kept up to date on what your—what your evaluations are and your recommendations from those.

General SCHOOMAKER. And, ma'am, you need to understand, too, they're held to the same standard that—upon return and reintegration, 90 to 180 days after being redeployed, they have to go through a post-deployment health reassessment that screens for the symptoms of post-traumatic stress.

Senator MURRAY. Right. I am told that in the first part of the war, the ratio of servicemember to psychological healthcare provider in-theater was close to 800 to 1. We've been working on this and trying to improve it, but it's back up to 740 to 1 and rising. What is being done to reverse that trend?

General SCHOOMAKER. Ma'am, we've always stayed below what our target was, which was better than one behavioral health specialist to 1,000 soldiers.

We've—our biggest problem, I would have to say—and we've revised this on the fly—is the distribution of our soldiers. Many of our soldiers, especially in Afghanistan and other parts of Iraq, work in very distributed teams that are not accessible to our forward-operating bases and places where we have a density of—of mental health workers.

What we've done is to try to redistribute mental health workers. We work closely with the Air Force at Bagram, for example, which has got the lead on much of the healthcare in the Bagram area, to get care out to the individuals.

We're also——

MENTAL HEALTH PROVIDERS

Senator MURRAY. Is the—is there a challenge in filling the billets for healthcare, mental health?

General SCHOOMAKER. Oh, yes, ma'am. Our behavioral health specialists, psychologists, social workers, psychiatrists are some of the most frequently deployed.

Senator MURRAY. Is that true across the services?

General ROUDEBUSH. Yes, ma'am, it is.

Admiral ROBINSON. Yes, it is.

General ROUDEBUSH [continuing]. We have Air Force providers in support of Army units and other distributed units. So it's a very joint approach to that. And I would emphasize that it also goes beyond, although it focuses appropriately on the mental health and behavioral health professionals, we are sure that our other providers—both our critical care and our primary care providers—are also trained in detecting and treating issues relative to behavioral or mental health concerns, and to be able to trigger and get the individual to more definitive care, if required.

So, it's a broader system than just the mental health professionals, but obviously that's a key and critical part of it.

Senator MURRAY. I think it's one that we do need to focus on. And interestingly, I have a member of my staff who is a psychiatrist and he tried to volunteer his time to help servicemembers and their families who have TBI and PTSD, and was told that he couldn't volunteer. And I know, if he's one psychiatrist who's willing to do that, there are others. Any idea how someone can volunteer?

General SCHOOMAKER. Actually, the American Psychiatric Association has come forward with an offer of individual volunteers. What we try to do is provide that knowledge to patients.

Our problem is, we cannot certify thousands of voluntary psychologists or psychiatrists, under our system, but we can certainly give our patients——

Senator MURRAY. But if they are certified——

General SCHOOMAKER [continuing]. Access to the——

Senator MURRAY [continuing]. Psychiatrists, is there a way for them to provide a service, at a time when we need——

General SCHOOMAKER. We can get back to your staff and talk to you.

Senator MURRAY. I would like to know that. I mean, I'm sure there are other people in the country today——

General SCHOOMAKER. Yes, ma'am.

Senator MURRAY [continuing]. Who feel very strongly——

General SCHOOMAKER. The APA has been forthcoming.

Senator MURRAY [continuing]. About supporting our soldiers when they come home. They are certified and it seems to me that, you know, we ought to be using them.

General ROUDEBUSH. Yes, ma'am, in fact we do some of that through the auspices of the Red Cross, we do have medical professionals who volunteer, both home and we've had individuals at forward locations, at Landstuhl, for example, in that regard, so I really appreciate your interest in that.

Senator MURRAY. Okay.

SUICIDES

Let me ask specifically about suicides. Because the suicide rate is very disturbing—as it should be—to all of us. And I know the military says that personal and family problems contribute to the increase, but it's also apparent that there are other significant contributors—increased lengths of deployment, repeated deployments, decreased dwell times—I think we all have to agree have had a huge impact on the psychological health of the men and women who are serving us.

I know that there are several initiatives in the military to reduce the stigma of seeking mental health, and to providing professional mental health care. I'd like to ask you all how you see the efficacy of those initiatives today?

General ROUDEBUSH. Ma'am, I can speak to the Air Force Suicide Prevention Program, which was initiated in 1996, which is a broad-spectrum, community-based program which focuses on both the individual de-stigmatizing the act or the request for getting help, but also leverages all of the capabilities—whether it's mental health, family support——

Senator MURRAY. Do you see it working?

General ROUDEBUSH. Our suicide rate is 28 percent lower now than it was in 1996 when this was implemented. And the program has been reviewed by the fact and outcome-based entities within the United States, and has been found one of the few that truly, substantively works.

Senator MURRAY. Admiral.

Admiral ROBINSON. I think there are a couple of factors that are very important in the suicide rate. First of all, it is the number of exposures to stress, the number of exposures to the types of things that will create destabilizing, psychological events in one's life. And so, therefore, you need to look at who's, in fact, going forward, fighting, and being exposed to that repeatedly, as you're looking at the total psychiatric, psychological health and emotion health of an individual, and their family.

The second factor is, there has to be embedded—and I think that I will emphasize embedded—mental health professionals—not always psychiatrists, but social workers, psychiatric nurse practitioners, psychologists, psych technicians—that are with the units so that the stigmatization and other things become much less because that person, those team of people, become a lot less.

Senator MURRAY. And you have that?

Admiral ROBINSON. We have OSCAR units, we have seven. We think we need 31, so to your question of numbers—yes, we do not have enough, we need more, and it is exceptionally difficult. And then if you take into consideration that those psychologists, psychiatrists and mental health professionals are deploying at about the same rate as my general surgeons, you will see that trying to get people to stay under those types of circumstances becomes problematic. So, those are issues that need to be considered.

And third, there has to be training and teaching that occurs at all levels—it has to be from the recruit to the war college, it has to be the lowest level, and it has to have line leadership that is involved with it. It is not a medical issue, per se, it is actually a line and a leadership issue. Medical takes the lead on the education, line takes the lead on the implementation, and utilizing it, and getting it out to the people that need it.

So, those factors, I think, when you consider them, will reduce some of the issues with suicide, and with psychological issues——

Senator MURRAY. But I'm hearing you say we still don't have enough of that, across-the-board professionals on the ground, and that's a concern.

General ROUDEBUSH. That is correct. We do not have enough.

Senator MURRAY. General.

General SCHOOMAKER. We are greatly concerned about—the Army is greatly concerned about the trends in suicide, and we are looking very carefully at this. We have a general officers steering committee that has met several times, and is recommending expansive changes to the leadership of the Army.

I go back to what Admiral Robinson just said—suicide prevention ultimately is a commander's responsibility, and it revolves around small unit leadership, NCO and officer leadership. We in the medics are in support—along with the chaplains and others—and we are looking at a comprehensive program within the Army of education and reaching out to change the behaviors of small unit leaders and fellow soldiers, to identify the behaviors that will predict this impulsive act, frequently around the rupture of a relationship—either with the Army, or with a loved one—that seems to trigger this within the Army.

Senator MURRAY. Do you know what the wait time is for a soldier to see a mental health professional?

General SCHOOMAKER. In an urgent situation, there is no wait time, ma'am.

Senator MURRAY. How do you know if it's urgent?

General SCHOOMAKER. I mean, if it's identified as an urgent issue——

Senator MURRAY. Sometimes, somebody just comes to a door and says, "I need some help." If somebody just comes to the door and says, "I want to talk to somebody," what's the wait time, do you know?

General SCHOOMAKER. Again, if it in any way relates to suicidal behavior, ideation, or fear of——

Senator MURRAY. I'm not asking from an aggressive point of view, I—because our job is to provide the resources, so that you all can provide the people out on the ground. And my question in asking about the wait time is, that's critical knowledge for us to know whether we're providing enough resources for people.

General SCHOOMAKER. I think I would have to answer that it would be highly variable based upon the community. In some communities it may be as long as a week or 10 days. In other communities, it may be nearly instantaneous.

And it really is a function—in Fort Drum, New York, for example, where we're constrained to get the mental health resources that are needed, it might be a little more difficulty. In the National Capital Region, or in San Antonio, it might be a completely different matter.

Senator MURRAY. Okay, well, that is disconcerting to hear. And obviously we need to, I think, make sure we are dealing with those invisible wounds of the war, and providing the personnel and the support and all of the right processes.

I have a number of other questions that I'll submit for the record, but thank you very much, Mr. Chairman.

Thank you, to all of you.

Senator INOUYE. Thank you very much.

Senator Feinstein.

Senator FEINSTEIN. Thank you very much, Mr. Chairman.

Good morning, gentlemen.

DEPLOYMENT TIME

Now that troop deployment time has been reduced from 15 months to 13 months, I wanted to ask you for your reflection—from a medical point of view—on the length of a deployment, as it relates to health, and particularly stress. It seems to me that the unpredictability of the kind of war that this is for an individual, makes long deployments very difficult. And I wonder if there is any medical recommendation as to what the deployment should be—and by should be, I mean, a deployment that makes sense, that gives the individual the best, optimum time, without some of the adversities that long deployments seem to bring about. Is there any medical advice as to what that length should be? General Schoomaker.

General SCHOOMAKER. Ma'am, that's a difficult question—there's actually three variables, I think. The length of the deployment, the frequency of redeployment, and the dwell time between deployments. All three variables are critical.

Senator FEINSTEIN. But how would you—what would you say would be a model system which would minimize health impacts?

General SCHOOMAKER. It would be a system that probably reduces deployment length to the 6 to 9 month range. It would include a dwell time that exceeds 1½ years, or resets around 1½ years, at best, in the minimum, and reduces redeployment, obviously, to the minimum. And I think all of those things are focuses of the Army leadership.

Senator FEINSTEIN. Thank you.

General SCHOOMAKER. The MHAT studies, ma'am, have documented, in terms of stress—self-reported stress—what the effects of the longer deployments have done.

Senator FEINSTEIN. Admiral.

Admiral ROBINSON. Yes, Senator Feinstein.

The last thing General Schoomaker said about the studies—there's no question that repeated exposures to stress, repeated exposure to traumatic situations, will increase emotional and psychological health issues. The inability to get proper dwell time, to come back and to recalibrate, has a devastating effect.

I think what General Schoomaker outlined is very reasonable, I think the marine model of, probably, 6-, 7-month timeframe is optimum, ideal. And if that could occur within a dwell time that would exceed that amount, and come back to recalibrate, to reset, as it were, would be very good.

Senator FEINSTEIN. General, would you like to comment?

General ROUDEBUSH. Yes, ma'am. Of course, in the Air Force, our deployment times have traditionally been shorter—we've moved from a 120-day, for example, Air Expeditionary Force (AEF) rotation, but depending on the availability of a capability, the deployment time may be longer than that, maybe 180 days, maybe 1 year.

I agree with my colleagues that the 6 months, plus or minus, is probably a goal to approach, however, there are operational issues. If you're on the ground, building relationships, 6 months may be inadequate to really build the kind of relationships and become

mission effective. So, there are going to be those times when perhaps operationally, the deployment would appropriately be longer.

But, I can tell you that my leadership pays very close attention to the rotational dwell time. The policy looks to optimize that for the weapons system that we're utilizing. We are also working to assure to take care of the families, as well. With an all-volunteer force, the individual chooses to join, but literally, the family chooses to stay.

Senator FEINSTEIN. Right.

General ROUDEBUSH. So, it's important that we consider all of those factors as we look at our rotational and deployment policies.

Senator FEINSTEIN. You mentioned—if I just might follow-up with the General for a minute—you mentioned, dependent upon the weapons that are used—are you saying the more technologically developed those weapons are, the shorter the time should be?

General ROUDEBUSH. No, ma'am. We have weapons systems that are very highly, technologically capable, but are in limited quantities, and high demand. So, those systems tend to stay deployed for longer.

Senator FEINSTEIN. I see, I see.

General ROUDEBUSH. We also have individuals, for example, operating Predators who live in Las Vegas, drive to Creech Air Force Base, Nevada every day, perform that critical mission, and then come home. But those folks require care, as well, because psychologically, and from a mission operations tempo, that's a very demanding mission. And you have to be able to balance a family life with an operational life, that, for some of our airmen, is a very demanding issue.

This war has created scenarios that we need to pay very close attention to.

Senator FEINSTEIN. General, you wish to——

General SCHOOMAKER. Ma'am, I just wanted to make sure—I want to qualify my comments earlier. You asked me for a medical assessment——

Senator FEINSTEIN. That's correct.

General SCHOOMAKER. Not an operational assessment.

Senator FEINSTEIN. That's correct.

General SCHOOMAKER. There are obviously operational imperatives that dictate length of deployments and redeployment and dwell times between. But, from the standpoint of what we empirically observe are the stresses upon individuals and families, the model that I depicted probably begins to approach what we think is sustainable.

And we have models, for example, in the special operations community, special operations soldiers, airmen, SEALS, will deploy multiple times—eight, nine times—but for a shorter duration, with longer dwell times, that allow them to reset and prepare for the next deployment.

Senator FEINSTEIN. Do you think operations like that, the shorter deployment, the longer dwell time, is really the formula that we should seek for the future?

General SCHOOMAKER. Ma'am, I think that's really a mixture of operational and other considerations, that I'm really not prepared to answer.

Senator FEINSTEIN. I think, because one of the things that comes into this, this war has gone on for so long, and could conceivably continue on. And the kinds of injuries require long-term care. I'm thinking, particularly, because battlefield medicine is so good today—fortunately—that people who would have died from traumatic brain injury are saved, and they go on.

VETERANS CARE

But what I'm finding in areas, is that they really need more than the system out there gives them to sustain their relationships and their lives over a substantial period of time. And one of the things that I've just been thinking about, because when I visit the VA—particularly in Los Angeles, the big campus on Wilshire Boulevard, it's over 300 acres—the thought occurs, if this could be a kind of residential community where families that really need help, because somebody is damaged to the point that they can't really operate really well, receives the kind of nurturing that's going to be necessary for the rest of their life.

I think on a young family, this is a very hard thing to come to grips with. And I don't know if you all kind of at the top of the medical infrastructure has given it much thought. But, if you have, I'd sure like to know your thinking on that, whether it makes sense for us, as part of the VA, then, to build some real—some communities for families, where they can come and live. If the wife needs to work, she can work, but if the husband has a brain injury that's really going to suspend his effectiveness for the rest of his life, they get some additional care, on site.

Admiral ROBINSON. Senator Feinstein, I think that approach is very good. I have given this thought from a surgeon's perspective—I mean a clinical surgeon, not Surgeon General, also from a commander, and not the Surgeon General perspective. Military medicine has traditionally been acute care medicine, we are a victim of our own success, now. You're absolutely right, TBI and many other injuries that we have now, we have only because we have such an incredibly wonderful survivability rate.

Systematic rehabilitative care, has been traditionally the purview of VA. We now have a morphing of that, because we now have the acute care, active duty, or the military side, that has gotten involved in systematic rehab care. We also have had, through the years, between Vietnam and this war, disconnects—those disconnects between DOD, between military medicine and VA are much, much, much, much less now. But there was a ramp-up, and there were learning curves, there were issues. They are not over.

And the issue, then, becomes, because the issue that I think about a lot, is the sustainment of the care——

Senator FEINSTEIN. Yes.

Admiral ROBINSON. Senator Mikulski said the 50-year war, that is absolutely correct. Because we know that many of the individuals that we have coming back are going to need a lifetime of care.

So the goal is—how do we get to a sustainment of the care needed by the members and families, that we now have? And that is

a huge problem, and burden, on us from a military perspective, because you are a soldier for life, you are an airman for life, you are a sailor for life, you are a marine for life, you are a Coastie for life—we have an obligation to care for you. The key is, how? And again, systematic rehabilitative care has traditionally been the VA.

Your thoughts as to a possibility of how, seem very innovative and creative and, I think, should be explored. But we need to even take a deeper look as to how we're going to meld the DOD, the direct care, and the VA, the systematic rehabilitative care.

Senator FEINSTEIN. Thank you, Admiral.

General.

General SCHOOMAKER. The Admiral has echoed my thoughts. I know that what you are discussing is of great interest and focus of Secretary Peake, and the VA. And I think we're in an unprecedented era of urgency about cooperating between the military services and the VA. We have very, very good relations and exchange of thoughts, ideas, people and the like.

I would—this may be a good point to insert—there have been several truly miraculous events, if any war has a good side. One, we've talked about this unprecedented survival of wounds. The fact that we have an Air Force medical system that, in cooperation with the Army and the Navy, has evacuated now 50,000 patients and strategic evacuation has not lost a single patient. Is running intensive care units (ICUs) in the air, and has not lost a single patient.

But the other thing that's important here, is that in the first year, our system returns to duty two-thirds of the wounded, ill and injured soldiers. So, it's not a one-way street into rehabilitation and disability. It's a process of renewing the force, and retaining—in the Army alone—up to two brigades worth of voluntary soldiers, who want to remain in uniform. And that's one of our key goals.

Senator FEINSTEIN. Right, right.

Well, I've been thinking—I've been out there twice now, and looked at it—it's, we've got 300 acres in the heart of Los Angeles, with neighbors around them not wanting commercial office highrises. And the opportunity to do something truly innovative, right in the middle, with a first-rate hospital there, all of the amenities that you need to provide the kind of living circumstance for families—because there's enough property to do it—I think is really exciting. And I think we've got to start to think that way.

I mean, I know of families where there has been traumatic brain injury, and they go back to a very rural community where they're isolated. And it's very difficult for them. Because they can't get the daily help they need to sustain that family.

So, if you gentlemen wanted to take an interest in that, I'd be happy to show you around the L.A. VA facility, because I think something truly innovative ought to be done there for veterans.

Well, right.

General ROUDEBUSH. Ma'am, your point is very well taken, and as we look at the continuum from the care within the active duty construct to include both rehabilitation and return to duty, the transition to the VA, where that's appropriate. But, for many of our guardsmen and reservists that live in communities that are not near a VA, I think we also need to be thinking beyond how we approach that continuum of care, and we don't have the answer yet.

But that is a concern, and something that I think we need to look at within our Nation in the more rural areas, where many of our reservists and guardsmen live—how we care for them, how we care for their families, and how we approach this.

But I would offer one thought as we look at how we position ourselves very well to take care of those men and women who are ill or injured as a result of this conflict. With your help in this subcommittee, it also keeps us looking over the horizon, to look at what the next conflict may be, or the next set of challenges, to be sure that we're appropriately positioned, resourced, trained and equipped to meet that challenge, as well.

So, it is a daunting task, and one that I know my work with the staff and with the members of this subcommittee—we very correctly focus on today's fight, but we also look over the horizon to see what might be next, to assure that we're able to meet that mission, as well. And it may be rather different than the fight we're fighting today.

Senator FEINSTEIN. Exactly.

Thank you very much.

Thank you, Mr. Chairman.

Senator INOUYE. Thank you very much.

In about 35 minutes, the Appropriations Committee will be meeting to consider the President's supplemental appropriations request. It's a very important hearing, and therefore, if we have further questions to ask, may we submit them to you? For your consideration and response?

I thank you very much.

Our next panel, Major General Gale Pollock, Chief of the U.S. Army Nurse Corps, Rear Admiral Christine M. Bruzek-Kohler, Director of the Navy Nurse Corps, Major General Melissa A. Rank, Assistant Air Force Surgeon General for Nursing Services.

May I first call upon General Pollock?

STATEMENT OF MAJOR GENERAL GALE POLLOCK, CHIEF, ARMY NURSE CORPS, UNITED STATES ARMY

General POLLOCK. Of course.

Mr. Chairman, Senator Stevens, Senators Mikulski, Murray, and Feinstein, thank you very much for joining us today, and it's a pleasure to appear before you today representing the Army Nurse Corps—107 years of Army strong.

Through the unwavering support of this subcommittee, we're able to serve soldiers—past and present—their families, and the strategic needs of this great Nation.

The total Army nursing force encompasses the officers and enlisted personnel on active duty in the Army National Guard and in the U.S. Army Reserve. We are a truly integrated and interdependent nursing care team. In that spirit, it has been my distinct pleasure to serve with Major General Deb Wheeling, of the Army National Guard, and Colonel Etta Johnson of the U.S. Army Reserve, who have been my senior advisors for their respective components over the past year.

I would also be remiss if I failed to highlight the exceptional work of Colonel Barbara Bruno, my Deputy Corps Chief. Without her total support and attention, I would not have been able to move

the Army Nurse Corps forward over the last 4 years. She will retire this summer, and I wanted you each to know of her dedication and support of the Army Nurse Corps and our Nation.

Despite long and repeated deployments to combat zones, Army nurses remain highly motivated and dedicated to both duty and one another. They serve in Iraq, Afghanistan, and along every route that wounded warriors travel to get home.

They're serving across Asia, Europe, and Central and South America, preparing and protecting our force. They're serving in every time zone, and at home, caring for those who need us.

Since 2003, we have activated Reserve component Army Nurse Corps officers, re-aligned active duty Nurse Corps officers, and recruited civilian registered nurses, to serve as nurse case managers to support the continuity of healthcare for our wounded warriors. Nurse case managers also help the soldiers and their families navigate the complex healthcare system within military hospitals, our civilian TRICARE network, and the transition to the Department of Veterans Affairs.

Recognizing the critical role of the nurse case manager in support of our wounded warriors, we now have 181 military and 216 civilian nurse case manager positions authorized for the warrior transition units. These authorizations establish a staffing ratio of 1 to 18 at our medications centers, and 1 to 36 at smaller medical activities.

Not only does this support our wounded warrior healthcare mission today, the establishment of authorized, documented positions ensures that we maintain a robust nurse case management program supporting our healthcare beneficiaries in the future, whether we are at peace or in conflict.

To ensure that our nurse case managers have the knowledge and skills necessary for this essential role, we standardize nurse case management training, using the military healthcare system, and the U.S. Army Medical Center and School, distance learning programs. Our next step is establishing a civilian university-based nurse case manager program for our military and civilian nurse case managers.

Recognizing the significant behavioral health issues associated with deployment and combat, we are reshaping the advanced practice psychiatric nurse role, from that of a clinical specialist, to a psychiatric mental health nurse practitioner role. In collaboration with USUHS and our sister services, we now have a new psychiatric mental health nurse practitioner program, scheduled to begin in May 2008. Nurses graduating from the program will function as independent behavioral health providers, with prescriptive authority and practice both in our fixed healthcare facilities, and in deployed combat stress units.

The Army Nurse Corps is also instituting an internship program scheduled to begin later this spring. This program bridges the gap between academia and practice for officers who are new to the profession. The anticipated outcome is better educated, and trained, medical surgical staff nurses, functioning independently.

Army Nurse Corps studies focus on the continuum of military healthcare needs, from pre- and post-deployment health, to nursing-specific practices necessary to best care for the warriors in the-

ater. Today, we have 33 doctorally prepared researchers working around the world. In addition to four well-respected, and well-established research cells at our regional medical centers, we're establishing five new cells at our other medical centers.

And finally, we have one doctorally prepared nurse researcher, two Army public health nurses, and one medical surgical nurse deployed to Iraq as part of the deployed combat casualty research team, conducting both nursing and medical research activities intheater.

The competitive market conditions and current operational demands continue to challenge us as we strive to ensure we have the proper manning to accomplish the mission. The Army Nurse Corps used incentives to assist in improving both recruitment and retention of Army Nurses. We have a Professional Nurse Education Program, the Army Enlisted Commissioning Program, the Army Nurse Candidate Program, the Funded Nurse Education Program, incentive specialty pay, nurse anesthesia specialty pay, nurse accession bonuses, critical skill retention bonuses, and a health professional loan repayment program.

We will continue to refine our retention strategies. A recent review of personnel records by the Department of the Army indicated that the Army Nurse Corps had the highest attrition of any officer branch in the Army. Ongoing research indicates that Army nurses leave the service, primarily because of less than optimal relationships with their supervisors, the length of deployments, and inadequate compensation.

I'm pleased to inform you that we now offer a Registered Nurse Incentive Specialty Pay Program, that recognizes the professional education and certification of Army nurses. Numerous studies have demonstrated the link between certified nurses and improved patient outcomes. These include higher patient satisfaction, decreased adverse events and errors, the improved ability to detect early signs or symptoms of patient complications, and the initiation of early intervention. Certified nurses also report increased personal and professional satisfaction, and improved multidisciplinary collaboration.

For our Reserve component nurses, the issue is primarily the imbalance of professionally educated officers in the company grades. Many Reserve component nurses do not have a bachelor's degree. Only 50 percent are educationally qualified for promotion. This creates a concern for the future force structure for the senior ranks of the Reserve components. We're grateful that the Chief of the Army Reserves is focusing recruiting incentives on those nurses who already have a BSN, and funding the specialized training and assistance programs, to allow both new accessions and existing Army Reserve nurses without a BSN, to complete those degrees.

The Army Nurse Corps continues adapting to the new realities of persistent conflict, but remains firm on providing the leadership and scholarship required to advance the role of professional nursing. We will maintain the focus on sustaining readiness, clinical competencies, and sound educational preparation, with the same commitment to serve those servicemembers who defend our Nation now, that we have demonstrated for the past 107 years.

I appreciate this opportunity to highlight our accomplishments, and discuss the issues we face.

PREPARED STATEMENT

Thank you very much for your support of the Army Nurse Corps and of me, over the 4 years in which I've had this position.

Thank you.

Senator INOUYE. Thank you very much, General Pollock.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL GALE S. POLLOCK

Mr. Chairman, Senator Stevens, members of the committee: it is a pleasure to appear before you today representing the Army Nurse Corps. Today, the Army Nurse Corps is 107 years Army Strong. Through the unwavering support of this committee, we are able to serve soldiers, past and present, their families, and the strategic needs of this great Nation. The Total Army Nursing Force encompasses the officers and enlisted personnel on Active Duty, in the Army National Guard, and in the U.S. Army Reserve. We are a truly integrated and interdependent nursing care team. In that spirit, it has been my distinct pleasure to serve with Major General Deborah Wheeling of the Army National Guard, and Colonel Etta Johnson of the U.S. Army Reserve, who have been my senior advisors for their respective components over the past year.

The Secretary and the Chief of Staff of the Army have set four core objectives for the Army: maintain the quality and viability of an all-volunteer force; prepare the force by training and equipping soldiers and units to maintain a high level of readiness for the current operations in Iraq and Afghanistan; reset our soldiers, units, and equipment for future deployments and other contingencies; and transform the Army to meet the demands of the combatant commanders in a changing security environment. Each of the respective components of the Army Nursing Force is actively engaged in working the ways and means to these strategic ends. In so doing, we are achieving our vision of a quality transforming force through the advancement of professional nursing practice, and we are maintaining our superiority in research, educational innovation, and effective healthcare delivery.

DEPLOYMENT

Army Nursing remains an operational capability fully engaged in the support of the Nation's soldiers, sailors, airmen, Coast Guardsmen, and marines—both at home and abroad. The Army Nurse Corps also operates as a strategic force with the capability to win hearts and minds through the provision of vital healthcare and humanitarian aid. This is a significant challenge in our various operational environments. Today, this group of nurses is the best trained in the history of operational nursing. Despite long and repeated deployments to combat zones, Army nurses remain highly motivated and dedicated to both duty and each other. They serve in Iraq, Afghanistan, and along every route Wounded Warriors must travel to get home. They serve across Asia, Europe, and Central and South America preparing and protecting the force. They serve in every time zone, and at home caring for Wounded Warriors on the long road to recovery.

There are currently three forward deployed hospitals serving in Iraq—the 31st, the 325th and the 86th Combat Support Hospitals. The 115th Combat Support Hospital is deploying to Iraq to conduct a relief in place with the 31st after a long 15-month deployment. The nurses serving in these units make an incredible difference in the lives of our Warriors and the Iraqi people.

Army nurses make no distinction among their patients; they provide all patients the highest quality care. On February 1, 2008, a 10-year-old Iraqi girl was brought to the 86th Combat Support Hospital (CSH) after sustaining 50 percent total body burns from a fire in her home. The fire left her with massive disfigurement from the waist down and a progressive infection. During the 10 days she remained at the 86th CSH, the nursing staff of the Intensive Care Unit and Intermediate Care Ward put tremendous effort into the care of both the young girl and her mother. She was transferred to Shriners Hospital for Children in Boston for extensive care of her burns on February 10th. As a testament to the quality of care this young girl received in Iraq, Shriners Hospital commented that the young girl arrived in far better condition than they had expected given the severity of injuries she had sustained. They said that the care provided by the 86th clearly saved her life, and she

survived because of the extraordinary efforts made by the team. The young Iraqi girl and her mother have expressed endless thanks for the team's work and compassion; because of their excellent care, a mother continues to smile upon her only daughter.

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 healthcare 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.

The role of the Nurse Practitioner (NP) in the Army Medical Department continues to adapt and evolve to meet dynamic mission requirements. NPs continue to provide excellent healthcare and leadership, whether serving on the home front or deployed in support of the global war on terror. The following experiences highlight some of the important contributions made by Army NPs in 2007.

Warrior Transition Units (WTUs) were developed at many installations across the Army Medical Department to enhance the excellent care provided to soldiers returning from deployments. Colonel Richard Ricciardi, Lieutenant Colonel Reyn Mosier and Lieutenant Colonel Mary Cunico are three NPs who were instrumental in training 32 active duty and reserve nurses from across the country as case managers. These three individuals helped establish the first WTU at Walter Reed Army Medical Center in a compressed timeframe. Lieutenant Colonel Cunico managed the design, development and remodeling of the Warrior Clinic and now serves as the Officer in Charge providing care to over 700 wounded, recovering and rehabilitating military personnel.

Lieutenant Colonel Jean Edwards is a primary care provider for the WTU at Vicenza, Italy, which was launched in June 2007. Her success includes new clinical skills in the areas of caring for skin grafts, the removal of bullets and shrapnel fragments, and the preparation of narrative summaries for medical boards.

Lieutenant Colonel Kathleen M. Herberger served as a staff officer on the President's Commission on Care for America's Returning Wounded Warriors. She was selected as the nurse representative on the staff due to her experience as a Family Nurse Practitioner. While on the commission, she was assigned as the Care Management Analyst. Lieutenant Colonel Herberger served on the Continuum of Care Subcommittee and as the clinical consultant for the Information Management and Technology Subcommittee. She provided research and analysis on issues related to Continuum of Care and the clinical care pathway that is necessary for the severely Wounded Warrior. The team visited over 23 sites to gather information from soldiers, their families, and healthcare providers on the challenges presented by the severely wounded. Lieutenant Colonel Herberger evaluated and recommended ways to ensure access to high quality care and analyzed the effectiveness of the processes through which we deliver healthcare services and benefits. She provided research information, and developed the background paper used to formulate the recommendations for the Federal Recovery Coordinator concept for the severely wounded.

Three Nurse Practitioners added to the success of the 7th Special Force's Group (Airborne) mission in support of Operation Enduring Freedom. Lieutenant Colonel Tamara LaFrancois, and Majors Jennifer Glidewell and Stacy Weina provided excellent care in very austere conditions at Fire Base Clinics and on Medical Civil Action Program (MEDCAP) missions in over 30 locations in Afghanistan. Using female providers to care for female local nationals and children opened up an entirely new perspective for the Special Operations Community. Helping Special Operations Forces (SOF) units with important non-kinetic missions by reaching a population of women who are not normally accessible not only allowed the local women to obtain healthcare for the first time, but enhanced the SOF unit's ability to develop good rapport with the local national population in their areas of operation. It led to many High Value Individuals who had important information being turned over by the locals and even joining forces with Coalition troops in fighting terrorism. This mission was so successful that a request for four NPs in fiscal year 2008 was submitted.

Major Amal Chatila from Fort Bragg was the first NP to be assigned to a Civil Affairs unit. She was requested based on her outstanding work in reestablishing the medical infrastructure in Iraq and her excellent care of Iraqi nationals on two separate deployments. Major Maria Ostrander is currently assigned in Iraq as a Civil Affairs Officer and works with the Baghdad Provincial Reconstruction Team as a Health Advisor for the State Department.

Efforts in providing medical care to the battle injured or those located far-forward is an ongoing concern for the military. In a war where there is no designated front-

line, any setting can be the scene of a combat engagement. Some of these locations are situated where medical assets are readily available, but there are many distant locations where soldiers are isolated from general logistics, including healthcare assets. Placing advanced healthcare practitioners in Forward Operating Bases (FOB) plays a significant role in conserving the fighting strength of our soldiers. The forward healthcare element in this case consisted of one NP and one medic, along with a comprehensive range of pharmaceuticals and medical equipment. The construction of a new Aid Station took approximately 3 days, although the team was functional almost immediately upon their arrival at the FOB. By placing healthcare teams far forward in areas prone to injury or illness, we can obviate the risk of sending ill or injured soldiers to distant locations on dangerous roads for non-urgent/non-emergent treatment of disease and non-battle injury. By putting prevention into practice, we improved and maintained our soldiers' health throughout their deployment.

In collaboration with senior Army Family Nurse Practitioners (FNPs), physician colleagues in family practice and various specialties, and the staff of the Uniformed Services University of the Health Sciences (USHUS), a FNP Residency Program was developed which provides a standardized program plan, required and optional rotations, rotation guides, and program evaluation tools. This residency program was developed in response to a long-standing request by FNPs and nursing leaders for a standardized NP residency program. The residency program was based on the recommendation of the National Council of State Boards of Nursing's "Vision Paper 2006," a 10-year plan for standardizing core curriculum, licensure, certification, and scope of practice for Advanced Practice Registered Nurses and a requirement for a residency program after completion of education at the master's level or above. The intent of the FNP Residency Program is to provide a structured role transition for the newly graduated FNP working within the Army healthcare system and a refresher program option for the FNP returning to clinical practice after a lapse of greater than 3 years. This program allows FNPs to be introduced to the Medical Treatment Facility staff, policies, and services in their newly acquired provider role. It facilitates orientation, as well as privileged practice in specialty and ancillary areas, and acquaints the FNP with the staff members and procedures for those specialty clinics with which the FNP consults.

Since 2003, we have activated reserve component Army Nurse Corps officers, realigned active duty Army Nurse Corps officers and recruited civilian registered nurses to serve as Nurse Case Managers to support the continuity of healthcare for our Wounded Warriors. These dedicated nurses have provided great support to our soldiers through their efforts to individualize care to the soldier. Nurse Case Managers also help soldiers and their families navigate the sometimes complex healthcare system within military hospitals, our civilian TRICARE network, and the transition to the Department of Veterans Affairs (VA). Recognizing the critical role of the Nurse Case Manager in supporting our Wounded Warriors, we now have 181 military and 216 civilian nurse case manager positions authorized for the Warrior Transition Units. These authorizations establish a staffing ratio of 1:18 at our medical centers and 1:36 at our medical activities. Not only does this support our Wounded Warrior healthcare mission today, the establishment of authorized, documented positions ensures that we maintain a robust Nurse Case Manager program supporting our healthcare beneficiaries in the future, whether in peacetime or during conflicts.

To ensure that our Nurse Case Managers have the knowledge and skills necessary for this essential role, we have standardized Nurse Case Management training using the Military Healthcare System and U.S. Army Medical Department Center and School (AMEDDC&S) distance learning programs. Our next step is to establish a civilian university-based Nurse Case Manager program for our military and civilian nurse case managers.

Within the Army Nurse Corps, we established a process that takes lessons learned from our support of the war effort to help shape Corps programs. Recognizing the significant behavioral health issues associated with deployment and combat, we are reshaping the Advanced Practice Psychiatric Nurse role from the previous clinical specialist to a Psychiatric Mental Health Nurse Practitioner role. In collaboration with the USUHS and our sister services, we now have a new Psychiatric Mental Health Nurse Practitioner program scheduled to begin in May 2008. Our Army Nurse Corps psychiatric nurse consultant, Colonel Kathy Gaylord, and our first faculty member, Major Robert Arnold, were actively engaged in the program development. This program provides an advanced practice degree and incorporates military unique behavioral healthcare issues into the curriculum. Nurses graduating from the program will function as independent behavioral health providers with prescriptive authority and practice both in our fixed healthcare facilities and in deployed combat stress units.

Late last year, the AMEDDC&S opened a new $11.1 million, 55,000 square foot building, named in honor of Brigadier General Lillian Dunlap, who was the 14th Chief of the Army Nurse Corps. The new academic building houses 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 the U.S. Army Graduate Program in Anesthesia Nursing Branch. The Department of Nursing Science, Army Medical Department Center and School is responsible for nearly all specialty-producing courses for the Army Nurse Corps. In addition, we provide leadership courses for nurses, and three enlisted programs. I would like to share the highlights of our program.

The U.S. Army Graduate Program in Anesthesia Nursing is rated number two in the Nation by U.S. News and World Report. This program trains an average of 35 Army, 5 Air Force and 3 VA Certified Registered Nurse Anesthetists (CRNAs) per year. Students score, on average, 37 points above the national average on the certification exam. The first-time pass rate for the certification exam is nearly 100 percent. These students' performance exceeds civilian community scores relative to trauma, regional blocks, and central line placement. The program faculty members are in constant communication with the field, especially the deployed CRNAs, to rapidly incorporate changes into this program to meet the needs of the Warriors we serve. Simulation enhancements in this program allow students to be more comfortable with various techniques, and therefore better prepared to function in the clinical Phase 2 clinical training environment. The faculty and student program of research investigate the effects of various complementary and alternative medication preparations on anesthesia—the only well-established program of research of this kind in the country.

The Licensed Practical Nurse (LPN) Program is highly successful in producing LPNs who can function in a variety of assignments, to include critical care in fixed facilities or deployed environments, a specialty not taught in most civilian LPN programs. This program produces 550–600 active and reserve component LPNs per year, with a first-time pass rate on the National Certification Licensure Exam of 94.4 percent compared to the national average of 88 percent. Half of the students serve in the reserve component, thus, we are also producing excellent LPNs that benefit the civilian community.

The Critical Care Nursing Course trains a total of 70 nurses annually, and the Emergency Nursing Course trains 15. These courses provide Army nurses with the knowledge, experience, and certifications necessary to function independently in these specialties following several months of structured internship. Graduation requirements include certifications in trauma, advanced life support, pediatric life support and burn care. We are working toward incorporating flight nursing concepts in these courses. The OB/GYN Course produces 30 trained professionals per year, who can function as post-partum and labor and delivery nurses. The Psychiatric Nursing Course produces an average of 8 specialists in psychiatry per year who are encouraged to advance to graduate level education in this much needed specialty. The Perioperative Nursing Course trains an average of 48 perioperative specialists per year. This particular specialty program is in its final stages of institutionalization at the AMEDDC&S and will include an option that allows students to become Registered Nurse First Assists (RNFA). Approximately 10 Army nurses have been through the RNFA Program.

The Department of Nursing Science also manages the nursing components of the officer leadership courses. To improve readiness we have added the Trauma Nursing Core Course and Acute Burn Life Support Courses and their respective certifications to these courses. Because our nurses are preparing patients for medical evacuation (MEDEVAC) flights, we have incorporated such content into these programs to better prepare patients for flight. The two nursing-specific leadership courses, the Head Nurse Course and Advanced Nurse Leadership Course, train approximately 400 nurse managers and supervisors per year.

The Department of Nursing Science manages the 150 students currently in the Army Enlisted Commissioning Program. Through close monitoring, we can identify potential problem students early in their academic programs and have substantially decreased the extensions in the program. The Army Nurse Corps is instituting an internship program scheduled to begin in spring 2008. This program, like many in the civilian sector, will bridge the gap between academia and practice for officers who are new to the profession. The anticipated outcome of this initiative is better educated and trained medical surgical staff nurses who can function independently.

Finally, the Dialysis Technician Program trains 7–8 dialysis technicians each year to perform hemodialysis, hemofiltration, and other similar procedures in our facilities. Additionally, we train about 400 surgical technicians each year, and we are currently investigating national program certification for this specialty.

LEADERSHIP IN RESEARCH

The TriService Nursing Research Program (TSNRP), established in 1992, provides military nurse researchers funding to advance research based health care improvements for the warfighters and their beneficiaries. 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 theater.

The Army Nurse Corps has a long and proud history in military nursing research established more than 50 years ago. Nurse researchers continue to contribute to the scientific body of knowledge in military-unique ways to advance the science of nursing practice. Today we have 33 doctoral-prepared nurse researchers working around the world. There are four well established nursing research cells at Walter Reed Army Medical Center, Brooke Army Medical Center, Madigan Army Medical Center, and Tripler Army Medical Center. Five additional research cells are being established at Womack Army Medical Center, Eisenhower Army Medical Center, Darnell Army Medical Center, William Beaumont Army Medical Center, and Landstuhl Regional Medical Center.

The focus of these research cells is to conduct funded research studies to advance nursing science and to conduct small clinical evaluation studies to answer process improvement questions. They also assist Hospital Commanders and Deputy Commanders for Nursing analyze and interpret data, resulting in improved patient care and business processes. These research cells are instrumental in assisting staff members and students in developing and implementing evidence based nursing practice.

Additionally, the Nurse Corps currently has one doctoral-prepared nurse researcher, two Army Public Health Nurses, and one medical-surgical nurse deployed to Iraq as part of the Deployed Combat Casualty Research Team who conduct both nursing and medical research activities in theater. The ongoing nursing studies in theater cover a broad range of acute and critical care nursing issues, to include pain management practices at the Combat Support Hospital, hand hygiene in austere environments, ventilator-acquired pneumonia prevention, use of neuromuscular blocking agents during air transport, women's health, sleep disturbance, compassion fatigue, and providing palliative care in the combat environment.

Thanks to the initiative and motivation of the nursing staff, Evidence-Based Practice is in full swing at Tripler Army Medical Center. In 2007, the nursing staff at Tripler completed 12 evidence-based practice projects that changed nursing practices to prevent ventilator-acquired pneumonia, improve the management of diabetic patients, and screen patients with depression for cardiovascular disease. Other successful projects included preparing children for surgery, improving postpartum education for new parents, and providing depression screening to family members of deployed soldiers. They initiated a competency training program for nurses preparing to deploy in support of Operation Iraqi Freedom and Operation Enduring Freedom. The robust evidence-based practice initiative at Tripler has improved nursing care to a variety of patients, including soldiers and family members, and enhanced the professional practice of nursing at Tripler. These evidence-based practice initiatives were spearheaded by Lieutenant Colonel Debra Mark and Lieutenant Colonel Mary Hardy, Tripler Army Medical Center Nursing Research Service and supported by the TriService Nursing Research Program.

Two evidence-based practice guidelines, Pressure Ulcer and Enteral Feedings, have been implemented at WRAMC and post-implementation data is being collected and analyzed. A third guideline, Deep Vein Thrombosis and Pulmonary Embolism Risk Assessment has been piloted and is ready for hospital-wide implementation at WRAMC. A fourth guideline regarding medication administration is currently in the initial stages of protocol development and funding acquisition. Once complete, the evidenced-based practice guidelines will be posted to the TriService Nursing Research Program's website for implementation across all Medical Treatment Facilities within the Department of Defense.

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 multi-discipline, 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's collaboration with Government and non-Government organizations around the world has helped streamline care where it was otherwise fragmented, and has introduced innovations in the delivery of care. I would like to share with you some examples of these innovations and collaborative partnerships.

Tripler Army Medical Center is in the process of implementing a new nursing care delivery model called Relationship Based Care under the guidance of Lieutenant Colonel Anna Corulli. This model of care's core principals are: patient and family centered care; registered nurse led teams with clearly defined boundaries for all nursing staff based on licensure, education, experience, and standards of practice; and primary nursing to promote continuity of care and ensure patient assignments are made to align the patient's needs with the competencies of the registered nurse. This is a resource driven model that necessitates a pro-active mindset regarding staffing, scheduling, skill mix and professional nurse development.

The Relationship Based Care program has resulted in improved communication among engaged nursing staff members who are part of the problem resolution process on the nursing ward/unit. The program has restored the personal relationship between the nursing staff and the patients, and among the individual nursing unit staff members; it has also promoted continuity of care and patient education. The model asserts the baccalaureate-trained Registered Nurse as team leader cognizant of the competencies and functions other members of the nursing care team bring to successful and safe patient outcomes.

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 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.

Professional partnerships are a vital way in which to promote professionalism and collaboration. The Army Nurse Corps is engaged in these partnerships across the country and around the world. Colonel Patricia Nishimoto, (Ret.), Colonel Princess Facen, and Major Corina Barrow, in collaboration with Dr. ReNel Davis, Associate Professor of Nursing at Hawaii Pacific University (HPU) and Director of the Transcultural Nursing Center at HPU, planned and organized the very first Transcultural Nursing Conference for the State of Hawaii in Honolulu in April 2007. The Transcultural Nursing Advisory Board is currently planning the next conference.

The University of Hawaii (UH) at Manoa School of Nursing and Dental Hygiene is in the planning stage of a formal partnership with Tripler Army Medical Center to establish resource sharing potential for faculty and student clinical practicum venues to strengthen the nursing profession in both the academic and clinical areas. In a first step toward this partnership, Lieutenant Colonel Patricia Wilhelm recently served as an acting UH faculty member to teach a pediatric clinical at Kapiolani Medical Center, filling a critical need for clinical faculty. The second major focus is to expand the graduate program by matching UH graduate students with Tripler's masters-prepared nursing staff serving in clinical faculty roles.

In December 2005, U.S. Army and Air Force nurses assessed military nursing in Vietnam and recommended short and long-term plans for the development of professional military nursing in Vietnam. A delegation from Vietnam then visited the U.S. in April 2007 to review bachelor's level curricula at the University of Hawaii, nursing education and practice at Tripler Army Medical Center, and Army Nurse Corps training at the AMEDDC&S. Allowing several months for the Vietnam team to incorporate changes in their administrative, clinical, and educational processes and curriculum, the next step is for four U.S. Army Nurse Corps officers and one UH faculty member to follow up with 2 weeks in Hanoi, Vietnam, in September 2008. They will help Vietnam educators develop a bachelor-level curriculum for Vietnam

Army Nurses, as well as troubleshoot, clarify, and problem-solve with hospital-based military nurses and the Vietnam Military Medical Department team. This exchange will enhance a positive U.S. influence and presence in Vietnam, improve readiness and interoperability in the Asia-Pacific region, and create competent coalition partners.

Colonel Debbie Lomax-Franklin and Colonel Nancy K. Gilmore-Lee have established a first ever Memorandum of Agreement with the Joseph M. Still Burn Center in Augusta, Georgia, to provide intensive burn care training to Army Nurse Corps officers throughout the region who are preparing to deploy. The Still Burn Center is the largest burn treatment center in the Southeast, serving Georgia, South Carolina, Florida, and Mississippi. This civil-military partnership has vastly improved the readiness of Army Nurse Corps officers and contributed to the quality of care delivered in theater.

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.

We access officers for the Active Component through a variety of programs, including the Senior Reserve Officers' Training Corps (ROTC), the Army Medical Department Enlisted Commissioning Program, the Army Nurse Candidate Program, and direct accession recruiting. However we must develop a range of recruiting options to ensure we remain competitive to diverse applicants. We have a number of programs to achieve this end. The Army Nurse Corps utilized the following incentives to assist in improving both recruitment and retention of Army Nurses: the Professional Nurse Education Program, the Army Enlisted Commissioning Program, the Army Nurse Candidate Program, the Funded Nurse Education Program, Incentive Specialty Pay, Nurse Anesthetist Specialty Pay, Nurse Accession Bonus, Critical Skills Retention Bonus, and Health Professional Loan Repayment Program.

The first of these is the Professional Nurse Education Program. In an effort to minimize the impact of faculty shortages, the Army Nurse Corps is piloting a strategy to leverage its resources on this important issue. This pilot program serves as a retention tool, as well as provides an additional skill set for the Officer. Six midgrade Army Nurses with clinical master's or doctoral degrees have been detailed to a baccalaureate nursing program to serve as clinical faculty for 2 years. The University of Maryland is the pilot site for this program. The presence of these officers in the Bachelor of Science in Nursing programs serves as an excellent marketing tool for Army Nursing. The University of Maryland was able to expand its undergraduate nursing program by 151 additional seats. In addition, the University is developing a clinical placement site at Kimbrough Ambulatory Care Center located at Fort Meade, Maryland.

The Army Enlisted Commissioning Program allows enlisted soldiers who can complete a Bachelor of Science in Nursing (BSN) degree within 24 months to do so while remaining on active duty. This program has provided a successful mechanism to retain soldiers, while ensuring a continuous pool of nurses for the Army. The number of seats available was increased from 75 to 100 per year for fiscal year 2008. 153 students are enrolled in the program; 52 students graduated in fiscal year 2007; and 26 students have graduated to date in fiscal year 2008.

The Army Nurse Candidate Program targets nursing students who are not eligible to participate in ROTC. It provides incentives to nursing students to serve as Army Nurses upon graduation from a BSN program. A bonus of $5,000 is paid upon enrollment, and another $5,000 is paid at either the start of the second year, or upon graduation for those enrolled for only 1 year. It also provides a stipend of $1,000 for each month of full-time enrollment. Individuals incur a 4- or 5-year active duty service obligation (ADSO) in exchange for participation in this program. For fiscal year 2008, 15 graduates accessed onto active duty took advantage of this incentive.

The Funded Nurse Education Program (FNEP) provides an additional accession source for the Army Nurse Corps. It gives active duty Army officers serving in other branches the opportunity to obtain, at a minimum, a BSN or higher level nursing degree and continue to serve as Army Nurse Corps officers. For both fiscal year's 2008 and 2009, 25 new starts were funded. Six individuals started nursing school in fiscal year 2008 under FNEP, and a recent FNEP board filled all 25 seats for starts in the fall of 2008.

The Active Duty Health Professional Loan Repayment Program is offered as an accession incentive. As participants in this program, nurses can receive up to $38,300 annually for 3 years to repay nursing school loans. In fiscal year 2008, 28 direct accession Nurse Corps officers were brought into the Army under this program.

The Accession Bonus remains attractive to direct accessions. In fiscal year 2008, 19 officers accepted an accession bonus of $25,000 and were accessed into the ANC in exchange for a 4-year ADSO, and 9 officers accepted an accession bonus of $15,000 and were accessed into the ANC in exchange for a 3-year ADSO. A combination of the Accession Bonus and Active Duty Health Professional Loan Repayment Program is also offered in exchange for a 6-year ADSO. In fiscal year 2008, 20 officers accepted these combined incentives and were accessed into the ANC.

We continue to scrutinize retention closely and we work constantly to refine our retention strategies. 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 their supervisors and hospital leadership and the length of deployments. Those who stay do so because of our outstanding educational opportunities, the satisfaction that comes with working with soldiers and their families, and retirement benefits.

We are pleased to note that we offer a Registered Nurse Incentive Specialty Pay (RN ISP) program that recognizes the professional education and certification of Army Nurses. This program, approved in August of 2007, is now fully implemented. The RN ISP offers eligible officers a payment schedule of $5,000 for a 1-year ADSO, $10,000 a year for a 2-year ADSO, $15,000 a year for a 3-year ADSO, and $20,000 a year for a 4-year ADSO. In order to be eligible for the active duty RN ISP, Registered Nurses must complete both post baccalaureate training and be certified in their primary clinical specialty. Certification is the formal recognition of the specialized knowledge, skills and experience demonstrated by achievement of standards identified by nursing specialties to promote optimal health outcomes. However, the real value of certification is in the numerous positive outcomes for our patients.

Numerous studies have demonstrated the link between certified nurses and improved patient outcomes. These include higher patient satisfaction, decreased adverse events and errors, the improved ability to detect early signs or symptoms of patient complications, and initiate early interventions. Certified nurses also reported increased personal and professional satisfaction and improved multidisciplinary collaboration.

The following clinical nursing specialties are eligible for the RN ISP: Perioperative Nursing (66E), Critical Care Nursing (66H8A), Emergency Nursing (66HM5), Obstetrics/Gynecological (OB/GYN) Nursing (66G), Psychiatric/Mental Health Nursing (66C), Medical-Surgical Nursing (66H), Community/Public Health Nursing (66B), Nurse Midwife (66G8D), and Nurse Practitioners (66P). Although only implemented in August 2007, the RN incentive specialty pay proved to be an excellent retention tool.

The total nursing population eligible for this incentive is currently 669 personnel. To date, 577 nurses have applied for incentive specialty pay which amounts to approximately 74 percent of the eligible population. Out of this population, the majority opted for the 4-year RN ISP.

Nurse anesthetists can also receive special pay in the amount of $40,000. Of the 170 nurse anesthetists that were eligible for this specialty pay, there were 161 on active duty that took advantage of this incentive. Nevertheless, 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. The U.S. Army's Graduate Program in Anesthesia Nursing has been rated as the second best in the Nation; however, we have not filled all of our available training seats for the past several years. Additionally, many of these outstanding officers opt 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 slow departures in the mid-career range. This coming June, we 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.

The Army is also concerned with retention of company grade officers, and recently announced the implementation of a Critical Skills Retention Bonus (CSRB) for regular Army captains, including Army nurses. This is a temporary program to increase retention among officers with specific skills and experiences. Qualified offi-

cers received a one time payment of $20,000 for a 3-year ADSO and 288 Army Nurse Corps officers have taken advantage of the CSRB to date.

For Reserve Component (RC) nurses, the issue is primarily the imbalance of professionally educated officers in the company grades. Many RC nurses do not have a BSN degree. As a result, only 50 percent have been educationally qualified for promotion to major over the past few years. This creates a concern for the future force structure of the senior ranks of the RC in the years to come. For this reason, we are grateful that the Chief, Army Reserve is focusing recruiting incentives on those nurses who already have a BSN degree and funding the Specialized Training and Assistance Program to allow both new accessions and existing Army Reserve nurses without a BSN to complete their degrees. 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.

The AMEDD student loan repayment program for current and new civilian nurse recruits has had an outstanding impact on recruiting and retaining civilian nurses. Over 185 civilian nurses have already elected to participate in the loan repayment program in exchange for a 3-year service obligation. The program has been so successful that the AMEDD will continue the education loan repayment program. We must sustain such initiatives in the future if we are to maintain a quality nursing work force.

More than ever, the Army Nurse Corps is focused on providing service members, retirees, and their families the absolute highest quality care they need and deserve. We continue adapting to the new realities of this protracted 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 107 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 INOUYE. May I now call upon Rear Admiral Christine M. Bruzek-Kohler.

STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER, DIRECTOR, UNITED STATES NAVY NURSE CORPS

Admiral BRUZEK-KOHLER. Thank you, good morning, Chairman Inouye, Ranking Member Stevens, Senator Mikulski, and distinguished members of the subcommittee.

As the 21st Director of the Navy Nurse Corps, I am honored to offer testimony in this, the centennial anniversary of the Navy Nurse Corps. My written statement has been submitted for the record, and I'd just like to highlight a few key issues.

Senator INOUYE. Without objection.

Admiral BRUZEK-KOHLER. In the past, the stigma of seeking medical attention for mental health issues hindered servicemembers from getting the full complement of care that they needed. The treatment of post-traumatic stress and traumatic brain injury are at the forefront of our caring initiatives. We have added a psychiatric mental health clinical nurse specialist to the Comprehensive Combat and Complex Casualty Care Program, and anticipate assignment of psychiatric mental health nurse practitioners with the marines in the operational stress control and readiness teams. These assets will expedite delivery of mental health services to our warriors.

Today's Navy nurses, especially those who have served for less than 7 years, know firsthand of the injuries and illnesses borne

from war. This is the only world of Navy nursing they have known. This "normal" world of caring is oftentimes a heavy cross to bear. Our Care of the Caregiver Program assists staff with challenging patient care situations by offering attentive listeners in the form of psychiatric mental health nurses who make rounds of the nursing personnel to assess for indications of increased stress. Another caring initiative, Operation Welcome Home, founded by a Navy nurse, and widely recognized at the Expeditionary Combat Readiness Center, has ensured that over 5,000 soldiers, sailors, airmen and marines return from operational deployments, and receive a "Hero's Welcome Home".

For a second consecutive year, I am proud to share with you that the Navy Nurse Corps has met its active duty direct accession goal. Our nurses' diligent work and engagement in local recruiting initiatives have contributed to these positive results.

But while I boast of this accomplishment, I fully realize that my losses continue to exceed my gains. These losses, and the continued challenge we face in meeting our Reserve component recruiting goals, mean fewer Navy nurses to meet an ever-growing healthcare requirement.

The Registered Nurse Incentive Special Pay Program is a new retention initiative designed to incentivize military nurses to remain at the bedside providing direct patient care. Wartime relevant undermanned specialties with inventories of less than 90 percent are eligible for this specialty pay.

Additionally, we have deployed innovative approaches to retain nurses. For the first time since 1975, Navy nurses within their initial tour of duty may apply for a master's degree in nursing via the Duty Under Instruction Program. The Government Service Accelerated Promotion Program has also been successful in retaining our Federal civilian registered nurses and reducing RN vacancy rates.

We are proud of the partnerships we have established in enhancing the education of our nurses. At the Uniformed Services University, our Nurse Corps Anesthesia Program, ranked third in the Nation among 108 accredited programs by the U.S. News & World Report, will merge with the Graduate School of Nursing to form one Federal program. We have also contributed faculty to the university's newly developed psychiatric mental health nurse practitioner track.

Tri-service nursing research is critically important to the mission of the Navy Nurse Corps, and I am committed to its sustainment. Our nurses are engaged in research endeavors that promote health, improve readiness and return our warriors to wellness.

Aligned with the Chief of Naval Operations maritime strategy, Navy nurses supported global humanitarian missions aboard USNS *Mercy* and *Comfort*, and will be critical crewmembers in future operations. The versatile role of advanced practice nurses, especially family and pediatric nurse practitioners, make them particularly well-suited for these missions. Other specialties such as obstetrics and pediatrics deployed infrequently in the past are now critical to the support of missions focused on the care of women and children. Navy nurses serve in operational roles in worldwide medical facilities in Africa, Europe, Southwest and Southeast Asia, the Middle East, and also aboard various naval ships. Among our

"firsts" in operational billets, a Navy nurse is now assigned to Fleet Forces Command in Norfolk, Virginia.

One of my family nurse practitioners served for 1 year as the medical officer of a provincial reconstruction team in Afghanistan where he provided care to civilians, Afghan military and police, as well as coalition forces. In this role he participated in over 100 ground assault convoys facing both direct and indirect fire. This depicts only one example of the challenging environments in which Navy nurses deliver care daily.

In the past year, I have had the opportunity to see my nurses at work in military treatment facilities ashore and afloat. They are indeed a different type of nurse than those I have seen in the past. They are seasoned by war, confident, proficient and innovative and fully recognize why it is they wear this uniform. It is said that the eyes are the mirror to the soul, and the eyes of my nurses yield more than words can ever impart. They truly love what they do, and they want to be no place other than where they are, caring for America's heroes.

PREPARED STATEMENT

I appreciate the opportunity to share some of the accomplishments of my nurses, and I look forward to continuing our work together as I carry on as Director of the Navy Nurse Corps.

Thank you.

Senator INOUYE. I thank you very much, Admiral.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

OPENING REMARKS

Chairman Inouye, Ranking Member Stevens and distinguished members of the subcommittee, I am Rear Admiral (upper half) Christine Bruzek-Kohler, the 21st Director of the Navy Nurse Corps and privileged to serve as the first Director at this rank. I am particularly honored to offer this years' testimony in this, the centennial anniversary of the Navy Nurse Corps. It has indeed been a century hallmarked by courageous service in a time-honored profession, rich in tradition and unsurpassed in its commitment to caring.

Today I will highlight the awe-inspiring accomplishments of a Navy Nurse Corps that is 4,000 nurses strong. Just like our nursing ancestors, today's Active and Reserve Component nurses continue to answer the call of duty whether it be at the bedside of a patient in a Stateside military treatment facility, aboard an aircraft carrier transiting the Pacific, in a joint-humanitarian mission on one of our hospital ships, in an Intensive Care Unit (ICU) at Landsthul Regional Medical Center, or in the throes of conflict in Iraq. Navy nurses stand shoulder to shoulder, supporting one another in selfless service to this great Nation.

We are a Nation in a continuing war and the true mission of the Navy Nurse Corps both today, and in 1908 when we were first established by Congress, has remained unchanged: caring for our warriors as they go into harm's way. Nurses play an invaluable role in Navy medicine. We are relied upon for our clinical expertise and are recognized for our impressive ability to collaborate with a host of other healthcare disciplines in caring for our warriors, their families and the retired community.

In the past year, nurses at the National Naval Medical Center (NNMC) have treated, cared for, cried with, laughed and at times mourned for, over 500 casualties from Operation Iraqi Freedom and Operation Enduring Freedom. The professionalism and humanity of this profoundly talented and dedicated nursing team, as well as all my nurses throughout Navy medicine, have made all the difference in the world to the wounded warriors and their families.

WARRIOR CARE

The Comprehensive Combat and Complex Casualty Care (C5) Program at the Naval Medical Center San Diego (NMCSD) was developed in 2006 to provide the highest quality of care for wounded warriors and their families. It now includes the addition of a psychiatric clinical nurse specialist and a Family/Emergency Room Nurse Practitioner. The nurse practitioner serves as the C5 medical holding company's primary care manager. The psychiatric clinical nurse specialist works in collaboration with one of the command chaplains. Together, they facilitate bi-weekly support groups for Operation Iraqi Freedom/Operation Enduring Freedom vets who are undergoing medical treatment at NMCSD. The focus of these groups is to facilitate discussions related to challenges and experiences servicemembers face and future outlooks for them.

The Balboa Warrior Athletic Program (BWAP) encompasses mastery of previous skills patients engaged in prior to sustaining a life-altering injury. Cooking classes, swimming, water and snow skiing outings, yoga clinics, strength, and conditioning training, have culminated in an unintended, yet positive consequence as these warriors begin to willingly disclose Post Traumatic Stress Disorder (PTSD) issues, medical challenges, and the effects of war on their current lifestyle.

Project Odyssey was initiated in November 2007 by the Wounded Warrior Project at NMCSD. This 3-day program focuses on self-development, knowledge and challenges recently returning warriors face from their PTSD using sports and outdoor recreational opportunities. The goal of this program is to reestablish structure and routine, enforce team work and decrease isolation among returning warriors.

At Naval Medical Center Portsmouth (NMCP), Wounded Warrior Berthing, also known as the "Patriot Inn," was developed in August 2007. It provides easily accessible accommodations, monitoring, and close proximity to necessary recovery resources for active duty ambulatory patients in varying stages of their health continuum within NMCP. The Patriot Inn staffing now include a case manager, recreation therapist, and clinical psychologist. A future construction plan includes reconfiguration of an existing site on the compound to increase capacity.

NURSE CASE MANAGEMENT

Case managers are members of multi-disciplinary teams and integral in the coordination of care for our servicemembers as they transition from military treatment facility to a VA facility closer to home, or another civilian or military treatment facility. Our case managers work in conjunction with the staff of the Wounded Warrior Programs, Navy Safe Harbor, and United States Marine Corps (USMC) Wounded Warrior Regiments. They have been assigned to the Traumatic Brain Injury (TBI) and PTSD patient populations specifically to ensure continuity of care and point of contact for ongoing coordination of services and support for C5 patients at NMCSD.

Efficacy of case managers' efforts may be best reflected in the following examples from some of our commands. A staff nurse assigned to the Camp Geiger Branch Medical Clinic serves as a case manager for the injured marines in the Medical Rehabilitation Platoon (MRP) at the School of Infantry-East. The number of marines in this platoon was maintained at 70–80 members over the past year with half of them returning to duty or training within 30 days. The nurse was able to expedite primary and specialty care appointments, ensure clear lines of communication with the Marine Corps leadership through weekly meetings and met with all the MRP marines on a regular basis to review and update their plan of care. Utilization of a case manager for the MRP improved compliance with the required care regimen and decreased the overall length of stay for marines in MRP.

Nurses in other military treatment facilities have also become active in case management. At Naval Healthcare New England, the nurses work in conjunction with Army points of contact to coordinate care for soldiers' recovery at home. Two case managers at Naval Health Clinic Corpus Christi co-manage cases with Brook Army Medical Center for the Wounded Warrior Program, coordinating care for Fort Worth enrolled Soldier/Warriors in the Transition Program. Nurses assigned to Naval Hospital (NH) Great Lakes work collaboratively with the North Chicago VA Medical Center in tracking their wounded warrior population. Nurse case managers in the Pacific Rim (Hawaii) are following 120 patients to ensure they receive continuity of care throughout the Military Healthcare System.

PSYCHIATRIC AND MENTAL HEALTH NURSING

Mental health care is a national concern, and we, in the Navy and Navy Nurse Corps, recognize our tremendous responsibility and accountability to ensure our pa-

tients receive the best possible mental health care. With this responsibility comes the realization that we have an ever increasing need for psychiatric mental health nurse practitioners and clinical nurse specialists. A pilot program of embedded staff with the Marines, the Operational Stress Control and Readiness (OSCAR) teams, is composed of Navy psychologists or psychiatrists, psychiatric technicians, chaplains or social workers. The goal of the pilot program is to establish permanently staffed teams that train and deploy with each regiment group. Psychiatric Mental Health nurse practitioners are being considered as potential providers for this requirement.

The requirement to fill OSCAR teams, combined with the increased Marine medical requirement and the growing need for dependent care, pose a significant impact to an already overburdened community of mental health nurses. I am presently undertaking a full review of the manning requirements for mental health nursing to ensure that Navy medicine has the right number and level of expertise in concentrated areas of patient mental health care needs.

FAMILY-CENTERED CARE

Our mission involves not only the care of the active duty member, but also their family, their dependents, and America's veterans who have proudly served this country. Such care is not delivered in a single episodic encounter, but provided over a lifetime in a myriad of locations here and abroad.

Obstetrical (OB) service continues to be one of our largest product lines. It can be challenging to find enough experienced labor and delivery nursing staff during peak periods. In some of our regions, this has required an increase in resource sharing agreements to supplement our military staff. As needed, our regional medical commanders utilize active duty nurses from low volume labor and delivery units to provide temporary additional duty at treatment facilities that are experiencing peak numbers of births.

In some of our pediatric departments, nurses manage the well-baby clinics and see mothers and babies within days after discharge to provide post-partum depression screening and education. Babies receive a physical exam, weight and bilirubin check. Thus the couplet is assessed independently, and as a unit, further reinforcing the Surgeon General's concept of family-centered care.

Naval Hospital Bremerton (NHB) offers the Centering Pregnancy model of group prenatal care which brings women together to empower them to control their bodies, their families and their pregnancies. Facilitated by a nurse practitioner, Centering Pregnancy was initially a Tri-Service funded research project conducted by NHB and the 1st Medical Group Langley with data collection concluding in 2007. The application of this model on military family readiness and military health care systems showed greater satisfaction and participation in care with the Centering Program, reduction in waiting time to see providers and participants had significantly less expression of guilt or shame about depression. Navy medicine is currently assessing ways to expand this program.

Four of our nurses (military and civilian) recently had an article published in Critical Care Nursing Clinics of North America. It spoke poignantly of lessons learned in caring for wounded warriors. It depicted the sacrifice and dedication required in coordinating sophisticated and multi-disciplinary care for these patients and their families. This further elucidates how family-centered care makes a tremendous difference for the recovery of the injured by including care of the family and their involvement in the overall care of the wounded warrior.

Lastly there is the care of the family by Navy nurses that no one sees: the lieutenant junior grade who travels to New York on his day off to attend the funeral of one of his patients and is immediately recognized by the family and invited to their home for dinner after the service; the nurse who held the hand of a blind and injured soldier, crying and praying with him on a night in which he is unable to wake himself from flashbacks and nightmares—who attributes the soldier's perseverance through the highs and lows of his recovery as a source of inspiration to her; the soldier who sustained TBI and an amputation of one of his legs and can recall nothing of his prolonged hospitalization, but his father remembers and escorts his son on a visit to the ward so the staff can witness his healing and hear tales of his snowboarding adventures in Colorado; the soldier who lost both of his legs and suffered multiple life threatening injuries and was in complete isolation until the nursing staff was able to assist him in safely holding his new baby daughter without worry of transferring infections to her. It is indeed this type of selfless and compassionate care that has been embraced by my nurses in the integral role they play in both patient and family-centered services.

CARE OF THE CAREGIVER

Today's Navy nurses, especially those who have served for less than 7 years, know firsthand the injuries and illnesses borne from war. This is the only world of Navy nursing they have known. This is their "normal" world of caring. And this new "normal" may oftentimes be a heavy cross to bear. At NNMC, our psychiatric mental health nurses and others with mental health nursing experience make rounds of the nursing staff and pulse for indications of increased staff stress. They then provide to the identified staff, education on "Care for the Caregiver." They are available to help staff with challenging patient care scenarios (increased patient acuity, intense patient/family grief, and staff grief) and offer themselves as attentive, nonjudgmental listeners through whom the staff may vent.

In addition to the classes on 'Compassion Fatigue' offered by command chaplains to our nurses and hospital corpsmen, some commands host provider support groups where health professionals meet and discuss particularly emotional or challenging patient cases in which they are or have been involved. Aboard the USNS Comfort, Psychiatric Mental Health Nurses and Technicians were located at the deckplate in the Medical Intensive Care Unit, Ward and Sick Call to help members that might not report to sick call with their complaints of stress.

In many of the most stressful deployed locations, our senior nurses are acutely attuned to the psychological and physical well-being of the junior nurses in their charge. They ensure that staffing is sufficient to facilitate rotations through high stress environments. Nurses are encouraged to utilize available resources such as chaplains and psychologists for guidance and support in their deployed roles and responsibilities.

Our deploying nurses have been asked to hold positions requiring new skill sets often in a joint or Tri-Service operational setting. As individual augmentees, they deploy without the familiarity of their Navy unit, which oftentimes may pose greater stress and create special challenges. Our nurses who fulfill these missions require special attention throughout the course and completion of these unique deployments. I have asked our nurses to reach out to their colleagues and pay special attention to their homecomings and re-entries to their parent commands and they have done exactly that.

At U.S. Naval Hospital Okinawa, nurses ensure that deploying staff members and their families are sponsored and assisted as needed throughout the member's deployment. A grassroots organization, Operation Welcome Home, was founded by a Navy nurse in March 2006 with the goal that all members returning from deployment in theater receive a "Hero's Welcome Home". To date over 5,000 sailors, soldiers, airmen and marines have been greeted at Baltimore Washington International Airport (BWI) by enthusiastic crowds who indeed care for them as caregivers.

FORCE SHAPING

In January 2008, Navy Nurse Corps Active Component manning was 94.5 percent and our Reserve Component manning was nearly the same at 94.4 percent. Our total force is 4,043 strong. For the second consecutive year, I am proud to share with you that the Navy Nurse Corps has met its active duty direct accession goal. Yet as I boast of this accomplishment, I fully realize that my losses each year continue to exceed my gains, by approximately 20–30 nurses per year. These losses, and the continued challenge we face in meeting our recruiting goals in the Reserve Component, culminate in fewer nurses to meet an ever-growing healthcare requirement.

RECRUITING

So what has made the difference in our recruiting success? Our nurses' diligent work and engagement in local recruiting initiatives have yielded positive results. We are ahead of our recruiting efforts this year, more than where we were at this same time last year. The top three programs working in our favor toward this successful goal achievement include the increases in Nurse Accession Bonus (NAB) now at $20,000 for a 3-year commitment and $30,000 for a 4-year commitment; Health Professions Loan Repayment Program (HPLRP) amounts up to $38,300 for a 2-year consecutive obligated service; and the Nurse Candidate Program (NCP), offered only at non-ROTC Colleges and Universities, which is tailored for students who need financial assistance while in school. NCP students receive a $10,000 sign-on bonus and $1,000 monthly stipend. Other contributors to our success include location of our duty stations and the opportunity to participate in humanitarian missions.

We created a Recruiting and Retention cell at the Bureau of Medicine and Surgery (BUMED) with a representative identified from each professional corps. These

officers act as liaisons between Navy Recruiting Command (CNRC), Naval Recruiting Districts (NRD), Recruiters and the MTFs and travel to and or provide corps/demographic specific personnel to attend local/national nursing conferences or collegiate recruiting events. In collaboration with the Office of Diversity, our Nurse Corps Recruitment liaison officer coordinates with military treatment facilities to have ethnically diverse Navy personnel attend national conferences and recruiting events targeting ethnic minorities.

The Nurse Corps Recruitment liaison officer has created a speaker's bureau of junior and mid-grade Nurse Corps officers throughout the country and they are reaching out to colleges, high schools, middle and elementary schools. Our nurses realize that each time they talk about the Navy and Navy nursing they serve as an emissary for our Corps and the nursing profession. Unique platforms such as USNS Comfort and Mercy are phenomenal recruiting venues. Officers provide ship tours to area colleges and civilian organizations (Schools of Public Health, Medicine and Nursing from Johns Hopkins University, Montgomery College School of Nursing, Boy Scouts of America, United States Coast Guard Auxiliaries), hospitals, recruiting centers, and sponsor speakers' bureau representatives from the ships to present at local civic and health groups about the rewards and lessons learned of serving on a humanitarian mission.

NMCP participated in Schools of Nursing Transition Assistance curricula for future Nurse Corps Officers by offering a 120-hour preceptor guided clinical externship. NMCP also developed the Coordination of Nursing mentorship experience which offers "Job Shadowing" of a Nurse for both enlisted staff and high school students who are considering the nursing profession as a career. U.S. Naval Hospital Yokosuka encourages seamen and corpsmen from area ships to "shadow" nurses to see if a career in the Nurse Corps is for them.

Our Reserve Component recruiting shortfalls particularly impact their ability to provide nursing augmentation in some of our critical wartime specialties. In addition to reserve accession bonuses and the stipend program, our reserve affairs officer has initiated telephone calls to Active Component nurses who are leaving active duty and shares information with them related to opportunities that exist in the Ready Reserve.

RETENTION

Naval Hospital Camp Pendleton (NHCP) has cross-trained their nurses for utilization during periods of austere manning secondary to increased op-tempo and deployments. Last year, several Outside Continental United States (OCONUS) military treatment facilities received ten Junior Nurse Corps (NC) officers who attended our new Perinatal Pipeline training program, designed for medical-surgical nurses who expect to work in Labor and Delivery or the Newborn Nursery at OCONUS military treatment facilities. This program has increased clinical quality for these commands and increased the knowledge and preparation of these junior NC officers. This year we will expand the training to geographically remote Continental United States (CONUS) facilities as well.

The Officer Career Development Board developed at Naval Hospital Oak Harbor for officers in the grade of lieutenant and below provides for career progression opportunities as both an officer and nurse professional. The board also offers guidance and mentoring for optimal career development.

The Registered Nurse Incentive Special Pay (RN–ISP) program is a new retention initiative begun in February 2008. This program is designed to encourage military nurses to continue their education, acquire national specialty certification, and remain at the bedside providing direct care to wounded sailors, marines, soldiers and airmen. In the Navy Nurse Corps, we selected critical wartime specialties manned at less than 90 percent for this incentive special pay. The specialties and their respective manning levels are perioperative nursing (86 percent), critical care nursing (62 percent), pediatric nurse practitioner (82 percent) and family nurse practitioner (82 percent). Since the program has only recently been implemented, there is not sufficient data to determine its efficacy in retaining nurses.

Among Navy nursing's retention tools are the Certified Registered Nurse Anesthesia (CRNA) Incentive Special Pay, Board Certification Pay for Nurse Practitioners, and the new Registered Nurse Incentive Special Pay. Service obligations are incurred in proportion to the amount of special pay received in the Certified Registered Nurse Anesthesia Incentive Special Pay and the Registered Nurse Incentive Special Pay. A recent increase in the Certified Registered Nurse Anesthesia Incentive Special Pay has encouraged many Navy CRNAs to stay on active duty.

The fiscal year 2008 Nurse Corps Health Professional Loan Repayment Program (HPLRP) was awarded to 42 nurses with an averaged debt load of $27,361. The se-

lected officers' years of commissioned service spanned 3 to 10 years and most will incur service obligations through 2010. Selected nurses were in the grades of Lieutenant Junior Grade to Lieutenant Commander and the majority of the loans incurred were from their baccalaureate education.

Military treatment facility nurses are actively involved in partnering with local universities to recruit NC officers, and they are serving as mentors with area Medical Enlisted Commissioning Program (MECP) students. Our facilities also serve as clinical rotation sites for many Schools of Nursing (SONs). NC officers serve both as affiliate faculty at Universities across the country and as clinical preceptors to students. Naval Health Clinic Cherry Point nurses act as preceptors to high school students in Certified Nursing Assistant programs.

We are challenged to retain nurses due to on-going deployment cycles, Individual Augmentee roles, intensive patient care requirements, and low inventories of critical war time specialties. The fiscal year 2007 Nurse Corps continuation rate after 5 years, which is the average minimum obligation, is 67 percent. Our 5-year historical average is 69 percent. Thus, further consideration must be given to initiatives that mitigate mid-grade Nurse Corps attritions.

In February 2007 the Accelerated Promotions Program for Civilian Registered Nurses was approved by the Chief, Bureau of Medicine and Surgery for implementation throughout Navy medicine. NHCP joined NMCSD in adjusting their nursing salaries for the first time in over 15 years, increasing the Navy's ability to compete for experienced nurses in the local community.

At NNMC, the Government Service (GS) accelerated promotion program has been tremendously successful and will be expanded. It helped reduce the Registered Nurse (RN) vacancy rate from 13 percent to <4 percent and increased continuing education training opportunities for all nurses. GS nurses hired under the accelerated promotion plan are integrated into the Nurse Intern Program, enhancing their transition into a military nursing milieu.

READINESS AND CLINICAL PROFICIENCY

In order to meet nursing requirements at home and in forward deployed settings, nurses must maintain clinical proficiency and competence. Our readiness and clinical proficiency team recently launched core competencies for medical/surgical, psychiatric, critical care and emergency nursing. These will be integral in standardizing nursing competency assessments throughout Navy medicine and, once initiated in a nurses' orientation to a clinical specialty, would then follow the nurse across the career continuum, thus eliminating rework of subsequent competency packets at each duty station.

An off-shoot from this group was the Tri-Service Nursing Procedures Standardization workgroup, which identified a web-based nursing procedure manual for acquisition and utilization in all military treatment facilities. This tri-service proposal was briefed and approved by my fellow Service Corps Chiefs at the Federal Nursing Service Council meeting. Navy members are now engaged in identifying contract vehicle and consolidated funding sources.

OPERATIONAL

The Navy Nurse Corps continues to be one of the largest deploying groups among all professional corps (Medical, Dental and Medical Service Corps) in Navy medicine. From January 2006 to March 2008, 232 Active and Reserve Component Navy nurses have deployed.

Our nurses served admirably in operational roles in Kuwait, Iraq, Djibouti, Afghanistan, Bahrain, Qatar, Indonesia, Thailand, Southeast Asia, Pakistan, Guantanamo Bay, Cuba, Germany and aboard both hospital ships USNS Mercy and Comfort and on many other grey-hulls. They are part of Provincial Reconstruction Teams (PRTs), Flight Surgery Teams, participate in the Sea Trial of the Expeditionary Resuscitative Surgery System (ERSS) and perform patient movement via Enroute Care at or near combat operations.

The nurses who perform Enroute Care have clinical experience in either critical care or emergency room nursing and prior to deployment attend specialized training at Naval Operational Medical Institute in Pensacola, Florida or Fort Rucker, Alabama. Their training includes physiologic changes of patients at various altitudes, airframe and equipment familiarization.

The nursing "footprint" is still essential and evident at Expeditionary Medical Facility (EMF) Kuwait. In a 6-month period (July 2007–December 2007), a total of 3,564 casualties were received and treated. Other activities supported by Navy nurses at EMF Kuwait include the coordinated, joint support of immunizations for Japanese, British and Korean troops and a Kuwait-staged mass-casualty/inter-

agency drill and Advanced Cardiac Life Support programs with the American Embassy in Kuwait.

At Landstuhl Regional Medical Center, 98 Navy Reserve Component nurses work alongside their colleagues from the Army and Air Force. During the past 2 years, Navy nurses from this contingent have also worked in the warrior management center and made great strides in the provision of optimal care to the wounded as they transit on flights from Landstuhl Regional Medical Center to military treatment facilities in the CONUS.

The top five deploying specialties in the Navy Nurse Corps include medical/surgical, perioperative, emergency/trauma, critical care and CRNAs. By the summer of 2007, 25 percent of all Active Duty CRNAs were deployed, from recent graduates with 1 year of experience to seasoned officers at the rank of captain. The CRNA community has held roles in every aspect of Operational Medicine: humanitarian missions, special warfare operations, routine ship trials and movements, deployments with the Marines. and as multiservice and international security force PRTs.

Though not identified among the "top five deploying specialties", our Family Nurse Practitioner (FNP) community is one in which 60 percent of current billets have associated deployment platforms. FNPs are integral to Family Practice residency training programs, continuing to provide access and deliver health care wherever they are assigned. Solidly grounded in disease prevention and health promotion, the FNP brings these tenets of nursing care to every patient encounter—positively impacting population health in our communities and reducing the disease burden and associated costs of chronic disease management. A study undertaken by the Center for Naval Analysis in 2007 will provide a comprehensive assessment of the emerging roles of the FNP, as well as the Pediatric Nurse Practitioner communities.

The preparation of our forward deployed nurses could not be as effectively accomplished without the support of Navy Individual Augmentee Combat Training (NIACT). Prior to deploying, personnel are sent to NIACT at Fort Jackson, South Carolina, where the training consists of combat, survival, convoy, weapons handling and firing, and land navigation. Nurses also wear the entire ensemble of Kevlar and Interceptor Body Armor (IBA) daily which in one nurse's words "sensitizes you to the hardships of wearing the gear everyday, every hour as those in Iraq do. I felt prepared when I arrived to Expeditionary Medical Facility Kuwait."

Proactive nursing leaders have front-loaded staff training with operational relevant topics. At Naval Hospital Great Lakes, Tactical Combat Casualty Care Course was taught to 98 staff members for deployment readiness. At NMCSD and NHCP nursing leaders are directing staff attendance at other war-fighting support programs such as Fleet Hospital training, Combat Casualty Care Course, Enroute Care Training, Military Contingency Medicine/Bushmaster Course offered at the Uniformed Services University of the Health Sciences, Joint Forces Combat Trauma Management Course, and Naval Expeditionary Medical Training Institute.

The Navy Trauma Training Course, developed in 2002 and hosted in conjunction with Los Angeles County/University of Southern California, continues to be an integral training platform for forward deploying nurses. Since the course inception, 241 nurses have received this training prior to reporting to their operational billet. This course, in which 39 Navy nurses were trained in 2007, combines didactic, simulation labs and clinical rotations in the main operating room, ICUs and the emergency department.

HUMANITARIAN ASSISTANCE

My precepts for Navy nursing align with the Chief of Naval Operations' Maritime Strategic Plan. Based upon successes of past global humanitarian missions in which Navy nurses were embarked aboard USNS MERCY and COMFORT, we will be critical crewmembers once again in upcoming dual missions planned for 2008.

The USNS COMFORT (T–AH 20) was deployed from June 2007-October 2007 to participate in a humanitarian training mission for the "Partnership for the Americas"; visiting 12 countries and seeing 98,650 patients in the Caribbean and South America including Belize, Guatemala, Panama, Nicaragua, El Salvador, Ecuador, Peru, Columbia, Haiti, Trinidad/Tobago, Guyana and Surinam. The COMFORT and its teams of multiservice healthcare professionals, military, reserve, civilians and Non-Government Organizations (NGOs) from various fields of study (Nursing, Public Health, Dentistry, Pediatrics, Infection Control, etc) provided a total of 1,197 classes to 28,673 students in 12 countries during the Partnership for the Americas cruise. Many of our nurses would later remark that while the days were long, the interactions with patients and feeling of having truly made a difference in someone's life would be lasting memories.

Even while deployed at sea on humanitarian missions, the necessity for discharge planning programs became quite evident. Two Nurse Corps officers with experience in community/public health and case management were provided with two other hospital personnel familiar with MEDEVAC procedures to coordinate plans for the development and implementation of a new nursing discharge planning team on the COMFORT. Utilizing a multidisciplinary approach, the team integrated services of 11 divisions and capitalized on host nation assets which included private physicians, Ministries of Health and NGOs to assure post-operative follow up care for over 2,200 patients in their homelands. This team initiated over 20 process improvements that streamlined admission to discharge care for 7,500 inpatients.

The USNS MERCY (T–AH 19) is slated for its next humanitarian mission, "Pacific Partnership," visiting regions of the Western Pacific and Southeast Asia in 2008. Augmenting crew members are expected to include joint, multinational and interagency personnel. In preparation for this mission, the senior nurse on board the ship has attended the Joint Operations Medical Managers Course and Military Medical Humanitarian Assistance Course.

Navy nursing's altruistic spirit and readiness to help were demonstrated in our own country during the horrific wildfires that ravaged Southern California coastlines in October 2007. Amidst evacuating their own families and ensuring their safety was preserved, Nurse Corps officers were rallying to support the needs of their command and any impending requirement to augment civilian health care delivery services that were severely taxed during this massive natural disaster.

During the subsequent evacuation of many civilian healthcare facilities due to imminent danger posed by the smoke and fire, 28 patients from a local skilled nursing facility were relocated to NMCSD on a rapidly deployed contingency ward jointly staffed by NMCSD and Naval Hospital Twenty-nine Palms personnel. The nursing staff impressively responded to this call for assistance and conducted expeditious patient assessments to determine patient acuity and how to best meet patient needs.

An additional ten patients were evacuated to NMCSD from Pomerado Hospital and were safely absorbed into the Medical/Surgical wards and the ICU. During and after this state emergency, 12 Nurse Corps officers from this hospital volunteered at the local stadium which became a temporary shelter, providing aid and assistance to hundreds of dislocated and homeless San Diego citizens.

During this same wild fire disaster, the Nurse Corps officer department head at Camp Pendleton evacuated the 52 Area Branch Clinics (School of Infantry) in less than 90 minutes. A temporary clinic was established and 24-hour medical coverage was available to wildfire evacuees which included approximately 400 patients. This officer further embedded a medical contingent of eight hospital corpsmen and one independent duty corpsman to ensure continuous medical support was available to 4,000 marines that were evacuated from their barracks and were living in a field environment.

The Nurse Corps officer department head from the 31 Area Branch Clinic (Weapons Training Area) evacuated his clinic and relocated his staff to another base clinic and provided round- the-clock medical care to 1,000 evacuees in the Del Mar area of Marine Corps Base Camp Pendleton.

EDUCATION PROGRAM AND POLICIES

Continuation of a Navy nurses' professional development via advanced educational preparation is necessary to better serve our beneficiary population, fortify their respective communities of practice and for promotion. My education program and policy team works to identify educational opportunities to Navy Nurses, expand the utilization of dual certified advanced practice nurses and formulate a mentorship program for entry-level nurses who are accessioned via the Nurse Candidate Program, Medical Enlisted Commissioning Program and the Reserve Officer Training Corps.

This year marks the first time since 1975 that nurses within their first tour of duty may apply for a master's degree in nursing via the Duty under Instruction (DUINS) out-service training program. Our long-term goal for this initiative is to increase service retention at critical junctures in a young officer's career and facilitate earlier entry into specialty communities of their choice. Over 70 new graduates with Masters of Science in Nursing will be assigned to new duty stations in 2008.

MENTORSHIP

The role that Navy Nurses hold as mentors to our corpsmen and junior officers also serves to bolster recruiting efforts in our pipeline programs for enlisted members through the Medical Enlisted Commissioning Program (MECP) and the Sea-

man to Admiral Program (STA–21) and supports the retention of subordinate colleagues who perhaps once pondered a career outside of Naval service.

Navy nurses enthusiastically embrace their role as mentors and activities involving such are pervasive throughout our treatment facilities. At NMCSD, 12 Nurse Corps option ROTC midshipmen spent 4 weeks in clinical rotation on medical/surgical wards. These "fledgling nurses" became proficient with venipuncture and had exposure to operational nursing roles at NHCP and aboard USNS MERCY.

NMCP promotes active mentoring roles with local MECP candidates. Navy Nurses assigned here also visit local job fairs as hosted by regional SONs and provide candid answers to queries from nursing students who are interested in service to their country.

COLLABORATIVE/JOINT TRAINING INITIATIVES

Many commands, perhaps not routinely affiliated with SONs, serve as practicum sites for students. At BUMED, senior nurse executives are preceptors for college juniors or seniors as they study nursing leadership. At U.S. Naval Hospital Naples, Italian nursing students are mentored by Navy nurses as they compare and contrast the medical systems of the two countries.

The Navy Nurse Corps Anesthesia Program, ranked third in the Nation among 108 accredited Certified Registered Nurse Anesthesia programs by U.S. News and World Report, will unite with the Uniformed Services University of the Health Sciences (USUHS) Graduate School of Nursing nurse anesthesia program to form one Federal Nursing anesthesia program. The first class matriculates in May 2008.

Additional partnerships with USUHS include the provision of a Psychiatric Mental Health Nurse Practitioner as faculty member to the newly developed Psychiatric Mental Health Nurse Practitioner Program. This nurse will join other colleagues from the Armed services who serve on faculty at the Graduate School of Nursing.

Home to a robust, state-of-the-art ICU, NNMC became a training site for our Air Force nursing colleagues who require rigorous exposure to critically ill patients in preparation for their role on Critical Care Air Transport Teams. Internationally recognized as a site of clinical excellence, each year the Greek Navy sends three active duty nurses to Bethesda for training in critical care, medical/surgical and oncology nursing.

Since July 2006, NMCP, in collaboration with Langley Air Force Base (AFB), has provided a comprehensive Perinatal Training Course for Air Force, Navy and civilian service RNs. Current Perinatal Training Programs provided at NMCP include a 6-week perinatal training consisting of a 2-week didactic curriculum at Langley Air Force Base and a 4-week clinical practicum with assigned preceptor. Collaboration among Perinatal Training Program Managers from NMCP and Langley AFB, Navy Medicine Manpower Personnel Training and Education Command and the BUMED Women's Health Specialty Leader led to proposed curriculum changes that will align with NMCSD's new program. NMCSD hosted and developed the Navy's 1st Perinatal Pipeline Training Program for Navy Nurses in receipt of orders for assignment to maternal-infant care units in overseas military treatment facilities.

In December 2007, two senior Nurse Corps officers from NMCSD participated in a project with the University of Zambia to develop a Masters degree in Community and Public Health Nursing with an emphasis on infectious disease (HIV/AIDS) surveillance, prevention, care and treatment. These officers will be returning to Zambia in the summer of 2008, where they will continue to assist the University with the development of this program as well as a Physician Assistants equivalent school, lab technology and medical assistant schools.

Despite their geographic remoteness, our OCONUS military treatment facilities are very actively engaged in activities with U.S. facilities and host nation communities. Naval Hospital Guam participated in a nationwide exercise conducted simultaneously in multiple states in which various disaster scenarios were enacted, requiring involvement of both military and civilian resources to achieve a safe and successful outcome. U.S. Naval Hospital Yokosuka offers annual training for Sexual Assault Nurse Examiner, Trauma Nurse Casualty Care, Perinatal Orientation and Education Program, Neonatal Orientation and Education Program and Neonatal Resuscitative program for tri-service and Japanese military Self-Defense Force participation. U.S. Naval Hospital Okinawa supports local nursing education via a clinical intercultural nursing experience hosted semi-annually with the Hokobu Nursing School.

RESEARCH

The Tri-Service Nursing Research Program (TSNRP) is critically important to the mission of the Navy Nurse Corps and I am committed to its sustainment. Our

nurses are engaged in research endeavors that promote health, improve readiness and return our warriors to wellness. An ongoing study conducted by a Navy Nurse, "Evidence-Based Practice Center Grant (2002) Study" provided training to nurses and funded initiatives from multiple military treatment facilities to translate evidence to practice. Another study entitled, "Clinical Knowledge Development of Nurses in an Operational Environment (2003)", uses information gleaned from interviews with nurses from Army, Navy, Air Force and Public Health Service who had deployed either in theatre or to natural disaster areas and identified subsequent knowledge necessary to this setting. "The STARS Project: Strategies to Assist Navy Recruit Success (2001)" culminated in BOOT STRAP Intervention which changed the policy of how Commanders approached recruits. The number of recruits separated from the Navy before completing basic training was reduced from a high of nearly 30 percent to <15 percent. A Navy nurse directed study on "The Lived Experience of Nurses Stationed Aboard Aircraft Carriers (2000)" changed policy about assigning new Ensigns to aircraft carriers.

In addition to TSNRP endeavors, our doctorally prepared Navy nurses assigned throughout our military treatment facilities have actively engaged many nurses in a plethora of robust research initiatives that include areas of maternal/neonatal care, pediatrics, anesthesia, critical care and military populations deployed on ships. One of the graduates of the Navy Nurse Corps Anesthesia Program competed against both medical and nursing colleagues and won the 2007 Navy-wide Academic Research Competition staff category for his study.

PUBLICATIONS

Navy nurses are prolific authors whose works encompass all specialty areas of nursing and have appeared in nationally recognized publications as follows: Critical Care Nursing Clinics of North America; AORN Journal; Nursing Spectrum; Advance for Nurse Practitioners; Journal of Nursing Education; The Nurse Practitioners Journal; Journal of Wound, Ostomy & Continence; Journal of Pediatric Healthcare; Journal of Obstetric, Gynecologic and Neonatal Nursing; Dimensions of Critical Care Nursing; Military Medicine.

EDUCATIONAL PARTNERSHIPS

While all of our nurses do not teach every day in traditional brick and mortar SONs, they are still teachers in their service as clinical preceptors and as guest faculty/lecturers to our corpsmen, military and Government service nurses. They are also role models and recruiters to civilian nursing students who seek an opportunity to gain a lifetime of personal satisfaction in service to humanity and our Nation.

One of our nurses teaches in an undergraduate nursing program at Hawaii Pacific University and another has precepted over 850 clinical hours for nurse practitioner students. Medical/surgical nurses are precepting civilian nursing and graduate students from Georgetown, Johns Hopkins, University of Guam, University of North Florida and the University of California at San Diego in our treatment facilities located in proximity to their SONs.

Staff Nurse Anesthetists (CRNAs) assigned to the NNMC serve as clinical and didactic instructors for student nurses from the Nurse Corps Nurse Anesthesia programs at Georgetown University and USUHS.

At Naval Hospital Beaufort, the nurse anesthesia staff established a memorandum of understanding (MOU) with the Medical University of South Carolina, College of Health Professions, and Anesthesia for Nurses program in September 2006. The first student arrived in December 2006 and Navy Nurse Anesthetists have precepted 14 students to date. The MOU critically supports this region's anesthesia program and hands-on training for nurse anesthetists. A senior Navy CRNA was selected Clinical Instructor of the Year for 2007 and was honored at the graduation ceremony in Charleston last May.

Because of the size and scope of clinical specialties found at our medical centers at Bethesda, Portsmouth and San Diego, they have multiple MOUs with surrounding colleges and universities to provide clinical rotations for nurses in various educational programs from licensed practical/vocational nursing (including Army LPNs at the Bethesda site), Bachelor of Science in Nursing, Master of Science in Nursing, to Nurse Practitioner and Certified Nurse Anesthetist Programs.

Our mid-sized MTFs are also actively engaged in training America's future nurses. Naval Hospital Twenty-nine Palms has developed a MOU with the California Educational Institute to serve as a clinical rotation site in support of developing the LPN to RN Bridge Program, while simultaneously maintaining current agreement with Copper Mountain College LPN and RN Nursing programs. Naval Hospital Great Lakes provides clinical sites for Family Nurse Practitioner clinical

training and offers classes in Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support, and Neonatal Resuscitation Program to staff from the North Chicago VA Medical Center.

It is not only the nurses of America that Navy nurses willingly teach, but also our own novice accessions. The Nurse Internship Program, available at each of our medical centers is a structured didactic and clinical curriculum involving a variety of nursing specialties which uses mentorship to transition the graduate nurse from the role of student to staff nurse. In 2007, we have cumulatively trained over 250 nurses. This program is also availed to our new civilian graduate nurse employees.

LEADERSHIP

The goals of the Nurse Corps leadership team include development and mentoring of future Nurse Corps leaders using identifiable leadership competencies across their career continuum.

This year we celebrated two firsts: A Nurse Corps officer as the first Navy nurse assigned to a Fleet Forces Command role and another as the first to command a surgical company in Iraq. In September 2007, the first Nurse Corps Officer was assigned to U.S. Fleet Forces Command to provide analysis and recommendations on all professional and technical matters relating to nursing policy and practice throughout the fleet. As a senior staff officer, she also provides recommendation for health services support programs and policies related to health protection initiatives.

CDR Maureen Pennington was awarded the Bronze Star in April 2007, for her role as the first Nurse Corps officer to serve as Commanding Officer of Charlie Surgical Company, Combat Logistics, 1st MLG, 1st MEF. CDR Pennington oversaw treatment of over 1,700 casualties. Despite increased numbers of patients with blast wounds from Improvised Explosive Devices, she and her team maintained an unprecedented 98 percent combat wounded survival rate. In October 2007, she was recognized by California's First Lady with the Minerva Award, which honors women who have "changed the State of the Nation with their courage, strength and wisdom."

Navy nurses are members and leaders not only at their military treatment facilities, but also in their community civic groups, non-profit organizations, local, State and national civilian nursing associations and Federal nursing organizations. A Senior CRNA served for the 5th consecutive year on the Board of Directors for the Virginia Association of Nurse Anesthetists and served on the Public Relations Committee for the AANA National organization. Other Navy nurses hold the following leadership roles: President-elect of Sigma Theta Tau at The Catholic University of America, Director-Federal Nurses Association and Board of Directors-American Association of Critical Care Nurses. Our junior nurses have embraced a sense of community volunteerism and often work off-hours to support local area homeless shelters by preparing and serving meals, collecting and distributing clothing and assisting with facility renovations.

PRODUCTIVITY

The Nurse Corps Productivity Team developed a tri-service business strategy for inpatient and ambulatory care patient acuity assessment and staff scheduling system. The team which now includes the Tri-Service Patient Acuity Staff Scheduling Working Group has met with Health Affairs and individual service representatives and are meeting with their respective Chief Information Officers to garner support as team activities move forward.

Naval Hospital Beaufort's nurse-managed clinics decreased the pneumonia rate by 45 percent, GABHS (Group A & B Hemolytic Streptococcus) strep throat by 51 percent, febrile response syndrome by 27 percent, and MRSA (Methicillin-Resistant Staphylococcus aureus) by 26 percent through preventive medicine interventions with USMC recruit populations. Nurses at Naval Hospital Camp Lejeune assigned to Camp Geiger Branch Medical Clinic at the School of Infantry-East engaged in a collaborative effort with the Medical Clinic at Parris Island Recruit Depot to improve tracking and documentation of health care provided for recruits from accession to training. In a 6-month period these efforts culminated in significant cost savings by eliminating unnecessary duplication of lab work and immunizations.

Nurse-run clinics established in four barracks at the Recruit Training Command (RTC) in Great Lakes facilitated triage and medical care of 200 recruits per day. The availability of these clinics decreased wait time in the main clinic from 3 hours to 20 minutes, recaptured 13,000 hours of previously lost recruit training time, provided for daily nursing rounds in ship compartments to monitor the status of Sick

in Quarters/Limited Duty Recruits, and generated substantial cost avoidance for the RTC.

Navy nurses at NMCSD were pivotal in developing an innovative model for telehealth nursing using the Armed Forces Health Longitudinal Technical Application (AHLTA) computer system. This project was developed with the goal of becoming a reliable system to provide documentation of patient calls which will improve continuity of care, while capturing nursing workload and improving nursing documentation. This project received the Access Award at the Healthcare Innovations Program Awards at the 2008 Military Health System Conference.

Naval Health Clinic Hawaii collaborated with Hickam Air Force Base's 15th Medical Group on an evidenced-based practice project in caring for adult patients with Diabetes Mellitus (DM), showing an increase patient compliance as evidenced by their improving HbA1C and LDL values.

COMMUNICATION

The overarching goal of the Nurse Corps Communication team is to develop two-way communication plans to optimize dissemination of official information that is easily accessible, current and understood. This has been accomplished via monthly "Nurse Corps Live" video tele-conferences on a variety of topics relevant to our nursing communities, monthly electronic publication of "Nurse Corps News" newsletter which offers a venue to share information, events and articles with all nurses and the Nurse Corps webpage. The webpage serves as a portal to the Navy Nurse Corps detailers, policy and practice guidelines, advanced education offerings, career planning and messages from the Director of the Navy Nurse Corps. In the future, communication team members will be conducting surveys on webpage users to determine new requirements to improve accessibility and better meet user needs.

CLOSING REMARKS

The practice of nursing has changed over the last 100 years with research and technology, but the basic tenets of the profession are unchanged and timeless. We volunteered to wear the uniform, to practice our profession in a different environment and through this we have unlocked the secrets to our humanity and what is most important about caring for those willing to make the supreme sacrifice. Thanks to the generations of Navy nurses who moved us forward through other wars, we have a solid foundation upon which to meet the challenge of tomorrow. Our junior officers are our future and based on the passion and competence I see daily, our future looks bright indeed. We exist because we were and ARE mission essential. They needed us then; they need us now. We can be proud of what we have done and should be inspired and humbled by what we have left to do in the next 100 years.

I appreciate the opportunity to share with you the remarkable accomplishments of my nurses. I look forward to continuing our work together as I carry on as Director and lead Navy nursing into its next century of excellence.

Senator INOUYE. And now may I recognize Major General Melissa Rank. General Rank.

STATEMENT OF MAJOR GENERAL MELISSA A. RANK, ASSISTANT AIR FORCE SURGEON GENERAL NURSING SERVICES AND ASSISTANT AIR FORCE SURGEON GENERAL MEDICAL FORCE DEVELOPMENT

General RANK. Mr. Chairman, and distinguished subcommittee members. It is an honor and great privilege to again represent your Air Force nursing team. The total nursing force is comprised of active duty, Guard, and Reserve officers, enlisted and civilian personnel.

I am honored to have served with Brigadier General Jan Young, Air National Guard, Colonel Laura Talbot, Air Force Reserves, and Chief Master Sergeant David Lewis, Aerospace Medical Service, Career Field Manager.

I look forward to serving with my new Reserve Mobilization Assistant, Colonel Anne Manly, and Chief Master Sergeant Joseph Potts, the newly appointed Aerospace Medical Career Field Man-

ager. Together we represent a powerful total nursing force, directly supporting the Air Force's Secretary and Chief of Staff's top priorities.

Whether at war or home station, our medics are providing world-class care. I offer this amazing act of heroism by one of our independent duty medical technicians, Staff Sergeant Jason Weiss.

He's assigned to the 36th Rescue Flight, Fairchild Air Force Base, Washington. He and his fiancé, Holly, were to be married on December 4, but he could not be there. Instead, his team was busy rescuing three injured, and nearly frozen, hikers trapped in an avalanche. Sergeant Weiss had to get the hikers to the extraction point before the chopper ran out of fuel. There would be no second chance.

Low crawling, near exhaustion, Sergeant Weiss dragged the patient through 80 yards of waist-deep snow, to lifesaving treatment. Sergeant Weiss was married 4 days later, and Holly explained, "He does such amazing things, that I have to share him."

The total nursing force is the backbone of deployed Air Force medical operational capability. A heightened demand has been placed upon us for advanced, highly complex clinical skills, and we are meeting the challenge.

The 332nd Expeditionary Medical Group in Balad Air Base, Iraq continues to meet the mission with incredible success. This Air Force theater hospital is the hub for Operation Iraqi Freedom polytrauma and burn cases, and sustains a 98 percent survival rate, the best in history.

From the moment a patient arrives into the Balad Air Base emergency room, until they reach definitive care at Landstuhl or stateside, an Air Force nurse and technician provide 24/7 expert, compassionate care.

On my recent trip to Balad Air Base and Bagram Air Base, Afghanistan members of our total nursing force related that their deployment has been the most personally and professionally rewarding experience of their lives.

I was particularly moved by the story of Major Linda Stanley from the 31st Medical Group in Aviano, Italy. Paraphrasing her journal, "I took care of a patient tonight, and I know I will never forget him. He had been on patrol, and lost his foot to an improvised explosive device (IED). For some reason, his bloody boot symbolizes all of the trauma patients that I'm taking care of—the vision of his boot, the sound of painful cries, and the smell of death are my senses side of war. I find life in these senses, and it reminds me of what is truly important in my own life. I am still glad that I deployed, and I hope I will always remember these feelings."

These are the heart-wrenching realities of war, and my team is committed to addressing the unique combat stress of caregivers. Our initiative is called R3—readiness, resilience, and rejuvenation. Our nursing team needs a high level of personal and professional readiness, an inner resilience, and the ability to rejuvenate after returning from deployment.

As we develop our R3 programs, we will leverage our unique military nursing experience and commitment to care for ourselves and each other. Lieutenant Colonel Susan Jano, nursing supervisor at Balad Air Base, described it best, "We saw mass casualties that

training never quite prepared us for. We reached deeper into ourselves than we ever thought possible, and we cared for one another because we were all we had. Together, we made a difference."

We also are making a difference in Afghanistan, where the humanitarian mission is particularly robust. Zach was a child who had been hit by a bus. When he arrived at the Bagram emergency room, he had no pulse, his temperature was 91 degrees, and he had astounding major abdominal injuries. Amazingly, after receiving extensive operations and nursing care, he went home with his family in just 30 days.

The rewards of these efforts are highlighted by Major Daisy Castricone, currently deployed to Bagram Air Base, when she stated, "You can see the appreciation and the love in their eyes for what we do, and you can feel the sincerity in the handshake—it's like electricity."

Thanks to the efforts of the 332nd Expeditionary Medical Group, and Expeditionary Civil Engineering Squadron, a piece of our nursing history will be preserved. On April 1, 2008 Trauma Bay 2, and a portion of the tent from the old Balad Air Base theater hospital were shipped to the National Museum of Health and Medicine, here in Washington, DC. Major Jody Ocker, Emergency Department Nurse Manager, related, "Every medic had their own personal experience. As a team, we had a profound collective experience. In these tents, we witnessed tragedy beyond comprehension, and rose to challenges unimagined. We sweated, cried, and laughed together, most importantly, we saved lives."

PREPARED STATEMENT

Mr. Chairman, and distinguished members, the preservation of the theater hospital's trauma bay is a testament to the Department of Defense nurses, and medics, who have held the hands of wounded warriors, said goodbye to the fallen, and offered their blood, sweat and tears to save our Nation's sons and daughters. United, we will win today's fight, provide world-class care, and prepare for tomorrow's challenges.

Thank you, sir, for your continued support.

Senator INOUYE. I thank you very much, General Rank.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL MELISSA A. RANK

Mr. Chairman and distinguished members of the Committee, it is an honor and gives me great pleasure to again represent your Air Force Nursing team. As we vigorously execute our mission at home and abroad, Air Force nurses and enlisted medical technicians are meeting the increasing challenges with notable professionalism and distinction. The Total Nursing Force is comprised of officer, enlisted, and civilian nursing personnel with Active Duty, Air National Guard (ANG), and Air Force Reserve Command (AFRC) components. Serving alongside Brigadier General Jan Young of the ANG and Colonel Laura Talbot of the AFRC has been my distinct pleasure. I look forward to serving with Colonel Anne Manly who was recently appointed in the AFRC Corps Chief position replacing Colonel Laura Talbot. Together we are a powerful total force nursing team directly supporting the Secretary and the Chief of Staff of the Air Force's top priorities to Win Today's Fight, Take Care of our Airmen, and Prepare for Tomorrow's Challenges.

EXPEDITIONARY NURSING

Air Force Nursing is an operational capability and Air Force Nursing Services remain at the forefront in support of the warfighter. A heightened demand has been

placed upon military nursing for highly complex clinical skills and our total nursing force is meeting this challenge. Every member of the Total Nursing Force team has told me that their deployments, caring for America's most precious sons and daughters, has been the most professionally rewarding experience of their lives. For instance, Captain Shelly Garceau is an emergency room nurse at the 332nd Expeditionary Medical Group (EMDG) in Balad Air Base, Iraq, one of the busiest trauma centers in the world. The emergency room treats 23 patients a day on average, 11 of which are trauma cases. In a 24-hour cycle, the facility's operating room staff typically handles more than a dozen cases and performs more than 60 procedures. In the past year, nursing was critical to the successful treatment of over 10,000 injuries. The hospital currently holds a 98 percent survivability rate for wounded Americans who arrive at the 332nd EMDG. Colonel Norman Forbes, 332nd EMDG Chief Nurse, states, "In a four-month period, the facility's statistics match or exceed activities at the R. Adams Cowley Shock Trauma Center in Baltimore, where many of our staff nurses were trained."

Behind every case and helping every patient who arrives at their doorstep, is the nursing staff of the 332nd EMDG. From the moment a wounded soldier arrives at the hospital to the time the patient lands in Germany or is medically evacuated to the United States, a nurse and technician are there to care for the wounded patient. The pride that erupts from the members of this medical group is felt and seen when you look at even just one situation: Two Marines were transferred out of the Balad Air Base emergency room with partial thickness burns to the face as a result of an explosion; Captain Garceau (332nd EMDG) stated, "That guy couldn't even see me. He wouldn't be able to show you who I am if he saw me. But he'd recognize my voice. And when he said thank you to me, it was like nothing else. There's nothing like the 'thank-you's' you get here—nothing at all."

Bringing wounded warriors home is mission #1 for our fixed-wing aeromedical evacuation (AE) system. AE is a unique and significant part of our Nation's renowned mobility resources. Its mission is to rapidly evacuate patients under the supervision of qualified AE crewmembers by fixed-wing aircraft during peace, humanitarian, noncombatant evacuation operations, and joint/combined contingency operations. The Air Force Reserve Component owns approximately 88 percent of the total AE force structure, with the remaining 12 percent distributed among four active duty AE squadrons. During November 6–7, 2007, active duty and reserve subject matter experts met to hold a capabilities review and risk assessment on the AE system. As a result of this meeting, the Air Force AE patient care information management and in-transit visibility modernization plan evolved. The recommendations for a new electronic patient medical record and the ability for combatant commanders to know where, when, and how their injured troops are doing, will bring AE to the leading edge of technology.

A major advancement in aeromedical evacuation system of the Afghan National Army (ANA) Air Corps is the work being done by individuals like Major Mical Kupke, Captain Marilyn Thomas, Master Sergeant Brian Engle, and Technical Sergeant Janet Wilson who opened a flight medicine clinic in Kabul, Afghanistan. These airmen are using all local resources available to perform work, including loading patients onto MI–17 helicopters, coordinating with the Czech Republic field hospital and working with the medevac unit located nearby at Bagram Air Base, Afghanistan. As Sergeant Engle stated, "The ultimate goal is for us to be able to step away as the ANA becomes self-sustaining." Sergeant Wilson stated, "The fact that we're able to bring something to their Air Corps and help the Afghan National Army build up their structure is very positive; it makes me proud that I can contribute just a tiny portion to that."

Our aeromedical staging facilities (ASF) provide critical support to the aeromedical system. The 79th ASF at Andrews AFB, Maryland is the busiest in the continental United States. Since January 2007, the staff has launched and recovered 699 missions, and facilitated the transport and care of 7,895 patients to Andrews, Walter Reed Army Medical Center and the National Naval Medical Center. The 79th ASF staff includes 31 permanent and 33 deployed active duty and reserve nursing and administrative nursing personnel. Army, Navy, and Marines liaisons also work in the ASF assisting their patients with transition back to the United States. The patients have a wide variety of injuries and illnesses, including those from improvised explosive device (IED) blasts, gunshot wounds, traumatic brain injuries, post-traumatic stress disorder, and extremity fractures.

In this calendar year, the 79th ASF received a $4.8 million grant to renovate and expand, increasing the bed capacity from 32 to 45. Nutritional Medicine from the 79th Medical Group implemented "The Burlodge," a program that provides every patient returning from theater a homemade hot meal. Dedicated American Red Cross volunteers are on hand to welcome every patient upon their return. These volun-

teers offer their assistance in many ways to meet the needs of the patients, providing toiletries, clothing, email assistance, and more. Major Leslie Muhlhauser and Captain Christopher Nidell of the ASF staff recall these patient encounters:

—One of the administrative technicians sat with a patient all night talking and watching movies, because the patient expressed not wanting to be alone and not being able to sleep.

—A security forces patient wanted to take a hot shower and wash her hair and was unable to do so on her own due to leg and arm injuries. Three of the ASF staff worked together to protect her wounds and help her shower.

—One of the nurses sat with a 19-year-old soldier from Kentucky suffering from migraines related to an IED blast exposure. He stayed with the soldier to help him relax until the medication he received began to relieve his pain.

—The staff coordinated with veterinary services for the care and lodging of two canine battle wounded heroes, one who received a Purple Heart.

—On one mission, the wind and weather prevented a C–17 and C–130 from landing at Andrews AFB Maryland. The ASF flightline crew quickly realigned the organizational plans and met the aircraft at a commercial airport in the National Capital Region (NCR).

—The nurses watched a mother's face as she and her family waited for the arrival of her son; seeing them together was a privilege.

SKILL SUSTAINMENT

Nursing skill sustainment has never been more important than it is during our steady state of deployment. Air Force critical care nurses have played an instrumental role in the care of wounded and ill patients in Operations IRAQI FREEDOM and ENDURING FREEDOM. Critical care nursing is a nursing specialty and both civilian and military sectors are dealing with a shortage of experienced critical care nurses. In an effort to ensure the needs of the critically ill are met, the Air Force Nurse Corps partnered with our sister services and initiated a fellowship training program in the NCR. During this fellowship nurses develop critical care skills at the National Naval Medical Center at Bethesda, Maryland, where many wounded patients are admitted to the intensive care unit. This fellowship program began in January 2007, and recently graduated the first qualified critical care nurses. The program produces deployment-ready nurses in 8 months. Captain (select) Jonathan Criss joined his fellow classmates Lieutenant Amy Tomalavage and Captain Dillette Lindo for graduation via video-teleconference from Iraq, where he deployed in November. Lieutenant Colonel Loreen Donovan, Balad Air Base Intensive Care Unit flight commander, praised the preparedness and skills of Captain (select) Criss. Lieutenant Colonel Donovan has since taken over as the director of the fellowship program, and will incorporate her deployment and clinical experiences into the curriculum. The program is designed to graduate 10 nurses annually and complements a similar program initiated by the Air Force in San Antonio, Texas, in collaboration with the Army.

The Critical Care Technician Course (CCTC) began in early 2007, as a result of the high demand for our critical care technicians. The program is conducted at Eastern New Mexico University-Roswell and presents 40 hours of didactic and hands-on education. The 59th Medical Wing, Wilford Hall Medical Center, located at Lackland Air Force Base, Texas, took the lead with this program, holding three classes in fiscal year 2007 for 36 technicians. The program has now been expanded for fiscal year 2008 into a 5-year contract anticipating four classes for 56 technicians per year. The 96th Medical Group, located at Eglin Air Force, Florida, has contracted with

ENMC–R for the CCTC and has two classes scheduled in fiscal year 2008 educating a total of 60 medical technicians. We anticipate pushing the possibilities of teaching over 400 critical care medical technicians over the next 5 years.

Whether at war or home station, these critical clinical skills remain relevant. Consider this story told by the 39th Medical Group Chief Nurse, Lieutenant Colonel Rebecca Gober, from Incirlik Air Base, Turkey. "Staying late catching up on access due to an increased exercise schedule, the personnel of the 39th Medical Group at Incirlik Air Base, Turkey, suddenly found themselves with four local national gunshot victims at their doorstep! Shouts of "Code Blue" were heard throughout the building. Within a matter of minutes, this small, outpatient clinic staff transformed into an emergency triage/treatment team rivaling a large trauma medical center. Past training kicked in and many were grateful for their recent training at the Center for Sustainment of Trauma and Readiness Skills. While lives were being saved by the clinical staff, ancillary support teams coordinated administrative needs to help identify patients, secure personal effects, and arrange transport to outside med-

ical facilities. Resuscitative efforts were successful for three of the four victims. Only 4 hours passed from the entry of the first victim until every supply item was replaced, every cart returned and every room was ready for normal operations again. With the number of staff present at that time of day, training and teamwork truly were keys to their success." I am so proud of our nursing team for their performance that day!

OPERATIONAL CURRENCY

In response to BRAC integration, additional opportunities to maintain operational currency in complex patient care platforms is critical. This year we gained 25 training affiliation agreements specific to officer and enlisted nursing personnel. This number is triple what we reported last year, a fact that assures me of the continued clinical readiness of our great Total Nursing Force. Our biggest gains were in agreements with civilian facilities. I am pleased to inform you that we partnered with nine civilian facilities to pursue skills sustainment in critical care, complex medical-surgical care, emergency/trauma, and ambulance services. Our Medical Treatment Facilities (MTF) remain an ideal training platform for many civilian nursing programs as well. In 2007, we added 33 training affiliations for civilian nursing programs awarding degrees at baccalaureate, masters, and doctoral levels.

In addition to our civilian training affiliations, I recently sent a team to conduct a site visit at the University Hospital in Cincinnati, Ohio. This visit was initiated to examine the possibility of centralizing an internship Nurse Transition Program (NTP). The program allows new graduates the opportunity to transition into clinical care with nurse preceptors closely at their side. NTP is currently offered at nine Air Force MTFs, but centralizing the program into one site would optimize clinical education. The University Hospital offers a larger patient population, diverse illnesses, and medical/surgical cases including an increased opportunity to care for higher level trauma patients. Time management and complex inpatient nursing are the number one skill sets required for deployment. NTP is currently a 12-week program, but with the offerings at this facility, the program may be pared down to 9 weeks. The University Hospital offers an ideal environment for a successful civilian NTP program and we look forward to the possibility of partnering with them to enhance Air Force NTP education.

We now face the emergence of a new set of issues specifically related to our current "steady state" of deployment. These include: (1) The need to maintain a high level of personal and professional readiness; (2) The inner resilience to sustain the mission despite daily wartime tragedies and prolonged exposure to secondary trauma; and (3) The ability to rejuvenate oneself upon return from deployment, and ultimately regain a sense of personal and professional balance. Readiness—Resilience—Rejuvenation (R3): Acknowledging and understanding the need to address the complexities these three concepts represent will pave the way to a vital, stable future for our Total Nursing Force. Our military nurse researchers are advancing understanding of issues related to R3. Their research data shows a common emerging theme: the positive impact of strong wing and unit reception upon return from deployment and periodic team debriefings. We look forward to additional data and findings in the very near future.

RESEARCH AND EDUCATION

Through your ongoing support of the TriService Nursing Research Program (TSNRP), Air Force Nurse Researchers continue to conduct innovative research with wide-ranging implications for the care of troops injured on the battlefield. Not only are these Nurse Researchers at the forefront of state-of-the-art-military research, they are involved in initiatives ensuring their research is translated into practical application, improving the clinical care delivered to our wounded warriors.

Since the start of Operation ENDURING FREEDOM in 2001, over 48,000 patients have been transported by the United States Air Force Aeromedical Evacuation system. Critical Care Air Transport Teams (CCATT) provide care for 5–10 percent of the injured or ill service members who are transported on military cargo aircraft to definitive treatment facilities. Through Air Force Institute of Technology sponsorship, Colonel Peggy McNeill attended the University of Maryland doctoral program in nursing and conducted research to determine the effect of two stressors of flight—altitude-induced hypoxia and aircraft noise. COL McNeill also examined the contributions of fatigue and clinical experience on cognitive and physiological performance of CCATT providers. This was accomplished using a simulated patient care scenario under aircraft cabin noise and altitude conditions. The findings from this research demonstrated that the care of critically ill patients is significantly affected by aircraft cabin noise and altitude. Safety and quality of care may be posi-

tively impacted with training and equipment better designed to assist in monitoring and assessment during aeromedical transport.

Air Force Nurse Researchers play a critical role in deployments as well. Lieutenant Colonel Marla De Jong, Director of Nursing Research at Wilford Hall Medical Center, deployed to Baghdad, Iraq, for 10 months. As the first Air Force Program Manager for the Joint Theater Trauma System (JTTS), Lieutenant Colonel De Jong used her research and leadership expertise to manage data from 15 separate locations for 9,000 battlefield casualties, author clinical practice guidelines, launch a new electronic joint trauma registry, improve trauma documentation and the electronic medical record, direct process improvement initiatives, educate clinicians, and promote in-theater research, pioneering contributions that transformed care on the battlefield. Clinical focus areas included administration of recombinant coagulation factors, fresh frozen plasma, and fresh whole blood; resuscitation of patients with severe burns; assessment for traumatic brain injury; use of tourniquets and HemCon bandages; and prevention of hypothermia and ventilator-associated pneumonia. Of particular importance, Lieutenant Colonel De Jong authored an intratheater air transport guideline that improved safe MEDEVAC transport of critically injured casualties. Finally, she helped infuse JTTS priorities into a North Atlantic Treaty Organization led hospital in Kandahar Airfield, Afghanistan. Collectively, these activities have saved lives and limbs and improved trauma care throughout the joint combat theater of operations.

Air Force Nurse Researchers are also on the cutting edge of putting research into practice on the battlefield. In collaboration with colleagues from the Army, Navy and civilian professional nursing community, Colonel (Select) Elizabeth Bridges, U.S. Air Force Reserve Nurse Corps, IMA Director at the Clinical Investigations Facility at Travis Air Force Base, California has developed a Battlefield and Disaster Nursing Pocket Guide. This guide was funded by a grant from the TSNRP Resource Center. In the coming months, this guide will be shared with the Department of Veterans Affairs and Public Health Service colleagues. It is a goal of the services to provide a copy of this guide to all military nurses and enlisted personnel who deploy in support of the war.

We are making incredible progress with our Center for Sustainment of Trauma and Readiness Skills (CSTARS). One of our 3 teaching affiliations is with the University of Cincinnati College of Medicine. This University is a tertiary referral center for a three-state region and is a verified level I trauma center. It is a 495-licensed bed facility holding 90 adult critical care beds, 51 of which are surgical. In 2007, the University trauma registry volume was 2,464 patients, with an average injury severity score (ISS) of 15.73 percent. This ISS is a measure of acuity and is used as a standard in all trauma centers. The ISS is to ensure our personnel are training to the level of care they would be providing during a deployment. The course provides 92 continuing education contact hours in just 11 training days. This consists of 30 hours of lecture material, 5 hours of lab, 48 hours of clinical time, 8 hours of simulator time, and 22 hours in flight operations. In addition to the Cincinnati site, we have CSTARS located in Baltimore, Maryland and St. Louis, Missouri. The CSTARS program is open to Active Air Force, ANG, AFRC, Navy, Army, and Department of Defense medical employees. In fiscal year 2007, the CSTARS program graduated 685, a 10 percent increase from fiscal year 2006 (614), and we are actively engaged in increasing that percentage in fiscal year 2008.

Recently, I had the opportunity to visit our medical readiness training center located at Sheppard Air Force Base, Texas. This site provides primary deployment preparation for over 5,000 students annually. Approximately 3,400 enlisted personnel receive their basic medical readiness training as part of their initial skills curriculum. This provides consistent baseline knowledge for all subsequent deployment preparation training they will receive throughout their Air Force careers. Another 1,600 medics are trained in one of the four advanced courses:

—Contingency Aeromedical Staging Facility (CASF);

—Aeromedical Evacuation Contingency Operations Training (AECOT);

—Expeditionary Medical Support (EMEDS); and

—Medical Readiness Planners Course.

These courses provide training for Air Force Medical Service (AFMS) deployment unit type codes. The CASF, AECOT, and EMEDS courses are 5-day field-condition, scenario-based training platforms that simulate the actual environment medics will live and function in during their deployment. Students attending one of these medical readiness courses are certified deployment ready with AFMS knowledge and skills required to be fully functional upon arrival in theater. The site's 32 instructors cover a total of 12 Air Force Specialty Codes.

During my visit to this incredible training center, I received overwhelming positive feedback from previous deployed airmen attesting to the value of this unique,

realistic training opportunity that now exists and the profound impact it will make on future deployers.

JOINT ENDEAVORS

Air Force nurses have a unique opportunity to participate in a historical Military Health System process directly shaping health care delivery for future generations. On September 14, 2007, it was announced that the Department of Defense (DOD) would establish the Joint Task Force National Capital Region Medical Command (JTF/CAPMED) in Bethesda, Maryland, to oversee healthcare delivery services for the Air Force, Army and Navy. This new medical command is tasked with the responsibility for world-class military healthcare in the NCR, integrating healthcare services across the entire region reporting directly to the Secretary of Defense. This is the first Command of its kind in the history of DOD! The NCR is the most complex area the military has due to the number of military services, medical facilities and patients, many of whom are casualties returning from the war. As America's primary reception site for returning casualties, the number one priority of this new Command is casualty care. This new medical establishment has several senior leadership positions ranging from specialties such as manpower and personnel to clinical operations, plans and policy, and education, training and research. Colonel Sally Glover and Chief Master Sergeant Joey Williams of the 79th Medical Wing are vital members of the JTF/CAPMED J3 nursing cell that is currently chaired by Air Force Nurse Corps Colonel Therese Neely. Partnering with the senior nursing leadership from all the MTFs in the NCR, this group has made tremendous strides in creating a joint nursing platform that will apply not only to the Walter Reed National Military Medical Center but to all the MTFs in the NCR. The perioperative nursing group was the first to integrate adopting national Operating Room Nursing standards across the board. In addition, clinical ladder development, clinical leadership position selection, and clinical performance metrics are being established with a focus towards Magnet Status. Chief Williams' leadership in the enlisted group has been critical to ensure the appropriate scope of practice for our medical technicians in this joint environment. He provides a strong focus on clinical skills sustainment for wartime readiness. Most recently, we announced Colonel Barb Jefts and Major Raymond Nudo to join the Joint Task Force for DOD in the Washington D.C.

We participate in international joint endeavors every day. One example of this occurred at Hickam Air Force Base, Hawaii. Five airmen from the 18th Aeromedical Evacuation Squadron (AES) at Kadena Air Base, Japan, teamed up with 11 members of the Royal Australian Air Force's (RAAF) Health Services Wing in Hawaii. The training focused on how the Air Force utilizes the C–17 Globemaster III for medical evacuations. Wing Commander Sandy Riley (RAAF) stated, "We've got expertise in AE, but not on the C–17. The C–17 was rapidly introduced into the Australian service so this is invaluable training for us to see the expertise of the Pacific Air Forces and the 18th AES." This small investment is likely to yield tremendous results. Bolstering the RAAF's AE capability means one of America's staunchest allies in the Pacific is now equipped with expanded latitude.

The Air National Guard provided five medical groups for humanitarian events throughout the world including Panama, Guatemala, Nicaragua, Bolivia, and El Salvador. State Partnership Programs link the United States with partner countries' defense ministries and other Government agencies for the purpose of improving international relations. Under this program, three medical groups combined efforts with the State Partnership Program to provide humanitarian support to the partner countries. The medical personnel provided assistance in Azerbaijan, Morocco, and Armenia working and exchanging knowledge with each country's counterparts. Recently the 144th Medical Group sent approximately 30 medics to Santa Teresa, Nicaragua for the Medical Readiness Training Exercise (MEDRETE) for New Horizons Nicaragua 2007. This program was a joint military humanitarian and training exercise which provided new medical clinics and schools to rural communities in Nicaragua. Other locations assisted were in Huehuete, Roman Esteban, and Nandaime, Nicaragua. The last exercise took place in Diriamba, Nandaime, and La Conquista. The total number of patients cared for by medics was 7,899. According to the Camp Commander, Lieutenant Colonel Aaron Young, the team "did an outstanding job." He went on to say, "It was a great joint training opportunity to work with our good friends in the Nicaraguan military and the Ministry of Health." At the final day of the MEDRETE, a ceremony was held with the Mayor of Thomas Umana, Nicaragua, Mr. Augustine Chavez. He presented the troops certificates in appreciation of their medical care. Mr. Chavez commented, "I could never repay you for the gift you've provided to our community." This heartfelt expression of gratitude is exactly why we do what we do.

Our Air Force Reserve is doing incredible work as well. In 2007, Air Force Reserve nurses and technicians showed a continued zest in volunteerism as airmen. A total of 144 reserve nurses and 230 medical technicians deployed in support of the Global War on Terrorism which included a combination of nurses specializing in flight nursing, mental health, critical care, emergency care and medical/surgical nursing. The reserve clinical training platforms trained 752 medics in sustainment of critical wartime nursing skills. One of our Reserve nurse deployers, a very experienced obstetrics nurse, Colonel Laura Saucer, participated in a Provincial Reconstruction Team teaching 57 midwives and midwifery students in a rural Afghanistan town. The team commented, "the courage of the students was inspiring." The team reported that female providers in rural areas of Afghanistan are in critical demand, and 16 of every 1,000 women die in childbirth largely due to no access to healthcare. Colonel Saucer described the students as "wonderful." After years of oppression, they are so excited to learn and are like sponges soaking everything up. This is only one story of good will among many from our deployers. Additionally, 133 multi-discipline airmen were key participants in the Air Force International Health Specialist (IHS) Program over the past year. The organization of IHS medical staff journeyed around the world in support of humanitarian missions and exercises to include the countries of Vietnam, Morocco, Guatemala, Belize, El Salvador, Senegal, Oceania, and Sri Lanka. An impressive 34,000+ patients were treated. These small teams of healthcare professionals delivered expert medical care and brought good will to disenfranchised people of the world while building on their own expert skill level. As you can see, our ANG and AFRC are providing world-class care, leadership and mentoring across the globe.

QUALITY CARE

Our Air Force Inspection Agency (AFIA) ensures our patient care is first-rate. AFIA conducted over 62 inspections covering active duty medical treatment facilities, aeromedical evacuation and clinics served by the Air Force Reserve and Air National Guard. Nursing programs were evaluated by the Joint Commission and the Accreditation Association for Ambulatory Health Care. All programs were reviewed to meet compliance with national standards in conjunction with Air Force directives for Air Force MTFs and units in fiscal year 2007. We have engaged with our Chief Nurses and Senior Aerospace Medical Service Technicians to lead the way, ensuring continued world-class medical care is provided to all of our DOD beneficiaries. Overall, our nursing programs did exceptionally well and will continue to do so in years to come with your continued support.

RECRUITING, RETENTION, AND FORCE DEVELOPMENT

Just as with the civilian sector, at the top of our list of concerns is what has become a chronic struggle with increasing nursing requirements and the growing national nursing shortage. Human resources are the single greatest influence on health care. The latest estimates developed by the Bureau of Labor Statistics indicate that the United States will require an additional 587,000 registered nurses (RNs) by 2016 to meet the nursing needs of the country

The Air Force is not immune to these statistics. Over the next 3 fiscal years, 28.6 percent (953) of our nurse inventory will be eligible to retire. Over the last 10 years, 54 percent of the Nurse Corps separated as Captains and 19 percent left as Majors. In fiscal year 2006, 161 nurses retired and 195 separated for a total loss of 356 (10.4 percent total attrition rate). Our loss rate has increased slightly in fiscal year 2007, with a total loss of 404—178 to retirement and 226 to separation (12 percent total attrition rate). Almost half of Nurse Corp officers who have separated have less than 8 years of military service.

In fiscal year 2006, Air Force nurse recruiting was reported at 62 percent of 357 with a slight increase in fiscal year 2007 to 63 percent. Our recruiting services forecast places our risk for nurse recruiting at "high" for fiscal year 2008 and "severe" for fiscal year 2009. We are currently offering an accession bonus to our nurse recruits in exchange for a 4-year commitment; this bonus will increase fiscal year 2009. In addition to our recruiting services, we also bring novice nurses into the Air Force through several programs. Utilizing the Air Force Reserve Officers' Training Corps (AFROTC), Airmen Education & Commissioning Program (AECP), and the Enlisted Commissioning Program (ECP), we brought in 47 nurses in fiscal year 2006 and 61 in fiscal year 2007.

In fiscal year 2009, we plan to support the nurse incentive special pay with $12.5 million. We anticipate that offering the nurse incentive special pay will retain approximately 31 percent (1,000 nurses of 3,262 as of January 11, 2008) of our current inventory for an additional 2 to 4 years beyond their current active duty service

commitment. Additionally, we currently offer incentive special pay to Certified Registered Nurse Anesthetists (CRNAs) at variable rates dependent on active duty service commitment. The annual average for this incentive special pay is approximately $35,000 per CRNA. Air Force Nurse Practitioners receive board certification pay at varying rates that are dependent upon the amount of time served in the specialty. Both the CRNA incentive special pay and the Nurse Practitioner board certified pay will continue to be offered in fiscal year 2009.

In this time of increasing nursing shortages, the need to grow our own has become evident. Since my last testimony, we have launched our Nurse Enlisted Commissioning Program (NECP). NECP is an accelerated program for enlisted airmen to complete a full-time Bachelors of Science in Nursing (BSN) at an accredited university while on active duty. This program will produce students completing their BSN and obtaining their nursing license in just 24 months. Airmen who successfully complete this program will be commissioned as second lieutenants. Our goal is to select 50 candidates per year by fiscal year 2010 for this new commissioning opportunity. On a recent trip to Ramstein Air Base, Germany, I spoke with Staff Sergeant "Rae" Amaya who is stationed at Ramstein with the 86th Aeromedical Evacuation Squadron. She has been serving her country for nine years and expressed her desire of becoming a nurse with this statement, "The vision of getting back to the "True North" (which is bedside nursing) was inspiring, especially since I'm trying to become a nurse. I have been fortunate to be mentored by some very awesome nurses who have made me the technician I am today. When I become a nurse—whenever that might be—I will do my best to remember, pass on and enforce this vision." With the NECP program in full swing, we can make dreams like this come true.

In addition, we have continued robust advanced practice nursing educational programs through the Uniformed Services University in Bethesda, Maryland Graduate School of Nursing, the Air Force Institute of Technology, Civilian Programs and the Army-Baylor Master's Program. This year we anticipate the graduation of 49 advanced practice degrees such as, Family Nurse Practitioners, CRNAs, and PhDs. Enrollment for fiscal year 2008 includes 45 advanced practice nurses. Opportunities such as advanced degrees foster an environment of professional growth and leadership. This further supports retention, recruitment and a bolstered force development.

RECOGNITION

General T. Michael Moseley, our Air Force Chief of Staff, developed the "Portraits in Courage" series to highlight the honor, valor, devotion, and selfless sacrifice of America's airmen. Two of our medical technicians were highlighted this last year, one in each category. The first was Staff Sergeant David Velasquez, a technician from Langley Air Force Base, Virginia. Sergeant Velasquez was one of 13 airmen recognized in the "Portraits in Courage." He volunteered for a 365-day tour to Afghanistan as a medical technician and completed more than 90 convoys and numerous missions with the Provincial Reconstruction Team and Quick Response Forces. His team was fired upon virtually every mission and survived eight serious attacks to their convoys. In one instance, Sergeant Velasquez's convoy was enroute to the U.S. Embassy when it was hit by an improvised explosive device. The vehicle directly in front of his was heavily damaged and two of its passengers were killed. His vehicle's turret gunner fell into the vehicle on fire and suffered severe shrapnel wounds to his left arm. Sergeant Velasquez quickly extinguished the flames, stopped the bleeding, and administered life-saving medical aid. This was just one of his many heroic acts. He was quoted as saying, "I was only doing my job, nothing special." Those who have received life-saving medical attention in the heat of battle from him would argue otherwise.

Six airmen received the new Air Force Combat Action Medal on June 12, 2007. This medal was created to recognize Air Force members who engaged in air or ground combat off base in a combat zone. This includes members who were under direct or hostile fire, or who personally engaged hostile forces with direct and lethal fire. One of those six warriors was Staff Sergeant Daniel L. Paxton, an aeromedical technician school instructor, who was assigned to the 42nd Aeromedical Evacuation Squadron at Pope Air Force Base, North Carolina at the time. He is now assigned as a flight instructor using his critical experiences from March 28, 2003. Sergeant Paxton was part of a mission to establish a series of tactical medical units along the border of Kuwait and Iraq. His convoy came under enemy fire from mortars, rocket-propelled grenades, machine guns and small-arms fire. Without the benefit of intra-vehicle communications, Sergeant Paxton and his team reacted to the ambush and returned fire, successfully defending their assets as they executed a co-

ordinated withdrawal. Under the cover of darkness and using night vision devices, the convoy embarked and the enemy again opened fire. During the next 18 hours, the convoy came under fire five subsequent times and Sergeant Paxton successfully engaged the enemy with return fire, defending himself and the convoy as they progressed on their mission.

In addition, I offer these amazing acts of heroism by our Independent-Duty Medical Technicians (IDMT): Staff Sergeant Jason Weiss smiled as he thought of Holly. It was just a year ago he had asked her to marry him. On December 4th they were to be wed. There was only one problem—he was not going to be there. As an IDMT, from the 36th Rescue Flight out of Fairchild Air Force Base, Washington, he was going out to search for three individuals who had been hiking in the mountains when the weather made a sudden change causing an avalanche. Two of them were swallowed up by the snow and the third hiker sustained a shattered limb and had the onset of hypothermia (body core temperature of 93.5 degrees). Weiss and his team arrived to find a critical situation. "Visibility was so poor that I couldn't see a thing out of my side of the Huey," said Sergeant Weiss. The Huey crew found a hole in the trees and lowered Weiss to the ground, roughly 80 yards from the victim. "When I stepped off the rescue hoist, I sank up to my chest in snow. I then crab-crawled for about 40 yards and was able to walk the last 40 yards in waist deep snow." Sergeant Weiss knew before he left the helicopter that there was no time to waste. Low on fuel, with the weather worsening, Sergeant Weiss raced to the victims and placed the 176-pound man over his shoulders in a fireman's carry, and trudged 40 yards through waist deep snow pushing himself to his limits. He then dragged his patient across the snow like a sled for another 40 yards, finally reaching the extraction point. On his hands and knees, huffing and puffing, with steam rising from his sweaty brow, Weiss's head and shoulders suddenly slumped. He could hear the distinctive whir of the Huey's engines, indicating his crew was leaving them behind to refuel. By this time Sergeant Weiss and the victim were in a full-blown whiteout blizzard, and then suddenly he heard the rhythmic sound of "whop, whop, whop," denoting the Huey was returning for another pass. The crew skillfully placed the forest penetrator (hoist) right next to Weiss. He then secured his patient for the ride up to the Huey, and once inside the helicopter, began treating the 38-year-old man for hypothermia, dehydration and a broken leg. He then went on to spend the next 3 days on alert, but on December 7th, Sergeant Weiss and Holly finally exchanged vows. Holly said admiringly, "He does such amazing things that I have to share him."

During a recent outing on the lake with his family, Senior Master Sergeant Michael Stephenson-Pino, Superintendent of the IDMT Course, witnessed a father and son launched 10–12 feet in the air as the cigar shaped tube they were being pulled on behind the boat buckled. This situation was further complicated with both of them being launched in opposite directions 20 feet apart and disappearing simultaneously under the water. As Sergeant Stephenson-Pino immediately sprang into action swimming towards the victims, the 10-year-old boy surfaced screaming as the father laid motionless face down in the water. Upon reaching the father, Sergeant Stephenson-Pino rolled the victim over onto his back, opened and maintained the airway effectively restoring his breathing. With the unconscious adult in tow, he swam towards the child who was panicked and struggling to stay afloat in a life preserver which was too large for him. Without losing control of the unconscious adult, Sergeant Stephenson-Pino positioned himself behind the child and neutralized him as a drowning hazard. Now finding himself stranded in 30 feet of water and with two near drowning victims in tow, Sergeant Stephenson-Pino started swimming towards shore. After having traveled 30 yards while swimming on his back to the point of near exhaustion with both victims, he succeeded in loading them into the boat and then utilized his 11 years as an IDMT to stabilize their injuries. He put into action what he and his staff teaches our enlisted physician extenders and through his advanced training, a humanitarian effort was instrumental in preventing the loss of life for the father and child.

These are just a few stories of many, reflecting the versatility of our medical technicians and the dynamic energy they bring to every situation.

OUR WAY AHEAD

Nursing is the pivotal health care profession, highly valued for its specialized knowledge, skill and care of improving the health status of the airmen in our charge and ensuring safe, effective, quality care. Our profession honors the diverse population we serve and provides officer, enlisted and civilian leadership and clinical proficiency that creates positive changes in health policy and delivery systems within the Air Force Medical Service. Our 5-year top priority plan includes, first and fore-

most, delivering the highest quality of nursing care while concurrently staging for joint operations today and tomorrow. Secondly, we are striving to develop nursing personnel for joint clinical operations and leadership during deployment and in-garrison, while structuring and positioning the Total Nursing Force with the right specialty mix to meet the requirements. Last, but not least, we aim to place priority emphasis on collaborative and professional bedside nursing care.

Mr. Chairman and distinguished members of the Committee, it is an honor to be here with you and to represent a dedicated, strong Total Nursing Force of nearly 18,000 men and women. United we will Win Today's Fight, provide world-class care for our airmen, and Prepare for Tomorrow's Challenges.

Senator INOUYE. As one who has served in the military, over 2 years in hospitals, I'm especially grateful to nurses. Without them, I don't suppose I would be sitting here.

But because of time constraints, I have many questions on recruiting and retention, also questions on incentive pay and bonuses. Also questions on the school of nursing, because I've been told there's some opposition to the establishment of that program, and others. But I will be submitting them to you, if I may, for your response.

And with that, may I recognize Senator Stevens.

Senator STEVENS. Mr. Chairman, I, too will submit my questions. I'm delighted to see you all here, and you do bring back memories for both of us from our days in the service.

So, thank you all for what you do.

Senator INOUYE. And, our special angel.

Senator MIKULSKI. Please, Mr. Chairman, I'll never live this down.

I just don't want the voters ever to clip my wings.

I just really have one question, but a comment. First of all, again, General Pollock, we want to, again, express our gratitude, the way you stepped in, at the request of Secretary Gates, during a very troubled time in military medicine. And we're so pleased to hear that you're heading up the human capital effort. Because it goes to physicians, nurses, social workers, other allied health—I'm sure you and General Schoomaker and others could talk about the need for x-ray technicians, and so on, so we look forward to that.

I found the testimony of all three of you so poignant, and the case examples that you gave, you know, were pretty powerful. And I would hope that my colleagues, as well as our staff, read them.

RECRUITING AND RETENTION

My question—and I've heard the list, now, of programs, and we've talked about this—in a nutshell, what more can we do to crack the nursing retention and recruitment? But the first one is, retain those that we've got and have them as part of the leadership team, and then—what more can we do, what creative ideas, or do I wait for yet one more report?

And just know, Senator Byrd has us at noon, as much as our regrets are with the time.

Admiral BRUZEK-KOHLER. I think we are finding that the incentive plans that we have put in place over the past years have been extremely successful for accessions and the loan repayment for retention has been dramatic. As we are seeing with the incentive specialty pay, that too may have dramatic effects.

Our nurses need to be competitively rewarded financially, as well as through improvements in the quality of life and through educational programs that we offer. We will continue to pursue these kinds of packages through the proper channels.

Senator MIKULSKI. So, can I say in a nutshell that, number one, stay the course in what we've done. That, in other words, we have some great ideas now, we don't need new ideas, what we need to do is stay the course, and don't fiscally wimp out on what we have underway, would that—and that would also go for retention, and also recruitment. Would that be number one? Make sure we stay the course?

Admiral BRUZEK-KOHLER. Yes, ma'am.

Senator MIKULSKI. The second thing is, and this would be another conversation. I believe that one of our ways to promote—first of all, the whole idea, for those who already know the military, to stay and also those to move up—do you feel that this Troops to Nurses, as well as perhaps, getting additional training in an accelerated way with the LPNs would help us crack the code that—because they know, they're in the military. They've served in the military. And for those who are ready to sign up for the culture of the military, as well as the challenges of the military, they would know what they were getting into. In a good way.

General RANK. I'd like to take first crack at responding to that.

I have been supportive of Troops to Nurse Teachers (TNT), and I've been supportive of it because of our retiring nurses, who are at that 20-year juncture, and there is as part of the pick list in TNT that they would go out on a scholarship program, and be able to get their next advanced academic degree and teach on faculty. That is extraordinary and I know we have retiring and retired nurses who are waiting for TNT.

You would be surprised to learn that there are over 855 nurses with time in service of greater than 15 years that never took the Montgomery G.I. bill.

Senator MIKULSKI. And I believe that was something that General Pollock had discussed with us—that you use the nurses who are about to retire to essentially teach the other nurses, which in and of themselves would be role models, mentors, et cetera, to recruit and be a magnet for military medicine. Is that——

General RANK. Ma'am, that is my perspective, and that may differ from my sister service corps chiefs, and I would also like to add to the second portion of your question, where Uniformed Services University of the Health Services (USUHS) is concerned, I believe it is time for the Air Force Nurse Corps, and hopefully our sister services, to offer a Bachelor of Science in Nursing (BSN) program to those that have an associates and diploma degree.

I am a diploma nurse and went out for my own bachelor's working at Baltimore City Hospital. We need this program to open the aperture, and allow an associates degree, and diploma nurses to come to USUHS, get their bachelor's and then assess them as a bachelor's, with a commitment of time out there.

They're out there. They want to join our services.

Senator MIKULSKI. Well, perhaps, then, Mr. Chairman and Senator Stevens, we can follow up on this. What essentially our head

of the Nurse Corps are talking about is that if you have a 3-year program——

General RANK. Two or three, ma'am.

Senator MIKULSKI. Or you've been to a community college——

General RANK. Yes, ma'am.

Senator MIKULSKI. You need to move up to a bachelor's level. There is wide experience in civil nursing programs in an accelerated way. Perhaps we could talk now about USUHS, you know, it's in my State, we're very familiar with it. But this could be one of the tools we could use, and work on.

I have other questions, but again, I'll submit them for the record. Thank you.

General POLLOCK. And I know we'll look forward to providing written responses, or coming down to meet with any of your staffs on your questions.

Thank you very much.

Senator INOUYE. I asked the doctors the question as to whether personnel under their command felt appreciated. Well, I want you to know that in the Army infantry, the person we admire the most and adore the most is the medic. He's the one who keeps us going and live.

ADDITIONAL COMMITTEE QUESTIONS

But unfortunately, the way they give out medals, they give it out for courage, and shooting ability and all of that nonsense. And as a result, nurses and doctors and medics don't get recognized. I hope you will take it upon yourselves to give recognition to the men and women in your command. Because they need a little boost.

[The following questions were not asked at the hearing but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL ERIC B. SCHOOMAKER

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

RECRUITING FOR SPECIALISTS

Question. General Schoomaker, the Army continues to have critical shortages in areas like family practice physicians, preventative medicine, emergency medicine, and dentists. These specialists are not only critical for our GWOT efforts, but make an enormous difference to the families of our service members. How is the Army addressing these shortfalls in recruiting and retention?

Answer. We continue to explore ways to provide significant incentives to recruit and retain our health care providers. We are currently working with Army leadership to develop the appropriate implementation guidance for the Critical Wartime Skills Accession Bonus for Medical and Dental officers. This bonus will enable us to offer new appointees a significant monetary incentive in exchange for an Active Duty Service Obligation. We are confident that this bonus will bring positive gains to our recruiting efforts. Additionally, we are aggressively utilizing the Health Professions Loan Repayment Program to attract those individuals who have incurred a debt while undergoing training. Finally, we are evaluating the proposed fiscal year 2009 special pay rates and considering potential increases in special pay for certain specialties.

Equally important, the Army continues to explore ways to improve quality of life for our health care providers. As an example, we recently expanded our 180-day provider deployment policy, extending this popular policy to a broader range of health care professionals. This policy reduces the length of deployment for providers, minimizing clinical skill degradation and eliminating the deployment length disparity

that existed between medical personnel of the Army and the other Services, resulting in improved morale and quality of life for our providers and their Families.

RECRUITING

Question. General Schoomaker, the Army recently restructured its recruiting command, forming a special brigade tasked to provide for the five medical recruiting battalions. Do you feel that the restructuring of the recruiting command is helping to improve recruiting efforts within the medical field?

Answer. MG Bostick's decision to stand up and resource the Medical Recruiting Brigade has proven to be one of the most significant administrative decisions to benefit medical recruiting in the past decade. I fully support his decision and will continue to assist in ensuring its success is sustained.

Establishment of the Brigade has enhanced medical recruiting by strengthening ownership of the recruiting mission and triggering positive changes in business practices. This new level of mission ownership is characterized by a direct chain of command and a one focus-one voice strategy for health care recruiting. MG Bostick's decision to supplement the recruiting force with 50 direct military overhires has also enhanced the recruiting force, providing more individuals focused on the mission.

The recruiting effort this year continues to improve over the same period last fiscal year. The Medical Recruiting Brigade is currently 461 contracts ahead in comparison to the same time period last fiscal year (249 in Regular Army and 212 in Reserves). For the past four years, recruiting for the Army Reserve Veterinary Corps has fallen short; however, we are postured to exceed the Veterinary Corps mission at an earlier point than any previous fiscal year this decade. The Army Nurse Corps continues to have sustained success in comparison to last fiscal year (ahead 74 Regular Army contracts and 145 Army Reserve contracts). The Brigade is ahead by 84 Medical Corps Health Professions Scholarship Program (HPSP) scholarships and 11 Dental Corps HPSP scholarships compared to this time last year.

SCHOLARSHIPS

Question. General Schoomaker, I am always told that the Health Professions Scholarship Program is one of the military's most valuable recruiting tools for health care professionals. However, I am told that the number of applicants per scholarship has substantially dropped over the years. To what do you believe this is attributed to and how can it be improved upon?

Answer. I believe that the drop in the number of applicants is a result of multiple influences. Obviously, the current Global War on Terrorism, coupled with the operational tempo associated with it, has had an effect. The availability of funding for school from other sources has had an impact also.

There have been a number of actions taken which seem to be helping in turning around the downward trend. In the past several years we have increased the monthly stipend we pay the student; it is currently at $1,605, and will increase on July 1, 2008 to $1,906. The authority provided in the National Defense Authorization Act of Fiscal Year 2008 to offer up to a $20,000 bonus to Health Professions Scholarship Program (HPSP) students will also be helpful. The current use of the Critical Skills Accession Bonus in this dollar amount has proven to be very effective, and has enabled us to increase the number of students we have recruited into the program this fiscal year. Continued support and funding for this program are extremely critical.

WARRIOR TRANSITION UNITS (WTUS)

Question. General Schoomaker, it is our understanding that the WTUs are almost serving at full capacity. What are some of the solutions you're looking at to ensure that the WTUs are fully equipped and staffed to address our soldiers' needs in the future?

Answer. Achieving the optimal staff-to-patient ratios for the Warrior Transition Units (WTUs) has been a challenge for the Army Medical Department (AMEDD). Army-wide manpower challenges affect our aggressive measures to staff some of the key positions at many of our WTU locations. Despite the challenges, however, we are making strides toward achieving full capacity. As the WTUs have achieved full capacity, we are reducing the level of borrowed military manpower.

The Medical Command is working closely with the Army Human Resources Command and civilian personnel to attract the very best Soldiers and civilians to staff the WTUs. The Medical Command and its subordinate commands are also utilizing multiple recruitment and relocation incentives to staff difficult-to-fill positions. We offer civilians recruitment incentives of up to 25 percent of their basic pay. We also offer a relocation incentive up to 25 percent of the basic pay to current employees

willing to relocate to fill critically short positions. Given the critical importance of attracting the very best Soldiers to fill the squad leader's positions in the WTUs, the Army recently approved special duty pay.

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

WALTER REED ARMY MEDICAL CENTER

Question. (a) The Dole/Shalala report recommended that the Army ensure top quality care at Walter Reed Army Medical Center up till the day it closed. Approximately 1 in 5 wounded soldiers go to Walter Reed. What is the Army doing to ensure continued high quality care at Walter Reed?

(b) What is the Army's plan to maintain civilian medical, administrative and maintenance staff until the last day?

(c) How will the Army maintain staff who cannot count on being reassigned to another DOD facility but are critical to ensuring high quality care?

Answer. (a) Over the past year, Walter Reed staff has very carefully and honestly reviewed every aspect of health care delivery. Where there was room for improvement, the staff quickly developed corrective action and programs to set a new standard for care, compassion and healing. The entire team was very proud last year when, at the height of the controversy generated by media coverage of outpatient problems, Walter Reed was inspected by the Joint Commission and fully accredited for health care delivery. With the core practices intact and validated, they set out to improve other support services that can make a huge difference in the hospital experience of their patients.

Walter Reed initiated action to improve housekeeping, hospitality, and responsiveness to all types of patient comments and issues. They improved in nutrition care, with room service meals and healthier menu choices. They enhanced the handoff with Warriors coming out of Theater by reaching forward with an air evacuation cell here to coordinate movement and receipt of patients. Walter Reed staff designed and purchased and will soon accept delivery of three vastly improved patient evacuation vehicles for transporting patients from Andrews Air Force Base to Walter Reed.

Walter Reed tightened up discharge planning, and the handoff from the ward to the Warrior Transition Brigade. They improved facilities for Warriors and their Families across the Walter Reed campus. To improve the coordination and tracking of Warrior in Transition care, the Walter Reed team developed the Military Medical Tracking System (MMTS). The MMTS automates data pulls from several existing computer systems and securely presents that data to case managers and other health care team members. This homegrown system has enabled them to more closely monitor and coordinate the Warrior healing process and is now set for deployment across the Army Medical Department. They also installed wireless connectivity throughout Heaton Pavilion and will begin deployment early next month of over 1,100 Tablet PCs to enhance provider-patient interaction throughout the medical center.

Recent accreditation site visits by the Accreditation Council of Graduate Medical Education (ACGME) resulted in 5 year accreditation cycle awards to several Walter Reed programs. Resident and fellowship training programs in Neurology, Physical Medicine and Rehabilitation, General Surgery, National Naval Medical Center Internal Medicine, and the internal medicine subspecialties of Gastroenterology, Hematology/Oncology, and Endocrinology have all received the maximum accreditation cycle of 5 years. In addition, Walter Reed and the National Capitol Consortium have an unprecedented 5 physicians on the national Residency Review Committees of ACGME.

Finally, Walter Reed was recognized at the Military Health System Conference for Excellence in Customer Service for 2007, outpacing all other large medical centers in the Continental United States. Walter Reed's current patient satisfaction is above 90 percent according to the Army Provider Level Satisfaction Survey (APLSS).

(b) As a result of Walter Reed Army Medical Center being identified on the Base Realignment and Closure (BRAC) list and given the direction by the Deputy Secretary of Defense in August 2007, the Army has improved its plan to maintain civilian medical, administrative, and maintenance staff until closure. The Army is using all existing authorities to recruit and retain civilian employees. A majority of the authorities have been used in the past successfully, as was a robust incentive awards program directed at the civilian workforce. In order to ensure that management had full knowledge of the available incentives, the Army Medical Command

developed and delivered a comprehensive supervisor training module on the use of the incentives. The Commander will develop a sound business case to seek additional funding to support a more robust implementation plan for the use of the incentives. A foundation for the business case will come from an employee survey that was distributed in mid-April. The survey asked the Walter Reed employees what incentive(s) would cause them to stay through the BRAC period. To date, nearly 2,000 surveys were completed and returned, nearly an 80 percent response rate. The Command is in the process of analyzing that data.

In mid-December, the Walter Reed Army Medical Center and Garrison leadership conducted a comprehensive review of their manpower authorizations and requirements. The review demonstrated the broad scope of Walter Reed's mission. The review also revealed the identification of new and expanded missions, which are in direct correlation with the needs and requirements of the Warrior in Transition Brigade located on the Walter Reed campus. These new missions emerged since the installation was listed as a BRAC activity. The Walter Reed Army Medical Center Commander started more than one year ago to recruit and fill positions associated with these new and expanded missions; however, additional resources are required. The manpower study that is now underway will validate critical human resource requirements and this will allow Walter Reed to increase the recruitment targets to fill these vital positions.

Recruiting new employees and retaining current workforce are top priorities for the Walter Reed Commander. A robust marketing effort, in combination with a strategic recruitment plan, will ensure a dynamic, targeted and focused recruitment effort is maintained. The recruitment plan is continually reviewed and revised as needed to meet the changing recruitment needs that directly support the new and expanded missions of the Walter Reed Army Medical Center.

(c) In August 2007, the Deputy Secretary of Defense directed that the employees at Walter Reed Army Medical Center receive an incentive entitled the Guaranteed Placement Program. The employees will be guaranteed a position at either the new Walter Reed National Military Medical Center or the new DeWitt Army Community Hospital at Fort Belvoir. The Army is coordinating with the Joint Task Force Capital Medicine on the provisions and details of this program. The Commander will brief the Walter Reed civilian workforce on the details as soon as guidelines are finalized.

The Commander will request funding for incentives and personnel overhires through fiscal year 2011. The Army is currently working with the Senior Oversight Committee program on the fiscal year 2010–15 Program Objective Memorandum (POM) submission for civilian medical health authorities and incentives. The Walter Reed civilian employee retention survey is the primary vehicle to obtain specific information regarding the incentives that will cause the workforce to remain until closure. The Commander intends to follow up in about six months with another survey focused on the issues of job satisfaction and communications within the organization.

The Walter Reed commander is aggressively pursuing efforts to ensure current and future Walter Reed employees are retained through the BRAC. On March 14th, the Commander hosted three very well attended and successful Town Hall meetings, which is a component of her "Care of People Plan." This plan reflects a comprehensive approach to the issue of employee retention. A key component of the plan is a very robust communications plan that ensures the flow of information to the workforce. Town Hall meetings, an up-to-date website, the Commander's BLOG and the employee survey are just a few examples of the Commander's efforts to ensure information flow to and from the workforce. The Commander has also hired a communications consultant to ensure that all possible lines of communication are open and functioning at all times and that directed attention is given to the issue of communicating with the workforce through this time of uncertainty.

WOUNDED SOLDIERS' FAMILIES

Question. (a) The Dole/Shalala report recommended enhancing care for the families of wounded soldiers throughout the soldier's recovery process. It noted that family members are vital parts of the patient's recovery team. What has the Army done to enhance care for family members of wounded soldiers?

(b) Who on a soldier's care team is primarily responsible for helping families? What training have they received?

(c) What has DOD done to leverage the help the private sector can provide?

Answer. (a) The Army Medical Action Plan (AMAP) represents a total transformation of the way the Army cares for wounded, ill, and injured Soldiers (Warriors in Transition) and their family members. Basic to this transformation is the

recognition that an integral part of caring for the Soldier is the need to also care for and support the Soldier's family. As part of the execution of the AMAP, the Army has established Soldier Family Assistance Centers at installations with Warrior Transition Units to provide both Warriors in Transition and their Families a "one-stop shop" for many services, including: Military personnel processing assistance; Child care and school transition services; Education services; Transition and employment assistance; Legal assistance; Financial counseling; Stress management and Exceptional Family Member support; Substance abuse information and referral; Installation access and vehicle registration; Management of donations made on behalf of Service Members; Coordination of federal, state, and local services; Pastoral care; Coordination for translator services; Renewal and issuance of identification cards; and Lodging assistance.

The AMAP also established a "Triad of Care" concept to manage the care and support of each Warrior in Transition and his or her family. For Soldiers undergoing a Medical Evaluation Board or Physical Evaluation Board proceeding, dedicated physicians, Physical Evaluation Board Liaison Officers, and Legal Counselors are available to help Soldiers and Families navigate the process. Additionally, Ombudsmen are available at Warrior Transition Units to provide Soldiers and Families an individual advocate to assist in resolving concerns.

(b) Under the "Triad of Care" concept, a physician who functions as the Primary Care Manager, a Nurse Case Manager, and a Squad Leader work together to manage the care and support needs of each Soldier and his or her family. These three individuals, like all Warrior Transition Unit staff, complete a tailored training course which prepares them to deal with the issues and concerns of Warriors in Transition and their Families. This training ranges from understanding how to identify behavioral health needs of Warriors in Transition to assisting with transportation and other needs. Additionally, Medical Evaluation Board physicians, Behavioral Health professionals, Physical Evaluation Board Liaison Officers, Legal Counselors, and Ombudsmen receive targeted training to enable them to effectively care for Warriors in Transition and their Families as an integral unit.

(c) As part of the development of the Army Medical Action Plan (AMAP), as well as with the development of performance standards for all Warrior Transition Unit staff, best practices were incorporated from a variety of disciplines, including private practitioners and accreditation bodies. The Comprehensive Care Plan developed by the multi-disciplinary team caring for each Warrior in Transition for the purpose of providing a holistic approach to recovery, rehabilitation, and reintegration was developed in collaboration with the National Rehabilitation Hospital to leverage industry expertise in order that the integral unit of Warriors in Transition and their Families benefit from the most up-to-date approaches possible.

COMPREHENSIVE RECOVERY PLAN

Question. (a) Dole /Shalala recommends that every wounded soldier receive a comprehensive recovery plans to coordinate recovery of the whole soldier, including all: Medical care and Rehabilitation, Education and Employment Training, Disability Benefits Managed by a single highly-skilled recovery coordinator so no one gets "lost in the system. Do all patients get a comprehensive recovery plan?

(b) What steps have you taken to train and hire skilled recovery coordinators?

(c) Do soldiers have the single coordinator to provide continuity? What training do recovery coordinators receive?

(d) Are they trained as soldiers, or as case managers?

Answer. (a) Warriors in Transition assigned to Warrior Transition Units have received dedicated planning and management of their care by the care Triad of Primary Care Manager, Nurse Case Manager, and Squad Leader. Warriors in Transition assigned to Warrior Transition Units since March 1, 2008 have further benefited from the development of Comprehensive Care Plans (CCPs). The CCP represents a holistic approach to managing care that addresses physical, mental, spiritual, and emotional healing and provides an integrated approach to recuperation.

(b) The Army Medical Action Plan (AMAP) established the Triad of Care concept for managing care which assigns each Warrior in Transition to a team comprised of a physician who functions as each assigned Soldier's Primary Care Manager, a Nurse Case Manager, and a Squad Leader. Nurse Case Managers are experienced Registered Nurses assigned to manage the care of 18 to 36 Warriors in Transition, depending on the complexity of care required. As with all Warrior Transition Unit staff, these Nurse Case Managers receive specific training in care management.

(c) The Care Triad manages the care of assigned Warriors in Transition throughout their recovery, rehabilitation, and reintegration either back to duty or prepared to be productive civilians. This approach ensures maximum familiarity by the mem-

bers of the Triad with each Warrior in Transition for which they are responsible. In the event Warriors in Transition must transfer to a different Warrior Transition Unit to continue their recovery, the Triad at the losing Warrior Transition Unit coordinates the transfer with the Triad receiving the Soldier at the new location to ensure a smooth transition.

(d) Each member of the Triad receives specific training in the care needs of Warriors in Transition and the processes in place at Warrior Transition Units for accomplishing this care. Specific certification training is provided to all Warrior Transition Unit staff to ensure a common understanding within and between Warrior Transition Units in how to care for Warriors in Transition. The Nurse Case Manager members of the Triad are Registered Nurses with considerable experience in developing and executing care plans. Their mission is to ensure that the care and support Warriors in Transition receive is carried out in the most effective manner possible. This mission both relies on professional training and experience as well as knowledge of the military and how to manage Soldiers.

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

GROW-THE-ARMY

Question. The Army is accelerating their Grow-the-Army initiative, and hopes to reach their goal of 547,400 personnel as soon as possible. Is the Army medical community also growing in personnel to address the increased need for combat medics? Do you have the resources to support this growth?

Answer. Each Brigade Combat Team (BCT) includes approximately 250 medical personnel, approximately 200 of which are enlisted health care specialists. With the acceleration of the "Grow-the-Army" initiative and the increase in BCTs, medical structure in the Operational Army will increase. In addition, the "Grow-the-Army" also includes increases in Army medical manpower in the Institutional Army.

In the absence of significant retention incentives, it will take several years to fully man these additional spaces. Our request for additional military medical manpower to support "Grow-the-Army" requirements is still being assessed within Headquarters Department of the Army. Depending on the results of this assessment, additional accession and retention incentives may be required to support this growth. These incentives would need to be developed in coordination with our Sister Services using the authorities provided to the Office of the Secretary of Defense in the fiscal year 2008 National Defense Authorization Act with regard to restructuring Medical Special Pays.

BRAC DEADLINE

Question. The Navy has announced an award for the design-build of the new Walter Reed National Military Medical Center at Bethesda. Do you believe this project is still on track to be completed by the BRAC deadline of 2011?

Answer. The Naval Facilities Engineering Command (NAVFAC) announced on March 3, 2008 the award of a design and construction contract required to establish the new Walter Reed National Military Medical Center (WRNMMC), Bethesda, MD. The construction contract was awarded to Clark/Balfour Beatty, Joint Venture in the amount of $641.4 million. The environmental planning process guided by the National Environmental Policy Act is still ongoing and the final issue of the Record of Decision is pending for May 2008.

The design and construction phases for the new WRNMMC, Bethesda have been closely coordinated between NAVFAC, TRICARE Management Activity and the Joint Task Force, Capital Medical and appears to be on track for completion by September 2011 pending any unforeseen complications. The design build contract allows for the greatest flexibility as we move forward with this project.

Question. What challenges still need to be addressed in completing the build out of this facility by the BRAC deadline?

Answer. The design, construction, and transition into the new Walter Reed National Military Medical Center, Bethesda poses many challenges. The Environmental Impact Study and subsequent signing of the Record of Decision must be completed on time. Delays in either of these areas will push back the construction schedule.

The design phase of the new Walter Reed National Military Medical Center is an iterative process requiring ongoing adjustments to the blue prints to ensure the functionality of all clinical areas moving from Walter Reed to the new Walter Reed National Military Medical Center. We must ensure that adequate space has been

provided to meet the mission and deliver world-class care to all beneficiaries entrusted to our care.

Walter Reed's Centers of Excellence must be included in the new Walter Reed National Military Medical Center. These world-class research, teaching, and clinical centers must maintain the same capability and capacity in their new facilities.

MEDICAL CENTER REALIGNMENT

Question. Are there Service specific concerns or issues with regards to this realignment that you are working through with your Navy counterpart? What are they?

Answer. The Army and the Navy have separate organizational structures for Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC). Each command contributed to the design of a common organizational structure for the new Walter Reed National Military Medical Center. The newly created organizational structure combines the best of both WRAMC and NNMC and will greatly facilitate the integration of clinical, clinical support and administrative processes.

The Army and Navy have strong health profession education programs. Most of Walter Reed's and National Naval Medical Center's Graduate Medical Education (GME) programs have functioned as fully integrated joint programs since 1997, under the National Capital Consortium. We have worked together to continue to integrate the three remaining GME programs (Transitional Internship, Internal Medicine Residency, and General Surgery Residency programs). Some health profession education programs are unique to the Army (e.g., Licensed Practical Nurse training for medics). We are concerned about the future of these programs in the National Capital Region after realignment.

QUESTIONS SUBMITTED BY SENATOR CHRISTOPHER S. BOND

BEHAVIORAL HEALTH SPECIALISTS SHORTAGES

Question. Thank you for appearing here today. I'd like to start by commending all the services for their selfless service on the front lines of the War on Terror. Our Military, young men and women, young Soldiers, Marines, Sailors and Airmen have performed admirably on an asymmetric battlefield and against an irregular enemy. Thank you.

We are obligated to provide the best support available to our service men and women. Many in our Active and Guard ranks are deploying to Iraq and Afghanistan for the 3rd and 4th times. An increasing number of military personnel are returning from combat duty with varying degrees of Post Traumatic Stress Disorder (PTSD). There is also an alarming spike in military suicide rates. It is clear that there is a relationship between suicide rates and PTSD. We must make sure that our men and women have access to the care they deserve when they return from combat. My staff has been investigating the status of behavioral health care throughout the military and has consistently found that behavioral health care assets remain in short supply. Of those specialists, few have experience working with soldiers returning from combat deployments. I'm also told that the military has had a challenging time trying to convince prospective specialists to relocate to a relatively desolate outpost. Twenty Nine Palms is a great example. If given a choice between working at a military base near an urban area with attractive living conditions, and a base off the beaten path, I believe a potential employee would choose the more lucrative living area 90 percent of the time.

What are you doing to alleviate the shortage?

Answer. The Army Medical Command (MEDCOM) is diligently working to fill 266 new behavioral health positions identified in the continental United States, and has currently filled 168 of those positions for a 63 percent fill rate. MEDCOM will also fill 64 new behavioral health positions in Europe and 8 behavioral health positions in Korea.

The military is competing in a market that suffers from a shortage of qualified mental health professionals. Additional incentives specific to behavioral health providers are needed to recruit and retain these professionals in the Army. Currently, Licensed Clinical Psychologists are offered the Critical Skills Retention Bonus (CSRB) at a rate of $13,000 per year for 2 years or $25,000 per year for 3 years. The Health Professions Loan Repayment Program (HPLRP) is available for the accessions of 5 Clinical Psychologists and the retention of 20 Clinical Psychologists per year at the rate of $38,000 per year. The Health Professions Scholarship Program is available to students pursuing a doctorate in Clinical Psychology in exchange for

an active duty service obligation. Social Workers in the grade of Captain are offered the Army CSRB at the rate of $25,000 per year for a 3-year active duty service obligation. The HPLRP is available for the accessions of 5 Social Workers and the retention of 20 Social Workers per year at the rate of $38,437 per year. A Masters of Social Work program has been established at the U.S. Army Medical Department Center & School in affiliation with Fayetteville State University. The program will accommodate up to 25 students per year starting in Academic Year 2008. Psychiatric Nurses and Psychiatric Nurse Practitioners are authorized to receive Registered Nurse Incentive Special Pay (RNISP) at a rate of $5,000 per year for 1 year, $10,000 per year for 2 years, $15,000 per year for 3 years and $20,000 per year for 4 years. The Uniformed Services University of Health Sciences has introduced a new Adult Psychiatric Mental Health Nurse Practitioner (PMH–NP) program. The PHM–NP program is a 24-month, full-time program beginning in Academic Year 2008; Army allocations are to be determined. Psychiatrists who execute a multi-year special pay contract (extending their active duty service obligation) are paid at the rates of $17,000 per year for a 2-year contract, $25,000 per year for a 3-year contract and $33,000 per year for a 4-year contract. The Critical Wartime Skills Accession Bonus is approved and programmed for future use as a lump sum bonus of $175,000 for 10 Psychiatrists in return for a 4-year active duty service obligation.

BEHAVIORAL HEALTH RESOURCES

Question. Thank you. To follow up, I'd ask Army leaders to consider a proposal to allow active duty forces to access the behavioral health care resources available at the nation's Vet Centers. These facilities provide care for PTSD and are manned by veterans and specialists familiar with the needs of veterans and our active duty forces. It seems a tremendous waste in resources to limit eligibility to our Vet Centers to veterans only if there are soldiers who require care but have limited or no assets available to them.

Would you support legislation that allowed active duty forces access to behavioral health resources at the nation's Vet Centers?

Answer. Any proposal that increases a Soldier's ability to access needed care is always welcomed, and we believe this may be a useful option over time.

EYE TRAUMA

Question. Switching gears, I'd like to talk about the Centers of Excellence recently developed by the Department of Defense. Congress, in the Wounded Warrior section of the NDAA enacted January 2008, included three military centers of excellence, for TBI, PTSD, and Eye Trauma Center of Excellence. The two Defense Centers of Excellence for TBI and Mental Health PTSD are funded, have a new director and are being staffed with 127 positions, and are going to be placed at Bethesda with ground breaking in June for new Intrepid building for the two centers. I'm sure you are aware that there have been approximately 1,400 combat eye wounded evacuated from OIF and OEF.

Does DOD Health Services Command have current funding support and adequate staffing planned for the new Military Eye Trauma Center of Excellence and Eye Trauma Registry? If not, when can the committee expect to be provided specific details on implementation?

Answer. The Assistant Secretary of Defense for Health Affairs recently directed the Army to take the lead in the joint effort to develop an implementation plan for a Center of Excellence in Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of Military Eye Injuries. Currently, no funds are dedicated to the Center of Excellence or the Eye Trauma Registry. The Department of Defense Health Affairs Steering Committee for this Center of Excellence is still finalizing the concept, staffing requirements, central office location, agenda, and timeline. Specific details on implementation should be available by the end of the third quarter, fiscal year 2008.

JOINT MILITARY HEALTH SYSTEM

Question. There has been a lot of discussion in recent years about making military medicine more joint. Do you believe changes in the governance of the Military Health System are needed to make military medicine more effective and efficient?

Answer. Absolutely. Our experiences in Operations Iraqi Freedom and Enduring Freedom highlight the necessity for jointness, coalition partnerships, and an appropriate mix of active and reserve component personnel. A Unified Medical Command has the potential to improve delivery of military medical support across the full spectrum of conflict, from combat operations to peacetime family member health care.

The Army Medical Department has looked hard at governance of the Military Health System (MHS) and developed a proposal for a Unified Medical Command that we believe provides the following advantages: a more effective and efficient governance; improved delivery of health care to the beneficiary population; efficiencies gained through elimination of Service stovepipes; a single accounting system; and a single point of accountability. It also ensures the Service medical departments retain their individuality where appropriate, as there are some differences in mission and skill sets that do need to remain.

However the governance ultimately evolves, it is important that it maintains a military command and control structure and that the chain of command be streamlined to maximize responsiveness and optimize outcomes. The recent activation of the Joint Task Force National Capital Region is an opportunity to help inform our efforts and shape the future transformation of MHS governance.

QUESTIONS SUBMITTED TO MAJOR GENERAL GALE S. POLLOCK

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

SPECIALTY PAY FOR NURSES

Question. General Pollock, the Army initiated a specialty pay (IPS) to retain highly skilled, certified nurses. However, only 50 percent of nurses eligible for the bonus have accepted. Is this due to a difficulty in communicating incentives, or is it just another strong sign at the difficulty to retain Army nurses?

Answer. Since last reported, the Army Nurse Corps is pleased to convey that the percentage of nurses who are eligible for Registered Nurse Incentive Special Pay (RN ISP) and have taken the bonus is up to 74 percent. Additionally, in response to this new incentive program, many Army Nurses are actively pursuing national certification in order to qualify for RN ISP. Therefore, we fully expect both the eligible population and the acceptance rate to steadily increase. In order to help facilitate certification, many Army Medical Treatment Facilities are offering review courses and study groups to assist nurses in preparing for certification exams. In addition, the Federal Nursing Chiefs have partnered with the American Nursing Association and American Nurses Credentialing Center to reinstate certification in several specialties. The RN ISP program has already proven to be an essential retention tool, as evidenced by the surge in Army Nurses pursuing certification to qualify.

NURSE/PANDEMIC FLU

Question. General Pollock, Northcom and Department of Defense Health Affairs office drafted the Department's plan to respond to a pandemic flu, but there is no mention of nurses. What role do you see nurses taking in a pandemic flu scenario?

Answer. The Army Nurse Corps recognizes that, in order for the Department of Defense's plan to be successful, human resources will be necessary to respond to and sustain any pandemic flu scenario. Nurses are an integral part of providing the medical services required in the event of an outbreak. From pre-hospital care, hospital/acute care, palliative care, and alternative care sites, the role of the registered nurse in responding to a pandemic emergency is critical and significant. The strategies for building surge capacity within the health care system to meet the significantly increased demand that a pandemic event would place on the system must include nurses in order to be successful.

SCHOOL OF NURSING

Question. General Pollock, the National Defense Authorization Act for Fiscal Year 2008 directed the Secretary of Defense to establish a school of nursing within the Uniformed Services University of Health Science. Is the Nurse Corps supportive of this effort and what is the timeline for establishing the school?

Answer. The Army Nurse Corps does not support the creation of an undergraduate nursing program at the Uniformed Services University of Health Science (USUHS). The nursing mission of USUHS is to prepare and educate students as advanced practice nurses, scientists, and scholars for service as future leaders in military operational environments, federal health systems and university settings. The Army Nurse Corps recommends that baccalaureate level education remain in the civilian sector, and that the Army continue to improve scholarship opportunities for all accession sources.

A Department of Defense School of Nursing is expected to produce 50 nurses for the first class graduating in fiscal year 2012. However, the Army would only receive

approximately 10–20 new accessions from the program, yet the Army Nurse Corps requires 250–450 accession per year. Therefore, an increased investment in existing civilian Bachelor of Science in Nursing (BSN) completion programs would help us recruit and access a greater number of nurses much faster.

Establishing a BSN degree completion program at USUHS would be more beneficial to the Army. Currently, there are a significant number of junior Army Nurse Corps officers in the U.S. Army Reserves who have not completed their BSN degree. To be promoted and serve in leadership roles, those officers will need to complete their education.

PROMOTION SELECTION

Question. General Pollock, the Army has promoted retention of clinical nurse specialists. Do the clinicians have the same promotion selection as nurses on the administrative track?

Answer. All Army Nurses have the same promotion opportunity rate through Lieutenant Colonel (LTC). Army Nurses are given the opportunity to progress in rank as they demonstrate nursing proficiency and effective leadership traits. However, the promotion opportunity to Colonel (COL) is very limited for all Army Nurse officers, regardless of specialty. Some specialties have a better promotion rate to COL because we have requirements-driven promotions for those groups.

The Army Nurse Corps is seeking more LTC and COL authorizations. COL authorizations with emphasis on clinical and leadership acumen are needed to better develop junior and mid-grade Nurse Corps officers to serve in a variety of complex clinical roles. We have a greater demand for more senior officers with a progressive clinical career pathway background to serve as mentors and coaches much like the Medical and Dental Corps now have under Defense Officer Personal Management (DOPMA) exemption. Current retention initiatives have increased retention significantly among field grade clinical nurses who are retirement eligible, despite limited opportunities to serve as a COL in a DOPMA-constrained promotion model. DOPMA exemption for the Army Nurse Corps would provide greater structure at the LTC and COL ranks to meet the needs of more senior and experienced clinicians at the bedside while improving retention rates among officers seeking a progressive clinical career pathway.

NURSE PSYCHOLOGICAL HEALTH

Question. General Pollock, the Army has instituted a number of programs to address the increase of psychological health issues among service members. However, nurses are also deploying and are responsible for treating psychological health issues. Are there any specific psychological health programs targeted at our military nurses?

Answer. The Army psychological health programs target all military members. Pre and Post deployment psychological screening, one component of health surveillance, has been used extensively to predict job or illness-related outcomes and to determine risk indicators. In addition, "Battlemind" training has been implemented throughout the Army. The goal of this training is to develop a realistic preview, in the form of a briefing, of the stresses and strains of deployment on Soldiers. Four training briefs have been developed and are available for Soldiers, Leaders, and Families.

The Army Medical Department (AMEDD) recognizes the impact of deployments on our staff, as well as the impact of the high-operational tempo on staff members who are not deployed, but who are taking care of the same injured OEF/OIF patients. Accordingly, AMEDD has implemented Compassion Fatigue and Resiliency program initiatives to target AMEDD staff. All medical treatment facilities have access to a centralized web-based program entitled, "Provider Resiliency Training." The Army Medical Department has also instituted an assessment, education, intervention and treatment program for Provider Fatigue and Burnout. Centralized products for Provider Resiliency Training have been developed, resulting in standardized, efficacy-based education and training that has enhanced resiliency of care providers who have participated and provided attendees who are experiencing Provider Fatigue and Burnout the tools necessary to mitigate their condition. Additionally, Behavioral Health Clinicians, hospital-level Provider Resiliency Champions and Care Team personnel have been trained and certified as Provider Fatigue Educators and/or Therapists. The Army Medical Department (AMEDD) is also establishing Care Teams at our Medical Centers and larger Medical Facilities to focus on provider compassion fatigue intervention. These Care Teams will use a community health model of intervention, taking services to the wards and clinics for providers and other staff in our hospitals.

CONTRACTING FOR NURSES

Question. General Pollock, in order to facilitate optimal nurse staffing, contract staffing support companies have been used. Have these companies met your needs for recruiting contract nurses in a timely manner, and providing quality nurse?

Answer. In order to compensate for the nursing deficit and the current operational tempo, we have expanded contract nursing support considerably. For fiscal year 2007, we contracted for 717.6 full-time equivalents in registered nursing across the U.S. Army Medical Command (MEDCOM) at a cost exceeding $53.6 million. The advantage of contract nursing is the ability to bring an individual on board quickly and provide flexibility to meet both short-term and long-term needs. Contract nurses can do this in a matter of a few days as opposed to the weeks/months it takes us to bring a General Schedule (GS) nurse onboard. The educational and credentialing requirements are the same for contract nurses and the overall quality of contract nurses is good.

While contract nursing supports operational needs, it is not a sound long-term strategy. Contract nurses pose additional complications, such as: (1) variance with nursing competencies and training backgrounds affects performance in a military hospital; (2) lack of loyalty to the organization; (3) a "short horizon" mindset; and (4) constant turbulence requires resources to train and orient. Wherever possible, medical treatment facilities throughout MEDCOM are replacing contract nurses with General Schedule (GS) nurses.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

PARTNERSHIP WITH UNIVERSITY OF MARYLAND

Question. The Defense Appropriations subcommittee asked each branch to report on the nursing shortage and efforts in which you are currently engaged or see potential.

In your response, you discussed the faculty augmentation program or the Army's partnership with the University of Maryland. In this partnership, you argue that DOD received no direct incentive to begin the partnership, yet the Army still benefits from the project. Can you please speak to these benefits and the future of the partnership?

Answer. The partnership program with the University of Maryland provides the opportunity for detailed Army Nurse Corps officers to acquire unique educational, training, and supervisory skills that better prepare these officers to serve in a variety of positions. Appropriate utilization of these officers could include a variety of educator positions within medical treatment facilities, in a number of phase II clinical training sites, clinical nurse specialists in large teaching facilities, and clinical head nurses who are pivotal in the training and development of junior civilian and military staff nurses. The skills these officers are expected to acquire through this program include developing and implementing curricula, supervising clinical skills of baccalaureate students, building partnerships with academia, evaluating collegiate-level students, developing testing and evaluation instruments, developing evidence-based clinical practice, developing a methodology evaluating critical thinking, integrating medical simulation into the education process, and evaluating scholarly writing.

A significant outcome expected from this program is improved recruiting for Army Nursing. The Army Nurse instructors are in uniform and demonstrate on a daily basis the quality and professionalism of the Army Nurse Corps. They serve as indirect recruiters and are readily available to answer questions from potential accession candidates, not only from the nursing school, but within the clinical settings of area hospitals.

NURSING SHORTAGE

Question. The United States is currently facing one of the most severe nursing shortages in its history. While nursing schools have been making a concerted effort to increase enrollments to meet current and projected demand, 40,285 qualified applicants were turned away in 2007 according to the American Association of Colleges of Nursing. The top reason cited was a lack of qualified nurse faculty.

The legislation I introduced earlier this year, The Troops to Nurse Teachers Act of 2008 (S. 2705), creates several avenues by which military nurses can become nurse educators. The subsequent increase in the number of nurse faculty would allow schools of nursing to expand enrollments and alleviate the ongoing nursing shortage in both the civilian and military sectors. Considering the military has a

significantly higher percentage of Masters and Doctorally prepared nurses than in the civilian population—ideal for vacant faculty positions—how does the Army view this program as part of a successful strategy to address the military nurse shortage?

Answer. The Army Nurse Corps supports the Troops to Nurse Teachers Act of 2008 and believes that using the expertise of our retired military nurse population to teach in civilian nursing education programs will help alleviate the national nursing shortage by increasing the civilian nurse instructor pool. Additionally, it will expose nursing students to the benefits of a military career. Finally, programs that detail qualified active duty nurses into collegiate nursing instructor positions could benefit military nurse recruiting and retention efforts. However, since this program addresses the national nursing shortage, the Department of Defense is not the best federal funding partner.

NURSING EDUCATION

Question. The Army recruits, in particular, nurses with a baccalaureate degree in nursing. The Agency for Healthcare Research and Quality has found that baccalaureate nurses are the key to providing safe, high quality care that leads to improved patient outcomes. What benefits do these nurses bring to military health care?

Answer. The Army Nurse Corps (ANC) has continued to recognize the quality of clinical care associated with higher-level preparation and seeks to maintain an all professional Corps with a standard entry-level education requirement. Bachelor of Science in Nursing (BSN) programs provide a uniform and standard curriculum accredited by certifying bodies under the auspices of the Department of Education. This accreditation process assures uniformity in the educational and clinical preparation of ANC accessions without significant variance. The BSN is also the minimum educational entry for advanced degree eligibility, professional certification, and post-baccalaureate training.

The research literature strongly supports the conclusion that nursing care provided by nurses with a BSN or higher-level degree results in improved patient outcomes, shorter hospitalization, greater patient satisfaction, and reduced patient mortality. These benefits are brought to the military health care system because all of our Active Component ANC officers have at least a baccalaureate degree in nursing. The Reserve Component has recently adopted this professional nursing model. All officers in the Army are required to have or attain a bachelor's degree, and it is imperative that Nurse Corps officers are educated to this standard to provide both top-quality care and required professional leadership.

Question. In your written testimony, you also emphasize the important role of Nurse Practitioners. Can you elaborate on the importance of Advanced Nursing degrees for the military and the importance of partnering with accredited schools of nursing?

Answer. As the Global War on Terrorism continues, the Army requires greater flexibility to meet the primary health care needs of Soldiers. These needs occur primarily at the operational unit level and at troop medical clinics on forward operating bases. Nurse practitioners have provided the Army with highly-qualified primary care providers who are able to offer their expertise at brigade and higher levels while helping to relieve some of the critical shortages faced by the physician and physician assistant communities. Soldiers and leaders are highly satisfied with the care provided by nurse practitioners, which has resulted in increased requests for nurse practitioners on the battlefield.

Health care delivery practices and theory continue to evolve and change. To address this dynamic environment, the Army Nurse Corps has forged professional partnerships with accredited schools of nursing. These partnerships focus on educating nurses and enhancing their ability to practice in a changing environment. Army nursing leaders believe that these formalized cooperative efforts have helped dissolve the traditional barriers between military and civilian education and practice. The partnerships also provide new education and practice opportunities that are vital in promoting nursing professionalism.

NURSING SHORTAGE

Question. Can you speak to the increasing demand for nurses in your branch as a result of the ongoing war in Iraq?

Answer. The persistent conflicts in Iraq and Afghanistan have placed increased demands on all military nurses. 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.

The Army Nurse Corps' high attrition rates can be attributed to the frequency and length of deployments. Nurses with high-demand specialties deploy more frequently. Based on exit survey results over the past four years, officers choose to leave the Army Nurse Corps after a deployment, rather than potentially deploy again. As a result, more nurses are needed to lower the frequency of deployments and help the Army Nurse Corps' retention efforts.

In addition, our re-deployed nurses are caring for the same Soldiers they cared for on the battlefield—Soldiers who have complex injuries that require more nurses with a higher skill level than ever before. The emotional toll from caring for these severely injured patients in both deployed and non-deployed settings creates a need for more nurses to ameliorate this effect.

NURSING RECRUITING

Question. One of the major recruitment strategies for the Army and other Military Nurse Corps is the Reserve Officers' Training Corps or ROTC. In recent years, how effective has this program been in recruiting and preparing nurses for a career in the Army Nurse Corps? How well does this program recruit underrepresented populations to the Army?

Answer. The Army Nurse Corps accesses officers for the Active Component through a variety of programs, including the Reserve Officers' Training Corps (ROTC), the Army Medical Department Enlisted Commissioning Program, the Army Nurse Candidate Program, and direct accession recruiting, with ROTC being the primary accession source. Over the past four years, we have not achieved our annual ROTC mission for 225 nurses; however, each year shows improvement. In an attempt to resolve continued strength shortfalls within the Army Nurse Corps, overproduction of the direct accession mission has been authorized and encouraged.

Demographic data provided by U.S. Army Cadet Command indicate that ROTC nurses are a more diverse population than the national nurse population. 68 percent of ROTC-contracted nurses are Caucasian, 12 percent are Asian-American, 7 percent are African-American, 7 percent are Hispanic, 2 percent are American Indian, and 4 percent are unknown. By comparison, national nursing statistics indicate that 88.4 percent are Caucasian, 3.3 percent are Asian-American, 4.6 percent are African-American, 1.8 percent are Hispanic, and 0.4 percent are American-Indian. Additionally, men represent about one-third of the Corps' strength compared to about 7 percent of civilian nursing professionals.

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

INTEGRATED CARE

Question. (a) The Dole/Shalala Report recommends DOD and VA develop integrated care teams with physicians, nurses, health professionals, social workers, and vocational rehabilitation professionals. The Army's Warrior Training Unit has physicians, nurse case managers, and squad leaders?

(b) Are we asking our nurses to do the job of social workers?

(c) What training do they receive to do this?

Answer. (a) Each Warrior in Transition (WT) Soldier is now assigned or attached to a Warrior Transition Unit (WTU), with an assigned military squad leader, nurse case manager, and primary care manager (physician). Commonly referred to as the "Triad of Care", this team forms the core of the WTU which is exclusively dedicated to overseeing and managing the healing process for each WT Soldier. At 35 Army hospitals around the world, each WTU serves with the singular purpose of helping each Soldier transition to productive lives, either within the Army as successful Soldiers or outside of the military as respected members of their communities, equipped with all of the Veterans benefits they are entitled.

(b) Nurse Case Managers (NCM) are not being asked to assume the duties normally associated with social workers. In the WTUs, case management is a collaborative process under the population health continuum which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet each Soldier's health needs through communication and available resources to promote quality, cost-effective outcomes. Clinical case managers are licensed health care professionals with varying levels of education and credentials who practice without direct supervision. All Warrior Transition Unit Case Managers are Registered Nurses. Social Workers are participants of the multi-disciplinary team, but their role and responsibilities are clearly established and distinct from those of nursing personnel. Each WTU has priority access or even exclusive use in some cases to licensed social

workers, behavioral health providers such as psychiatrists and counselors, and vocational rehabilitation professionals such as occupational therapists.

(c) Case Managers are required to complete nine Distance Learning Training Modules and 40 hours of classroom training during their orientation. The Army Medical Department (AMEDD) Center & School (C&S) sponsors this training. The AMEDD C&S is finalizing an agreement with a well known University to offer a 80-hour comprehensive CM training course for the Army's military and civilian NCMs. Completion of the course will prepare the NCM for National Certification in Case Management. As a matter of standing regulation, we require all medical professionals serving within the AMEDD to maintain their respective professional credentials.

NURSE PSYCHOLOGICAL HEALTH

Question. (a) The Army nurse corps has the highest attrition of any officer branch of the Army. What are you doing to monitor the stress on our nurses?

(b) What service are we providing them to help deal with that stress?

(c) How many additional nurses do you need to recruit to ensure we can meet our commitment to our wounded soldiers?

(d) What is your plan to meet the growing need?

(e) What are the major obstacles?

Answer. (a) Army Nurse Corps (ANC) leaders monitor stress on nurses in a variety of ways. Supervisors and Deputy Commanders for Nursing, as well as ANC Branch Career Managers talk with officers on a regular basis to address their individual and collective stressors. Deployment equity, length of deployment, shift work, career progression tracks and retention programs have all been modified to alleviate the stress on Army nurses. In addition, the ANC instituted an exit interview in order to study and address attrition variables from the view of those who decided to leave Army service.

(b) Several services have been implemented as part of the Army Medical Department Care Giver Support Program at Walter Reed Army Medical Center (WRAMC), Landstuhl Regional Medical Center (LRMC), and Brooke Army Medical Center (BAMC). BAMC has a formalized stand-alone program for dealing with Provider Fatigue, and BAMC's Department of Behavioral Health responds to staff requests for assistance and provides training and sensing sessions. WRAMC, LRMC and BAMC each have access to a centralized web-based program entitled, "Provider Resiliency Training." The Army Medical Department has also instituted an assessment, education, intervention and treatment program for Provider Fatigue and Burnout. Centralized products for Provider Resiliency Training (PRT) have been developed, resulting in standardized, efficacy-based education and training that has enhanced resiliency of care providers who have participated and provided attendees who are experiencing Provider Fatigue and Burnout the tools necessary to mitigate their condition. Additionally, Behavioral Health Clinicians, hospital-level Provider Resiliency Champions and Care Team personnel have been trained and certified as Provider Fatigue Educators and/or Therapists. The Army Medical Department (AMEDD) is also establishing Care Teams at our Medical Centers and larger Medical Facilities to focus on provider compassion fatigue intervention. These Care Teams will use a community health model of intervention, taking services to the wards and clinics for providers and other staff in our hospitals.

The Army's Institute of Surgical Research (ISR) received $1 million and is in the process of creating a Compassion Fatigue program with a respite room for staff. It will be a prototype. We are already providing services and have a roster of experts who will come to teach and train staff. We have also had an Advanced Practice Psychiatric Nurse working with staff for a year.

(c) In order to meet our commitment to our wounded Soldiers, the Army Nurse Corps recently identified a need for additional budgeted end strength of 300 Army Nurses. The current mission shortfall is 184, and the ANC needs an additional 116 nurses to meet "Grow-the-Army" requirements.

(d) An analysis of current shortfalls has been incorporated into the plan to grow the Army Nurse Corps. The analysis indicates that the following mission areas require additional assets: Warrior Transition/Case Management; Psychological Nursing; Rehabilitation; Intensive Care Mission; Emergency Nursing; Residency for New Graduates; and Training. The plan to meet these needs will be carried out over the next four years and include requests to expand all Army Nurse accession and retention programs.

(e) There are several major obstacles impeding retention of Army Nurses. These include competition with the civilian job market, rising civilian salaries, and poor promotion opportunities for ANC officers. Other factors include the operational

tempo, frequency of deployments, and the emotional burnout of caring for Wounded Warriors.

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

NURSING SHORTAGE

Question. With a shortage of nurses to recruit from, and as the Army continues to grow their end strength by 65,000, how do you maintain the Army Nurse Corps to support a larger force?

Answer. We anticipate that the size of the Army Nurse Corps will grow. The increase in forecasted end strength is based on force projection models that take into consideration current and future workload. In addition, as the Army Nurse Corps increases in size, our civilian nurse work force will also grow to support the expanded medical requirements a larger force will bring. To maintain this Army Nurse force, growth is required throughout the structure to ensure junior clinicians receive appropriate mentoring and coaching, and to allow senior nurses to organize and lead the very dynamic trends in both the Army and nursing.

QUESTIONS SUBMITTED TO REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

NURSE CORPS AGE EXEMPTION

Question. Admiral Bruzek-Kohler, I have been informed that the Nurse Corps is one of the only medical fields without the ability to recruit individuals who are older than 42 because of a Title 10 restriction which requires a person to be able to complete 20 years of active commissioned service before their 62nd birthday. Currently the Medical Corps, Dental Corps, and Chaplain Corps are exempt from this age requirement. Are there efforts to exempt Nurse Corps officers to also be exempt from this age requirement?

Answer. There are currently no efforts to seek this age exemption for the Nurse Corps. The Nurse Corps met its recruiting goal for fiscal year 2007 for the first time in four years and with recent increases in the Nurse Accession Bonus (an increase to $20,000 for a three-year commitment and $30,000 for a four-year commitment), Navy is projecting to meet its fiscal year 2008 recruiting accession goal within the current age limitations of Title 10.

The Nurse Corps Community Manager closely monitors the changing demographic of individuals entering into the nursing profession, and will consider legislative relief as a possible course of action should the requirement arise.

HUMANITARIAN MISSIONS

Question. Admiral Bruzek-Kohler, what role does the Nurse Corps have in drafting the Pandemic Flu plan or other humanitarian missions?

Answer. Navy nurses have been involved in a myriad of activities related to Pandemic Flu (Influenza) Plan at both at the Bureau of Medicine and Surgery (BUMED) level and their local military treatment facilities in which they work.

For example, one of our nurses went to Hawaii to assist a six person planning group for Pacific Fleet Pandemic Influenza plans, carrying over concepts for the Pacific Command Pandemic Influenza plan (some of which originated at the BUMED's Homeland Security code). Navy nurses have availed assistance with the review of the Navy Medicine Pandemic Influenza instruction and offered recommendation on equipment, logistical requirements and medication (Tamiflu) shelf life extension programs in coordination with the Navy Medicine Logistics Command.

Our nurses have also been engaged in Pandemic Influenza planning and training sessions hosted by the Guam Department of Homeland Security.

Navy nursing specialties with backgrounds and training expertise in disaster relief and emergency management are particularly well-suited to assist with planning responses for pandemic influenza and humanitarian missions. These nurses can readily serve as leaders in planning and surveillance issues surrounding patient care and force protection. Navy nurses may also be called upon to serve in the role of Public Health Emergency Officer (based on location of the treatment facility and availability of other health professional resources). Additionally, our nurses may be representatives on command Emergency Management Committees, participating in local Pandemic Influenza tabletop training and exercise.

There are Navy nurses on both of our hospital ships as well as on grey hulls located around the world. While their jobs are more directly aligned with the provision of nursing care in humanitarian missions, they may be involved in the planning stages to ascertain the numbers and types of nursing specialties necessary to meet mission objectives and patient care requirements.

USUHS NURSING SCHOOL

Question. Admiral Bruzek-Kohler, the National Defense Authorization Act for Fiscal Year 2008 directed the Secretary of Defense to establish a school of nursing within the Uniformed Services University of Health Science. Are the Nurse Corps supportive of this effort and what is the timeline for establishing the school?

Answer. The Navy Nurse Corps would welcome the exploration of the following possible student populations for admission to a School of Nursing at USU:

—Associate Degree Nurses (ADN) who could pursue BSN or even bridge to MSN. The ADN pool holds an "untapped" recruiting opportunity that has not been fully explored as accessions to the Navy Nurse Corps must hold a BSN. Additionally, this population of candidates possesses greater clinical experience and offers a more mature, dedicated student with finite professional goals.

—Students who have completed liberal arts prerequisites and are seeking admission into programs that are focused on core curriculum leading to degree conferral of BSN/MSN.

—Opportunities for distance education/on line degree completion programs would also be appropriate for the two aforementioned groups and are of interest to the Navy Nurse Corps.

—Non-nursing degree holders (BS or BA) who seek BSN or MSN degrees. The Navy Nurse Corps Community Manager has received calls from officers in the Unrestricted Line Community (Surface Warfare and Nuclear) who were interested in staying in the Navy and acquiring their BSN.

The Navy Nurse Corps understands that the timeline for establishment of the school of nursing will be reported in a report to Congress that is being prepared by the DOD/Uniformed Services University of Health Science in response to Sec. 955 of the fiscal year 2008 National Defense Authorization Act.

NURSE PROMOTION RATES

Question. Admiral Bruzek-Kohler, do you see low promotion rates for nurses as a reason for Navy nurses to separate?

Answer. No, I do not see low promotion rates as a reason for Navy Nurses to separate. Navy nursing is DOPMA constrained in the controlled grades and over the last six years from 2002 to 2008 have met DOPMA constraints. Active plans are underway to adjust grade strength to meet promotion needs.

MENTAL HEALTH TREATMENT RESEARCH

Question. Admiral Bruzek-Kohler, what role do Navy nurses have in research for post war mental health treatment?

Answer. A Navy Nurse Corps officer has a trajectory of research looking at the mental health needs of Navy Service members—from assimilation at Boot Camp to reintegration. His latest study is developing methods for both the patients and caregivers to cope with anxiety-stress to PTSD. These studies are conducted across the branches. Several Navy nurses are co-investigators on his studies as well as the Army. It is funded via the Tri-Service Nursing Research Program

We also join our colleagues from sister Services in the support of nursing research endeavors related to Stress, and Post Traumatic Stress Disorder vs. Mild Traumatic Brain Injury through the Tri-Service Nursing Research Program. Studies funded in fiscal year 2007 and future fiscal year 2008 studies will be conducted on topics of Deployment and Coping.

CONTRACT NURSE REQUIREMENTS

Question. Admiral Bruzek-Kohler, the entry requirement for active duty Navy nurses is a bachelor's in nursing. To provide consistent, quality care, is the same standard applied when hiring contract nurses?

Answer. With rare exception, Navy Medicine contracts allow for Bachelors of Science in Nursing degrees (BSNs), associates degrees, or nursing school diplomas. This is a long standing practice. All of the aforementioned levels of academic preparations meet the requirement for taking the registered nurse licensing exam. We have not had any issues with "consistent, quality care" that are attributable to the educational experience of any one of those groups versus any other. We face an ex-

tremely tight labor markets for nurses at many of our hospitals and do not wish to decrease our overall level or quality of care by trying to limit our recruitment to only BSN nurses at this time.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

MILITARY NURSE RECRUITMENT AND RETENTION

Question. What do you consider the most challenging aspects to military nurse recruitment and retention? Can you discuss your most successful nurse recruitment and retention initiatives?

Answer. Last fiscal year, we met our active duty direct accession goals and are on track to do so this fiscal year. Our top three programs which yield the greatest success in recruiting include the Nurse Accession Bonus (NAB), Health Professions Loan Repayment Program (HPLRP) and Nurse Candidate Program (NCP).

The Nurse Accession Bonus is targeted towards civilian nurses who hold bachelors or masters degree in nursing from an accredited school of nursing and avails $20,000 for a three year commitment and $30,000 for a four year commitment.

The Health Professions Loan Repayment Program assists nurses with accumulated nursing school tuition costs. While primarily a retention tool, HPLRP has been used in conjunction with the NAB as a recruiting incentive to yield a five year active commission service obligation.

The Nurse Candidate Program offered only at non-ROTC Colleges and Universities, is directed at students who need financial assistance while in school. NCP students receive a $10,000 sign-on bonus and $1,000 monthly stipend.

The establishment of a Recruiting and Retention cell at the Bureau of Medicine and Surgery (BUMED) with a representative from each professional corps has also been helpful to our recruiting endeavors. These officers act as liaisons among Commander Naval Recruiting Command (CNRC), Naval Recruiting Districts (NRD), recruiters and our military treatment facilities. They also travel to local/national nursing conferences or collegiate recruiting events.

Student Pipeline Programs are very successful in attracting future candidates and ensure a steady supply of trained and qualified Nurse Corps officers. These pipeline programs include Nurse Candidate Program, Medical Enlisted Commissioning Program, Naval Reserve Officer Training Corps (NROTC) Program and the Seaman to Admiral Program.

We have also established mentorship programs to cultivate professional growth while enhancing retention of our Nurse Candidate Program and NROTC students, who are our best recruiters. Other factors contributing to recruiting success: location of duty stations and the opportunity to participate in humanitarian missions.

We have implemented a number of retention initiatives to offset this attrition. Our critical juncture appears to be among nurses at the 6 to 10 year length of service.

The Health Professions Loan Repayment Program Scholarship assists Navy Nurse Corps officers with accumulated nursing school tuition costs. In fiscal year 2008, 42 active duty nurses were selected with average debt load of $27,300 with two years of obligated service. Interest in this program typically exceeds available funding.

Additionally, the Duty under Instruction Program for Nurse Corps Officers provides the Nurse Corps Officer the opportunity for advanced educational degrees in nursing at the Masters and Doctoral levels. For the first time since 1975, this program was made available to nurses within their first tour of duty.

A Tri-Service Registered Nurse Incentive Special Pay (RN ISP) Plan was released for Navy Nurses in February 2008 to target retention of undermanned critical wartime specialties as identified by the Chief, Bureau of Medicine and Surgery. For the Navy Nurse Corps this included: perioperative, critical care, family and pediatric nurse practitioners. This program offered tiered bonuses $5,000/1 year of obligated service, $10,000/2 years of obligated service, $15,000/3 years of obligated service and $20,000/4 years of obligated service. This program requires the nurses to work in their specialty area full-time, maintain national specialty certification and possess either a Masters of Nursing in the concentrated area of practice or have completed a Surgeon General's approved course.

TROOPS TO NURSE TEACHERS

Question. If the Troops to Nurse Teachers program were authorized and funds were appropriated, how do you think it would impact the Navy Nurse Corps' recruitment and retention efforts?

Answer. For the second consecutive year, the Navy Nurse Corps is on track to meet direct accession goals.

The Navy Nurse Corps views this program primarily as a retention incentives program that gives Nurse Corps Officers an "off ramp" opportunity to teach for two to three years. They would then accrue obligated service back into the Medical Department with the hope that they would continue a 20 year or longer career.

Should the program be funded, the most appealing provision would be the "off ramp" that gives nurse corps officers the opportunity to teach for two to three years. As a retention tool, it would accrue obligated service back into the Medical Department with the hope that they would continue a 20 year or longer career. It would essentially provide another way to retain nurses who might otherwise be disinclined to remain on active duty.

CASE MANAGEMENT

Question. In your written testimony, you discuss the importance of case management and how the Navy works in conjunction with other branches to coordinate care for soldiers' recovery at home. For example, you discussed the Naval Hospital Great Lakes work with the North Chicago VA Medical Center. Can you elaborate on this partnership and how the nursing shortage is affecting the ability to expand the program?

Answer. The collaborative efforts initiated between Naval Hospital Great Lakes and the North Chicago VA Medical Center began in anticipation of the integrated federal health care center. Meetings involving Utilization Management/Case Management departments have occurred and have been most helpful in aligning and coordinating patient services in other parts of the Midwest (particularly in other Veterans Integrated Service Networks—VISNs). These early meetings have also fostered shared use of training resources, enhanced rapport and identified system unique (VA and Navy Military Treatment Facility) processes that must be reviewed and reconciled during the move towards the integration.

At Naval Hospital Great Lakes, there are presently three personnel working in case management roles (two are registered nurses and one is a licensed clinical social worker). They anticipate that by October 2008, they will have two more case managers on board. Case management at Naval Hospital Great Lakes is available not only to returning warriors, but also to their families. Naval Hospital Great Lakes indicated that there should be no challenges with program expansion if the anticipated positions are acquired as planned.

INCREASING DEMAND FOR NURSES

Question. Can you speak to the increasing demand for nurses in your branch as a result of the ongoing war in Iraq?

Answer. The Navy Nurse Corps Psychiatric mental health nursing community estimates it will need six additional Psychiatric Mental Health Nurse Practitioners to meet the expected demands of Marine Corps Operational Stress Control and Readiness (OSCAR) teams, but is allowing for up to 18 nurses in this specialty to facilitate rotations. This growth is being built into our future out service training program plan.

We anticipate a requirement for at least 24 critical care nurses (with likely "plus-up" to 36 critical care nurses) based on modifications in USMC growth calculations. These assets will reside in the ICUs of our Military Treatment Facilities during non-deployed phase of rotation cycles. The Registered Nurse Incentive Specialty Pay program will help fortify the inventory of critical care nurses and perhaps actually draw some nurses from our communities of Medical/Surgical or General Nursing to Critical Care. Our ER/Trauma inventory is presently manned at 109 percent, and this specialty group may also avail support to the growing critical care need.

MOUS WITH UNIVERSITIES

Question. In your written testimony, you discuss the Memorandums of Understanding that the Navy Nurse Corps has with neighboring universities. You talk about the role of nurses as clinical preceptors, guest lecturers, and the importance of naval medical centers serving as sites for clinical rotations. Can you discuss the benefits that the Navy Nurse Corps Officers receive from these MOUs?

Answer. Teaching has long been a role associated with Navy Nursing. We teach our patients, hospital corpsmen, novice nurses in our Corps, and at times even young interns. Navy nurses serving as faculty, guest lecturers and preceptors for local nursing students via our MOUs reap countless, albeit non-tangible rewards. They have the opportunity to engage with civilian students and faculty, provide a wealth of clinical and operational experiences to nurses who perhaps have never

been exposed to nursing in a wartime environment and serve as ambassadors of the United States Navy. Our young nurses are not too far removed from the days in which they too were going through clinical rotations, thus they are often readily "identified with and looked up too" by students.

Likewise, our nurses are encouraged and mentored by the faculty from these schools of nursing we partner with. The faculty challenges them to pursue advanced education and research opportunities as they recognize the scope of their clinical experience in the military greatly supersedes that of their civilian colleagues.

ROTC

Question. One of the major recruitment strategies for the Navy and other Military Nurse Corps is the Reserve Officers' Training Corps or ROTC. In recent years, how effective has this program been in recruiting as well as preparing nurses for a career in the Navy Nurse Corps? How well does this program, or other recruitment programs, recruit underrepresented populations to the Navy?

Answer. Board review of eligible applicants for NROTC scholarships are held throughout the year. Each application is thoroughly reviewed and presented to the board members. In fiscal year 2008 Commander, Navy Recruiting Command (CNRC) was tasked with providing 220 applications for the NROTC Nurse Corps option and attained 250 applications. Of these, 126 were selected and offered a scholarship, equaling a 50 percent selection rate. In fiscal year 2007 the application goal was 220 and 264 applications were attained. Of these, 123 were selected and offered a scholarship, equaling a 46 percent selection rate. The show rate at the schools that year was 75 students (61 percent of those selected).

The NROTC Program has been very effective in attracting applicants for the Nurse Corps. We have a production goal of 60 Nurse Corps officers yearly and with that in mind we select approximately 120–125 applicants each year to meet this goal. Successful preparation for applicants is assured through a strong nursing program at affiliated schools. The programs prepare the Midshipman or Officer Candidate to be successful when taking the National Council Licensure Examination—Registered Nurse (NCLEX–RN). Our pass rate is very high for our nursing graduates, until we achieve nearly all of our production goals.

The NROTC Nurse Corps option does a good job in attracting underrepresented populations. The CNO benchmark for diversity is that 36 percent of the Officer corps in 2037 should be diverse. Applicants for the Nurse Corps option for the 2007–2008 program year were 41 percent diverse. As a comparison, applicants to the four-year NROTC program were 28 percent diverse in 2007–2008. The current board year (fiscal year 2008) data indicates that 50 percent of the diversity nursing applicants were selected for NROTC nursing scholarship offers. We have also placed two Candidate Guidance Officers at the Naval Service Training Command, Pensacola, Florida, for the express purpose of reviewing and assisting diversity applicants with successful application completion and selection for NROTC scholarships.

The Nurse Corps option of the NROTC Program is sought after by applicants, selects and enrolls diverse students, and produces outstanding officers to the Navy's Nurse Corps.

NURSING SHORTAGE

Question. The United States is currently facing one of the most severe nursing shortages in its history. While nursing schools have been making a concerted effort to increase enrollments to meet current and projected demand, 40,285 qualified applicants were turned away in 2007 according to the American Association of Colleges of Nursing. The top reason cited was a lack of qualified nurse faculty.

The legislation I introduced earlier this year, The Troops to Nurse Teachers Act of 2008 (S. 2705), creates several avenues by which military nurses can become nurse educators. The subsequent increase in the number of nurse faculty would allow schools of nursing to expand enrollments and alleviate the ongoing nursing shortage in both the civilian and military sectors. Considering the military has a significantly higher percentage of Masters and Doctorally prepared nurses than in the civilian population—ideal for vacant faculty positions—how does the Navy view this program as part of a successful strategy to address the military nurse shortage?

Answer. While retired military nurses as faculty could help assuage the nursing faculty shortage, the impact of military nurse recruiting is difficult to predict. One might hypothesize that by virtue of having a former military nurse as an instructor, the students would be more receptive to military careers.

The most appealing provision of the Troops to Nurse Teachers program is the "off ramp" that would give nurse corps officers an opportunity to teach for two to three years. As a retention tool, it would accrue obligated service back into the Medical

Department with the hope that they would continue a 20 year or longer career. It would essentially provide another way to retain nurses who might otherwise be disinclined to remain on active duty.

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

STRESS ON NURSES

Question. Military nurses are more stressed than they have been in 40 years, with multiple deployments, heavy loads of wounded soldiers, and time away from their own families and communities? What are you doing to monitor the stress on our nurses? What service are we providing them to help deal with that stress? How many additional nurses do you need to recruit to ensure we can meet our commitment to our wounded soldiers? What is your plan to meet the growing need? What are the major obstacles?

Answer. At the National Naval Medical Center, our psychiatric mental health nurses and others individuals with mental health nursing experience make rounds of the nursing staff and pulse for indications of increased stress. They then provide to the identified staff, education on "Care for the Caregiver." They are available to help with challenging patient care scenarios (increased patient acuity, intense patient/family grief, and staff grief) and offer themselves as attentive, non-judgmental listeners through whom the nurses may vent.

In addition to the classes on "Compassion Fatigue" offered by command chaplains to our nurses and hospital corpsmen, some commands host provider support groups where health professionals meet and discuss particularly emotional or challenging patient cases in which they are or have been involved. Aboard the USNS Comfort, Psychiatric Mental Health Nurses and Technicians were located at the deckplate in the Medical Intensive Care Unit, Ward and Sick Call to help nurses that might not report to sick call with their complaints of stress.

In many of the most stressful deployed locations, our senior nurses are acutely attuned to the psychological and physical well-being of the junior nurses in their charge. They ensure that staffing is sufficient to facilitate rotations through high stress environments. Nurses are encouraged to utilize available resources such as chaplains and psychologists for guidance and support in their deployed roles and responsibilities.

Our deploying nurses have been asked to hold positions requiring new skill sets often in a joint or Tri-Service operational setting. As individual augmentees, they deploy without the familiarity of their Navy unit, which oftentimes may pose greater stress and create special challenges. Our nurses who fulfill these missions require special attention throughout the course and completion of these unique deployments. I have asked our nurses to reach out to their colleagues and pay special attention to their homecomings and re-entries to their parent commands and they have done exactly that.

At U.S. Naval Hospital Okinawa, nurses ensure that deploying staff members and their families are sponsored and assisted as needed throughout the member's deployment. A grassroots organization, Operation Welcome Home, was founded by a Navy Nurse in March 2006 with the goal that all members returning from deployment in theater receive a "Hero's Welcome Home". To date over 5,000 Sailors, Soldiers, Airmen and Marines have been greeted at Baltimore Washington International Airport (BWI) by enthusiastic crowds who indeed care for them as caregivers.

The Navy Nurse Corps Psychiatric mental health nursing community estimates it will need six additional Psychiatric Mental Health Nurse Practitioners to meet the expected demands of Marine Corps Operational Stress Control and Readiness (OSCAR) teams, but is allowing for up to 18 nurses in this specialty to facilitate rotations. This growth is being built into our future out service training program plan.

We also anticipate a requirement for at least 24 critical care nurses (with likely "plus-up" to 36 critical care nurses) based on modifications in USMC growth calculations. These assets will be maintained in the ICUs of our Military Treatment Facilities during non-deployed phase of rotation cycles. Our ER/Trauma inventory is presently manned at 109 percent, and this specialty group may also avail support to the growing critical care need.

QUESTION SUBMITTED BY SENATOR TED STEVENS

NAVY NURSE CORPS SUPPORT TO ARMY AND USMC

Question. I am told that the Navy has stepped in to take on additional missions to support the Army and Marine Corps in theater. What ways have the Navy Nurse Corps stepped up to support our deployed service members.

Answer. Navy nurses continue to support joint missions at Expeditionary Medical Facilities (EMFs) in Kuwait and Djibouti, Landstuhl Regional Medical Center and with deployed units in Afghanistan and Iraq.

At EMF Kuwait, our nurses provided care for 3,564 casualties (received and treated over six month period from July-December 2007). They additionally coordinated and supported immunizations for Japanese, British and Korean troops and a Kuwait-staged mass-casualty/interagency drill and Advanced Cardiac Life Support programs with the American Embassy in Kuwait. In addition to EMF Kuwait, Navy nurses serve on a 35 member team at EMF Djibouti, providing medical services to more than 1,800 personnel assigned to Combined Joint Task Force-Horn of Africa and care for an average of 315 patients any given week.

At Landstuhl Regional Medical Center, 98 Navy Reserve Component nurses work alongside their colleagues from the Army and Air Force. During the past two years, Navy nurses from this contingent have also worked in the warrior management center and made great strides in the provision of optimal care to the wounded as they transit on flights from Landstuhl Regional Medical Center to military treatment facilities in the Continental United States.

The preparation of our forward deployed nurses is accomplished with the support of the Navy Individual Augmentee Combat Training (NIACT). Prior to deploying, personnel are sent to NIACT at Fort Jackson, South Carolina, where the training consists of combat, survival, convoy, weapons handling and firing, and land navigation.

The Navy Nurse Corps Psychiatric mental health nursing community requires six additional Psychiatric Mental Health Nurse Practitioners to meet the Operational Stress Control and Readiness team, but is allowing for up to 18 nurses in this specialty to facilitate rotations. This growth is being built into our future out service training program plan.

We anticipate a requirement for at least 24 critical care nurses (with likely "plus-up" to 36 critical care nurses) based on modifications in USMC growth calculations. These assets will be maintained in the ICUs of our Military Treatment Facilities during non-deployed phase of rotation cycles. The Registered Nurse Incentive Specialty Pay program will help fortify the inventory of critical care nurses and perhaps actually draw some nurses from our communities of Medical/Surgical or General Nursing to Critical Care. Our ER/Trauma inventory is presently manned at 109 percent, and this specialty group may also avail support to the growing critical care need.

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QUESTIONS SUBMITTED TO VICE ADMIRAL ADAM M. ROBINSON

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

SAFE HARBOR PROGRAM

Question. Admiral Robinson, the Navy operates the Safe Harbor program to provide case management for injured sailors and marine. Are there lessons learned from the Army WTUs that should be incorporated in the Navy and vice versa for the Army?

Answer. The Department of the Navy operates two programs, Navy Safe Harbor for wounded, injured and ill Sailors, and the Marine Corps Wounded Warrior Regiment to care for wounded, injured and ill Marines. The Bureau of Medicine & Surgery provides medical case management for all members of the Department of the Navy but relies on Safe Harbor and the Wounded Warrior Regiment to provide effective and timely non-clinical case management for its members. These two tightly

aligned programs also work very closely with the Army's Warrior Transition Unit (WTU)/Army Wounded Warrior (AW2) programs, as well as the Air Force Wounded Warrior program. Through numerous venues, the Services collaborate on new initiatives and institutionalizing best practices, including: Wounded, Injured and Ill Senior Oversight Committee Lines of Action Working Groups; Quarterly Wounded Warrior Program Commanders meetings; Working Group meetings on the fiscal year 2008 National Defense Authorization Act; and Joint/Interagency Federal Recovery Coordinator Training Sessions.

While the focus of these forums are primarily non-medical case management issues there is an inextricable link between the medical and non-medical needs of a recovering service member and their family. Although the delivery mechanisms and organizations providing service and support are different among the services the commonality across the DOD enterprise is to ensure the most consistent level of high quality of care and assistance to those recovering.

RECRUITING AND RETENTION

Question. Admiral Robinson, what are your top constraints to recruiting and retaining the appropriate levels and quality of military medical personnel? Is legislative or financial relief being sought to address these concerns?

Answer. The top constraint to Medical Recruiting is, generally, medical professionals do not consider military service as a first option for employment. Civilian salaries are more lucrative than military pay and continue to outpace the offer of financial incentives (bonuses and loan repayment) to our target market. We are also limited by the size of the pool of Medical and Dental School graduates. Over the last ten years the percentage of females in Medical school has increased. Females tend to have a lower propensity to join the military. Other challenges include concerns over excessive deployments and mobilizations, both of which impact on Navy's ability to meet Reserve Medical Officer Recruiting goals. Some Medical Professionals fear the potential loss of their private practices.

Navy Recruiting continually evaluates areas where we need help meeting recruiting requirements for health professionals, and as we identify new tools and incentives, we would request new legislative and/or financial relief.

All services work with Assistant of Secretary of Defense (Health Affairs) to develop compensation levels for all Health Service professionals in the military.

The medical communities work within the Navy's budgetary process to address financial issues related to compensation.

Navy has implemented significant increases in retention bonuses across all Medical and Dental specialties in recent years.

The top constraint for retention for medical department officers is pay disparity between military compensation and civilian compensation. Military compensation, especially for the certain specialties, lags their civilian counterparts.

Recently enacted legislation in NDAA fiscal year 2008 consolidating the special and incentive pays of the health care field will provide the Navy flexibility for special and incentive pays.

The Medical and Dental Corps was approved for a Critical Skills Retention Bonus (CSRB) in February 2007, and received an increase to their special pays in October 2007.

The Medical Service Corps enacted CSRB in September 2007 for clinical psychologists at the first retention decision point.

Several Nurse Corps undermanned specialties were recently granted an incentive special pay to boost retention. This is the first time the Nurse Corps received a special pay to increase retention in undermanned specialties.

For non-monetary issues, the Navy has a Task Force looking at qualitative retention initiatives (i.e., sabbatical, telecommuting and increasing child care availability).

SPECIALIST POOL

Question. Admiral Robinson, all three Services are having difficulty recruiting and retaining in medical fields such as psychology and psychiatry because you are competing for the same individuals in many instances and because there is a national shortage in these specialties. Is there anything that the military can do to increase these pools of specialists?

Answer. To improve recruiting success, the Navy can either improve our penetration into the existing pool of specialists or try to increase the pool. We can improve our penetration by offering accession bonuses to attract existing mental health providers, and we can increase the pool of specialists by offering scholarships, internships, fellowships or collegiate programs as an incentive for new students to enter

these fields with a military commitment. Furthermore, section 604 of the 2009 National Defense Authorization Request contains a provision for an accession bonus for fully trained clinical psychologists.

The Navy has developed the following initiatives to increase the number of mental health specialists.

—The Navy has recently developed a Post-doctoral Clinical Psychology One Year Fellowship program to reduce the inventory deficit by tapping the demand for post-doctoral training in the civilian community. This program provides the opportunity to obtain supervised training hours, and become licensed within their first year of active duty. The Navy has also increased the number of clinical psychology internship seats for 2009, and is in the process of further expanding the clinical psychology internship program at Naval Medical Center, Portsmouth VA.

—The Navy recently implemented a Critical Skills Retention Bonus for Clinical Psychologists. The incentive is $60,000 ($15,000/year) for 4-year contract at MSR. Clinical Psychology Officers with 3–8 years of commissioned service are eligible.

—The Navy has recently established a Critical Wartime Skills Accession Bonus for accessing fully trained Psychiatrists, and has increased the number of psychiatry residency seats for training new Psychiatrists.

—In order to retain Psychiatrists on active duty the Navy increased the 4 year Psychiatry Multi-Year Special Pay (MSP) from $17,000/year in fiscal year 2006 to $25,000/year in fiscal year 2007 and increased it again to $33,000 in fiscal year 2008. There is discussion at DOD Health Affairs to increase this retention bonus again in fiscal year 2009.

—The Navy has also initiated a Nurse Corps graduate program at the Uniformed Services University of the Health Sciences (USUHS) to educate psychiatric/mental health nurse practitioners to support mental health requirements.

HPSP

Question. Admiral Robinson, I have been made aware that the Navy has had difficulty utilizing the HPSP as a recruiting vehicle. If this program doesn't work for the Navy, what will?

Answer. In fiscal year 2008, Navy funded a $20,000 accession bonus for Health Professions Scholarship Program (HPSP) participants in addition to the scholarship and stipend. Additionally, DOD increased the HPSP monthly stipend amount significantly from $1,349 to $1,605. The stipend will increase again effective July 1, 2008 to $1,907. Together, with a renewed focus on medical recruiting, these monetary incentives have positively impacted interest in the HPSP program. To date, in fiscal year 2008, we recruited 38 percent of our annual goal compared to 27 percent at this point last year. Also, an increase of tuition for Dental School has helped in recruiting of HPSP. Additionally, in fiscal year 2008 and fiscal year 2009 we are offering the Health Services Collegiate Program (HSCP) for the Medical Corps for the first time. We will evaluate the impact of this new program and determine if we should continue it in fiscal year 2010 and beyond.

We will continue to evaluate areas where we can improve this program or identify other programs to meet our recruiting requirements for health professionals.

MILITARY TO CIVILIAN CONVERSIONS

Question. Admiral Robinson, Navy medicine has been hardest hit by the military to civilian conversions. I understand that the Department's guidance is still under review and the Navy had planned additional conversions in fiscal year 2009. What are your anticipated personnel and financial shortfalls in fiscal year 2009?

Answer. Navy Medicine is not planning to convert additional billets in fiscal year 2009, as per section 721 of the fiscal year 2008 National Defense Authorization Act which prohibits the conversion of military medical and dental positions to civilian positions. Under this section there are 4,216 military medical positions that will be restored during the period 2010 to 2015. The Navy's projected fiscal year 2009 Mil-Civ plan, which is dependant on our access to military personnel funds, calls for 282 restorations (200 enlisted, 42 physicians and 40 nurses) at a cost of approximately $26.75 million. The Navy's recruiting accession plans have been modified to accommodate these increases.

QUESTIONS SUBMITTED BY SENATOR BARBARA A. MIKULSKI

INTEGRATED HEALTH CARE TEAMS

Question. The Dole/Shalala Report recommends DOD and VA develop integrated care teams with physicians, nurses, health professionals, social workers, and vocational rehabilitation professionals. What is the Navy doing to implement this recommendation? Are we asking our medical personnel to do the job of social workers? To the extent that medical personnel are assigned in case manager or social worker, what training do they receive to do this?

Answer. Per Navy Medicine's policy, the multi-disciplinary teams meet each week for inpatients and every other week for outpatients to discuss the care and coordination services for all severely injured or ill service members. The multi-disciplinary team consists of physicians, nurses, discharge planners/social workers, clinical and non-clinical case managers, therapists, chaplains, VA representatives to include Federal Recovery Coordinators, medical board and wounded warrior program personnel.

The role of the social worker may overlap with other members of the health care team, for the identification of needs and referrals to appropriate resources; this process is multidisciplinary. Clinical case managers may be either nurses or social workers. Each individual must have 2–3 years of experience in the related field. Certification in case management is expected within 3 years of hire. Each individual receives orientation and training on case management at that facility before engaging with a patient. Training opportunities via teleconferencing are also provided on a biweekly basis. Non-clinical case managers are involved in the planning, formulation, administration, evaluation, consultation and coordination of actions and services dealing with the continued care and support of wounded, ill and injured Sailors and their families. They are trained and have significant experience in assisting injured Sailors and family members in understanding and dealing with current life events through information and referral, as well as, guiding them through the maze of bureaucracy during a time of stress and transition.

FAMILIES OF WOUNDED WARRIORS

Question. The Dole/Shalala report recommended enhancing care for the families of wounded soldiers throughout the soldier's recovery process. It noted that family members are vital parts of the patient's recovery team. What has the Navy done to enhance care for family members of wounded service members in its care? Who on a service member's care team is primarily responsible for helping families? What training have they received? What has DOD done to leverage the help the private sector can provide?

Answer. Navy military treatment facilities (MTF) use social workers, health benefit advisors (HBA) and administrative support personnel to provide assistance and answer questions to all beneficiaries, particularly families, about healthcare benefits and medical support services available as a TRICARE benefit or in the civilian sector. Multidisciplinary teams consisting of medical providers, nurses, clinical case managers, non-clinical case managers from the Navy's Safe Harbor Program and the USMC's Wounded Warrior Regiment, ancillary service personnel, pastoral care personnel, social workers and patient administration officers assist family members of wounded, ill and injured service members in understanding treatment regimens, administering after-care requirements and providing appropriate/timely disability evaluation counseling throughout the continuum of care. Management and coordination of the service member's care is a "team" effort which includes the treating provider, MTF support personnel (i.e. social workers, patient administration) and the family. Clinical and non-clinical case managers and social workers are responsible for helping families. DOD and Navy Medicine is committed to providing resources and programs for families of all wounded, ill and injured services members. There are a number of family support programs that are successfully contributing to the well-being of the family.

Navy's Fleet and Family Centers provides comprehensive, 24/7 information and referral services to family members through the Military One Source links and center support programs.

Navy Safe Harbor Program provides proactive non-clinical case management to Sailors and their families in dealing with personal challenges from the time of injury through transition from the Navy and beyond. The Navy's commitment is to provide wounded, ill, and injured Sailors personalized non-medical support and assistance and guide them through the existing support structure. This is accomplished through addressing the non-medical needs and reinforcing the message that they, our heroes, deserve the very best attention and care of a grateful nation.

The Ombudsman Program promotes healthy and self-reliant families. The Ombudsman serves as a critical information link between command leadership and Navy families. They are trained to disseminate information both up and down the chain of command, including official Department of the Navy and command information, command climate issues and local quality of life (QOL) improvement opportunities. The Ombudsman provides the family a command level advocate to ensure the family understands and is engaged in determining best course of medical care and recovery for the service member.

The Navy Morale, Welfare and Recreation (MWR) administers a varied program of recreation, social and community support activities on U.S. Navy facilities worldwide. Their mission is to provide quality support and recreational services that contribute to retention, readiness and mental, physical and emotional well-being of Sailors and their family members. Many of these programs provide recreational relief for family member responsible for the long-term rehabilitation and recovery of wounded, ill and injured service members.

Naval Service Family Line is a volunteer, non-profit organization dedicated to improving the quality of life for every Sea Service family. This is achieved by answering questions form spouses about the military lifestyle, referring spouses to organizations which may be able to assist them, publishing and distributing free booklets and brochures which contain very helpful information, and developing successful educational programs for the Sea Service spouse.

Marine Corps Community Services (MCCS) exists to serve Marines and their families wherever they are stationed. MCCS programs and services provide for basic life needs, such as food and clothing, social and recreational needs and even prevention and intervention programs to combat societal ills that inhibit positive development and growth.

Wounded Warrior Regiment currently has Patient Affairs Teams (PATs) located at strategic Medical Treatment Facilities to assist and support families of wounded, injured, and ill Marines and Sailors with any requirements they may have. These teams are located at the following sites: Landstuhl Regional Medical Center, Germany; National Naval Medical Center, Bethesda, MD; Walter Reed Army Medical Center, Washington, DC; Portsmouth Naval Hospital, Portsmouth, VA; Richmond VA Polytrauma Center, Richmond, VA; Tampa VA Polytrauma Center, Tampa, FL; Minneapolis VA Polytrauma Center, Minneapolis, MN; Camp Lejeune Naval Hospital, Camp Lejeune, NC; Brooke Army Medical Center, San Antonio, TX; Balboa Naval Hospital, San Diego, CA; Camp Pendleton Naval Hospital, Camp Pendleton, CA; Naval Hospital Twenty-nine Palms, Twenty-nine Palms, CA; Tripler Army Medical Center, Honolulu, HI; and Palo Alto VA Polytrauma Center, Palo Alto, CA.

These PATs assist family members with numerous administrative and logistic issues such as: lodging, travel arrangements, in-and-around travel, Invitational Travel Orders, Bed-side Orders, charitable organizations support, travel advances, travel claims, service intermediaries with hospitals, benefits assistance, Department of Veterans Affairs liaison, Social Security Administration Claims processing, and any other requirements they may have.

Military One Source provides both a web site and toll-free number for service members and their families to locate information and resources dealing with deployment planning, family support resources and referral to private sector agencies supporting the military family.

COMPREHENSIVE RECOVERY PLAN

Question. Dole/Shalala recommends that every wounded soldier or Marine receive a comprehensive recovery plan to coordinate recovery of the whole soldier, including all Medical care and Rehabilitation, Education and Employment Training, and Disability Benefits Managed by a single highly-skilled recovery coordinator so no one gets "lost in the system."

Do all patients get a comprehensive recovery plan?

Answer. The Senior Oversight Committee, Co-Chaired by Deputy Secretary of Defense (DEPSECDEF) and Deputy Secretary of the Veterans Administration (DEPSECVA), Line of Action (LOA) #3 (Case Management), is currently working to address Recovery Care Coordinator functions, responsibilities, workload, and resources. DON Representatives from Navy Safe Harbor, Marine Corps Wounded Warrior Regiment and Navy Medicine are actively engaged in this LOA 3 effort. LOA #3 is identifying Recovering Service Members based on a tiered approach by acuity of wound, illness, or injury and psychosocial needs that would benefit from a comprehensive recovery plan.

Question. What steps have you taken to train and hire skilled recovery coordinators?

Answer. LOA #3 is working towards a unified training solution with standardized curriculum modules for all services, allowing for some service unique required training.

Question. Do service members in the Navy's care have the single coordinator to provide continuity?

Answer. The identification of a recovery care coordinator who will oversee the completion of a comprehensive recovery plan as recommended by Dole/Shalala, will be a further enhancement to the Navy's already robust care management program. The Navy's comprehensive casualty care program provides support and assistance to all wounded, ill and injured Sailors and their family members throughout their phases of recovery to reintegration or to transition from the service.

Question. What training do recovery coordinators receive?

Answer. Standardized training is currently under development.

Question. Are they trained as soldiers, or as case managers?

Answer. Training will focus on non-medical case/care management with modules on how to access medical support if presented with clinical issues.

QUESTIONS SUBMITTED BY SENATOR TED STEVENS

SUPPORT TO USMC GROWTH

Question. The Marines are growing an additional 27,000 personnel in end strength, while the Navy has planned a reduction in forces. What steps are you taking to try and meet the need of a larger Marine Corps ground force for deployments while maintaining the right size force in the Navy?

Answer. President's Budget 2008 included a top line funding and 922 end strength increase for Navy in support of the USMC's growth of 27,000 personnel. The Navy increase includes approximately 800 discrete billets, with the remainder comprised of student training billets. Out of the 800 specific billets, the majority are Hospital Corpsmen and medical officers. The billet requirements were provided by USMC Total Force Structure Division, Deputy Commandant for Combat Development and Integration.

In addition to the manpower funding, Navy was also allocated a funding increase for general skills and flight training.

Sailors and Naval Officers are being assigned to the new billets in a phased manner in parallel with the ramp up of the USMC growth. The assignment of the first several hundred personnel is underway, and Navy foresees no obstacles in filling the remaining billets.

WRNMMC BETHESDA DEADLINE

Question. The Navy has announced an award for the design-build of the new Walter Reed National Military Medical Center at Bethesda. Do you believe this project is still on track to be completed by the BRAC deadline of 2011?

Answer. Barring any unforeseen site conditions or major design changes, the Navy believes that the schedule for this project is on track to meet the BRAC 2005 deadline of September 2011.

WRNMMC DEADLINE CHALLENGES

Question. What challenges still need to be addressed in completing the build out of this facility by the BRAC deadline?

Answer. Challenges can arise from several areas including the timely receipt of funding, completion of traffic flow improvements, equipment installation, unforeseen conditions found during building renovation work and unknowns encountered in the field such as lead, mercury, and asbestos. The coordination of several contractors concurrently working on site and the movement of staff from Walter Reed to Bethesda will also be challenging. All these challenges must be successfully managed in order to meet the deadline of September 2011.

WRNMMC REALIGNMENT

Question. Are there Service specific concerns or issues with regards to this realignment that you are working through with your Army counterpart? What are they?

Answer. There are issues of governance and operational efficiencies that are presently being worked by Navy and Army for the new Walter Reed National Military Medical Center. I am diligently working with the Commander, Joint Task Force National Capital Region Medical and the Surgeon General of the Army to ensure that

the planning, construction and future governance of the state of the art military medical center in the National Capital Region fully complies with the BRAC requirements, best serves our warriors and military beneficiaries and is an icon for world class medical care when completed in 2011.

MILITARY TO CIVILIAN CONVERSION STANDSTILL

Question. I understand that all medical military to civilian conversions are at a standstill as directed by the fiscal year 2008 Defense Authorization Act that was signed into law this past January. Can you tell us how this will impact care in the Medical Treatment Facilities? Do you have a plan in place to fill the slots that were originally supposed to be converted?

Answer. There will be some shortfalls in staffing for the next several years. However, the reversal of the military to civilian conversions is not the sole reason for the shortfalls. Certain health professional specialties are very difficult to access and retain for both military and civilian positions.

Depending on our access to military personnel funds, the Navy is planning to restore 282 military billets in fiscal year 2009, with the remaining military positions being bought back between fiscal year 2010 and fiscal year 2015. The plan is to use contract personnel and term government service employees to alleviate this gaps caused by the time lag until the military endstrength can be completely restored and filled.

MILITARY TO CIVILIAN CONVERSION—BENEFITS OF MILITARY PERSONNEL

Question. What are the benefits to having military personnel in these medical professions?

Answer. More medical professionals in uniform increases Navy medicine's ability to surge when necessary during extended conflicts. The increased uniform medical personnel reduces the stress on the force during high-tempo periods of operations thus causing a trickle down effect increasing retention and allowing a healthy operational rotation of medical professionals.

MILITARY TO CIVILIAN REVERSAL CHALLENGES

Question. Despite funding challenges, what other challenges do you foresee in the coming year with regards to a reversal of Military to Civilian conversions?

Answer. The recruiting and retention of medical professionals will be increasingly difficult for the foreseeable future. There is a growing national shortage of medical professionals in the United States and there will be an increased competition to recruit health care professionals in both the military and civilian sector. The military's best strategy to recruit and retain medical specialists is to grow our own specialists through strong graduate and resident education programs coupled with competitive incentive packages after training obligations have expired.

QUESTIONS SUBMITTED BY SENATOR CHRISTOPHER S. BOND

BEHAVIORAL HEALTH CARE ASSETS

Question. Army and Navy Surgeon General Question. What are you doing to alleviate the shortage?

Answer. Currently the Services have numerous incentives to attract and retain behavioral health specialists. Some have been recently enacted from the fiscal years 2007 and 2008 NDAA and we are monitoring the effects on recruiting and retention.

Psychiatry (Medical Corps)

Eligible for the following entitlements: Variable Special Pay, Additional Special Pay, and Board Certified Pay.

Eligible for the following discretionary special pays: Incentive Special Pay (ISP) $15,000/year and Multiyear Special Pay (MSP) 2 year—$17,000/year, 3 year—$25,000/year, and 4 year—$33,000/year. The 4 year MSP for Psychiatrist has increased from $17,000/year in fiscal year 2006 to $25,000/year in fiscal year 2007 to $33,000 in fiscal year 2008. The Health Professional Incentive Work Groups (HPIWG), a tri-service work group run by DOD Health Affairs, is contemplating another increase in fiscal year 2009.

The NDAA 2008 allows up to $400,000 Critical Wartime Skills Accession Bonus (CWSAB) for board certified direct accessions. DOD/HA has authorized $175,000 accession bonus for psychiatrists who accept a 4 year commitment. The HPIWG will be increasing the CWASB amounts in fiscal year 2009.

Psychiatrists are eligible for the Health Profession Loan Repayment Program (HPLRP) if they meet eligibility requirements. HPLRP can be used as an accession incentive and as a retention incentive. This program provides up to $38,300 per year to repay qualified school loans. HPLRP obligation runs consecutively with other obligations.

Clinical Psychologists (Medical Service Corps)

The Navy recently implemented a Critical Skills Retention Bonus for Clinical Psychologists. The incentive pays $60,000 ($15,000/year) for 4-year contract at MSR. Clinical Psychology Officers with 3–8 years of commissioned service are eligible.

Psychologists are eligible for the Health Profession Loan Repayment Program (HPLRP) if they meet eligibility requirements. HPLRP can be used as an accession incentive and as a retention incentive. This program provides up to $38,300 per year to repay qualified school loans. HPLRP obligation runs consecutively with other obligations.

Clinical Psychologists are eligible for Board Certified Pay.

The HPIWG is currently working on implementing an accession bonus and retention bonus for Clinical Psychologists in fiscal year 2009 using the new consolidated medical special pay authority in NDAA 2008.

Social Workers

Social Workers are also eligible for Health Professionals Loan Repayment Program (HPLRP) as an accession and retention tool.

Social Workers are eligible for Board Certified Pay.

The HPIWG is currently working on implementing an accession bonus and retention bonus for Social Workers in fiscal year 2009 using the new consolidated medical special pay authority in NDAA 2008.

Mental Health Nurse Practitioners

Nurse Corps recently recognized Registered Nurse Mental Health Nurse Practitioners with subspecialty code.

Once approved by Assistant Secretary of Health Affairs Mental Health Nurse Practitioners will be eligible for board certified pay.

Mental Health Nurse Practitioners are eligible for the Health Profession Loan Repayment Program (HPLRP) if they meet eligibility requirements. HPLRP can be used as an accession incentive and as a retention incentive. This program provides up to $38,300 per year to repay qualified school loans. HPLRP obligation runs consecutively with other obligations.

Fully qualified Mental Health Nurse Practitioner entering the Navy would qualify for the Nurse Accession Bonus (NAB), $20,000 for a 3 year commitment or $30,000 for a 4 year commitment. This bonus can be combined with the HPLRP as a 3 year NAB accession incentive requiring a 5 year commitment.

Starting in fiscal year 09 Mental Health Nurse Practitioners will be eligible for the Registered Nurse Incentive special Pay. This is a multi-year special pay up to $20,000 per year for a 4 year contract.

VET CENTERS

Question. Thank you. To follow up, I'd ask Army leaders to consider a proposal to allow active duty forces to access the behavioral health care resources available at the nation's Vet Centers. These facilities provide care for PTSD and are manned by veterans and specialists familiar with the needs of veterans and our active duty forces. It seems a tremendous waste in resources to limit eligibility to our Vet Centers to veterans only if there are soldiers who require care but have limited or no assets available to them.

Would you support legislation that allowed active duty forces access to behavioral health resources at the nation's Vet Centers?

Answer. Yes, Navy Medicine would support legislation for this; however, we already have authority to share resources and have some agreements in place where mental health services are exchanged, primarily the VA providing the mental health services to DOD. Our main concern would be whether the VA has the capacity to provide mental health services to active duty service members.

MILITARY EYE TRAUMA CENTER OF EXCELLENCE AND EYE TRAUMA REGISTRY

Question. Switching gears, I'd like to talk about the Centers of Excellence recently developed by the Department of Defense. Congress, in the Wounded Warrior section of the NDAA enacted January 2008, included three military centers of excellence, for TBI, PTSD, and Eye Trauma Center of Excellence. The two Defense Centers of Excellence for TBI and Mental Health PTSD are funded, have a new director and

are being staffed with 127 positions, and are going to be placed at Bethesda with ground breaking in June for new Intrepid building for the two centers. I'm sure you are aware that there have been approximately 1,400 combat eye wounded evacuated from OIF and OEF.

Does DOD Health Services Command have current funding support and adequate staffing planned for the new Military Eye Trauma Center of Excellence and Eye Trauma Registry? If not, when can the committee expect to be provided specific details on implementation?

Answer. The Office of the Secretary of Defense (Health Affairs) is coordinating the implementation of the Military Eye Trauma Center of Excellence.

MILITARY HEALTH SYSTEM GOVERNANCE

Question. There has been a lot of discussion in recent years about making military medicine more joint. Do you believe changes in the governance of the Military Health System are needed to make military medicine more effective and efficient?

Answer. Navy Medicine supports a governance structure where the three Surgeon's Generals participate collaboratively. The current governance structure allows for services to address issues in a "joint-like" environment thereby ensuring effective and efficient use of resources. The structure also recognizes unique service requirements, such as health services training to support the future agility of the Marine Corps, where there may be no overlapping service capability. There is no need to change the governance structure at this time, however, Navy Medicine will continue to foster participation in Joint requirements and acquisition projects to ensure interoperability between services.

SUBCOMMITTEE RECESS

Senator INOUYE. And with that, I thank you very much for your testimony, and the subcommittee will stand in recess until April 23, and at that time, we'll receive testimony on the Missile Defense Agency.

Thank you very much.

[Whereupon, at 11:48 a.m., Wednesday, April 16, the subcommittee was recessed, to reconvene subject to the call of the Chair.]