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## DEFENSE HEALTH PROGRAM

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HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES  
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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HEARING HELD

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#### DEFENSE HEALTH PROGRAM

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## DEFENSE HEALTH PROGRAM

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HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE ON MILITARY PERSONNEL,  
*Washington, DC, Wednesday, April 21, 2010.*

The subcommittee met, pursuant to call, at 1:40 p.m., in room 2118, Rayburn House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

### **OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mrs. DAVIS. Good afternoon. Today the Military Personnel Subcommittee will hold a hearing on the President's fiscal year 2011 budget request for the Defense Health Program (DHP).

Testifying before us are the senior medical leaders of the Department of Defense (DOD). Dr. Charles Rice is the President of the Uniformed Services University of Health Sciences, and is currently performing the duties of the Assistant Secretary of Defense for Health Affairs. This office is responsible for the preparation and oversight of the Defense health budget, as well as the execution of private sector care.

We also have with us the service surgeons general, Lieutenant General Eric Schoomaker from the Army, Vice Admiral Adam Robinson from the Navy, and Lieutenant General Bruce Green from the Air Force, who are responsible for the provision of care in military hospitals and clinics. Thank you all for being here. Welcome.

This year's budget request, much like last year's, lacks many of the objectionable proposals of years past. For example, there are no onerous TRICARE fee increases that seek to place a burden of improving the system on beneficiaries instead of on the Department of Defense. There are no "efficiency wedges," an interesting term that meant "We think the services are spending too much, but we don't know exactly where, so we are just going to cut their budgets and let them figure it out." There are no proposed conversions of military medical positions to civilian medical positions. And the absence of all of these things from the proposed budget is a very good start.

However this budget request, while devoid of these negatives, doesn't have so many positives that are forward-looking. We continue to see little if any evidence of a comprehensive, multifaceted strategy for moving the Military Health System (MHS) forward. For the past few years Congress has been pushing the Department of Defense to improve the health status of the beneficiary population and improve cost-effectiveness of the care provided to our

beneficiaries by adopting proven practices, the fiscal year 2009 National Defense Authorization Act contains many initiatives to improve preventive and wellness care. But 18 months, now, after it was signed into law, we are still waiting for most of them to be fully implemented.

That same bill also gave the Department great latitude and authority to conduct demonstration projects to test other methods of improving health while reducing costs. We would like to hear today how the Department plans to take advantage of that authority.

Further, the 2010 National Defense Authorization Act contained a requirement for the Department to undertake actions to enhance the capability of the Military Health System and improve the TRICARE program. Congress felt that such action was needed because private sector care, which was originally intended to be and is still described by the Department as a program to fill gaps in the direct care system, is projected to account for about 67 percent of the Department of Defense health-care expenditures in fiscal year 2011 versus 65 percent this year. It is strange logic to characterize something that accounts for almost 70 percent of a program as a gap-filler.

We recognize that several factors have contributed to the unintentional growth in private sector care, such as two wars, staffing shortages, and broad reserve globalization.

With that said, without appropriate planning, the effect of these factors could be an irreversible trend, placing medical readiness in future contingencies in jeopardy. Congress clearly believed the Department must develop a long-term plan to maximize the capabilities of the direct care system, and we would like to hear from our witnesses today any ideas they may have.

This has been a momentous year for health care in this country. Last month the Patient Protection and Affordable Care Act and the companion improvements bill were signed into law. Further, just last week, the Senate unanimously passed the TRICARE Affirmation Act introduced by the chairman of this committee, Ike Skelton, which had previously passed unanimously in the House.

The TRICARE Affirmation Act explicitly states that TRICARE and nonappropriated fund, NAF, health plans meet all of the health-care requirements for individual health insurance under the newly enacted health-care reform law. TRICARE and the NAF health plans already meet the minimum requirements for individual health insurance coverage in the recently enacted health-care bill, and no TRICARE or NAF nonappropriated fund health plan beneficiary will be required to purchase additional coverage beyond what they already have.

However, to reassure our military service members and their families and make it perfectly clear that they will not be negatively affected by the health-care reform law, the TRICARE Affirmation Act explicitly states that TRICARE and the NAF health plans meet the minimum requirements for individual health insurance.

Now that the bills are law, parents across the country will now be able to extend their health coverage to their dependent children up to age 26. Being true to their word, congressional Democratic leadership ensured that the health reform bills do not involve TRICARE in any way. But since care was taken to guarantee that

the Department of Defense health programs under Title 10, U.S. Code, were not touched by the health reform bills, this means that the new law does not allow TRICARE beneficiaries to extend their health coverage to their dependent children.

Fortunately, a member of this committee, Mr. Heinrich of New Mexico, quickly crafted and introduced a bill, H.R. 4923, the TRICARE Dependent Coverage Extension Act, that would amend Title 10 to precisely match the health reform law to allow TRICARE beneficiaries to extend their health coverage to their dependent children up to age 26. I want to thank Mr. Heinrich for introducing this important legislation and I want to let everyone know that I certainly intend to include that bill in this subcommittee's mark for this year's National Defense Authorization Act in a few weeks.

Since Mr. Heinrich is not a member of the subcommittee, I would ask unanimous consent that he be allowed to participate in today's hearing and be allowed to ask questions after all the members of the subcommittee.

Hearing no objection, thank you for being here.

Mr. Wilson, we welcome you. We are sorry we got underway because we just had everybody ready to go here and we appreciate the fact that you were trying to get here as well.

Please, we are happy to have any of your comments.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

**STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mr. WILSON. Thank you, Chairwoman Davis. Today the subcommittee meets to hear testimony on the Defense Health Program for fiscal year 2011. Although we routinely have an annual hearing on the Defense Health Program, I believe there is nothing routine about the Military Health System and the extraordinary care it provides to our service members and their families. I have first-hand knowledge of these remarkable military and civilian medical professions from my second son, who is an orthopedic resident in the Navy, and my other three sons who are current members of the Army National Guard.

The subcommittee remains committed to ensuring that the men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries.

I would like to express my deep appreciation to all the Military Health System leadership and personnel who are responsible for delivering the highest quality health care during these most challenging times.

To begin, I want to commend the Department of Defense for sending us a budget that does not rely on raising TRICARE fees to help finance the Defense Health Program. It appears the Defense Health Program is fully funded. However, I remain concerned a portion of the funding is based on projected savings from several programs that may not be fully realized.

I would like to know how the Department of Defense plans to cover any unexpected shortfalls in the Defense Health Program if the savings from initiatives such as the Federal Pricing for Pharmaceuticals doesn't materialize.

With that, I am anxious to hear from our witnesses today about the progress the Department has made in developing a comprehensive approach to providing world-class health care to our beneficiaries while at the same time controlling cost. I would like to know how the Military Health System is meeting the medical needs of our beneficiaries today and what process you use for determining the medical requirements of future beneficiaries. I am interested in knowing how you have included the stakeholders in military health care and the discussions about providing world-class health care in the future of the Military Health System. Further, I would like to hear from the witnesses on how the Defense Health Program supports the critical mental health services needed by our service members and their families, particularly the National Guard and Reserve members who rely primarily on TRICARE standard.

I would also like to better understand from our military Surgeons General whether the Defense Health Program will fully support their responsibility to maintain medical readiness, provide health care to eligible beneficiaries, provide battlefield medicine to our brave men and women in Iraq and Afghanistan, care for combat veterans through the long recovery process when they become injured and wounded.

Finally, with regard to TRICARE, which is now regarded as a health-care delivery system worthy of emulation, I quite frankly don't understand why the Department of Defense would not want to explicitly protect it from any unintended consequence that may arise from the health-care takeover.

Congress has already acted to make clear, explicit, that the recent health-care bill did not, that TRICARE meets the statutory requirement for minimal essential health care. The Department of Defense did not object to that recent congressional action. Now it is time to make explicit in the law what has been promised that would be explicit in the health-care reform.

The Secretary of Defense would remain in control of the DOD Health Care Program. No one should object to Congress making that control explicit in the law. While some may feel that this is an unnecessary precaution, we owe our military that clearly stated protection.

With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony.

Mrs. DAVIS. Thank you, Mr. Wilson.

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

Mrs. DAVIS. Dr. Rice, please begin.



**STATEMENT OF CHARLES L. RICE, M.D., PERFORMING THE  
DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE FOR  
HEALTH AFFAIRS, AND PRESIDENT, UNIFORMED SERVICES  
UNIVERSITY OF HEALTH SCIENCES, U.S. DEPARTMENT OF  
DEFENSE**

Dr. RICE. Madam Chair, members of the committee, thank you for the opportunity to discuss the military health care system's priorities and our budget submission for fiscal year 2011. It is a privilege to be here with my colleagues, the Surgeons General of the three military services.

We have enduring obligations to the men and women of our armed forces, as you have observed, and to their families who serve with them, and to the millions of retired personnel who have served us in the past. This obligation begins the moment a recruit walks through our doors. In our budget for the coming year we acknowledge that lifetime commitment we have to those who serve today, or who have served in the past, and to their families. For those service members who honorably conclude their service before reaching military retirement, we have an obligation to ensure that their medical experience is fully captured and easily shared with the Department of Veterans Affairs (VA) or with their own private physician.

For those who retire from military service, our obligation to them and to their families often extends for a lifetime. And for those who have borne the greatest burden through injury or disease suffered in our nation's conflicts, we have an even higher obligation to the wounded and to their families.

As Secretary Gates stated with the introduction of the Defense budget, "Recognizing the strain that post-9/11 wars have put on so many troops and their families, the Department will spend more than \$2 billion for wounded warrior initiatives, with a special focus on signature ailments of the current conflict, such as post-traumatic stress disorder and traumatic brain injury (TBI), manifestations of the last injury."

"We will sustain health benefits and enlarge the pool of medical professionals. We will broaden electronic information sharing between the Department of Defense and the VA for wounded warriors making the transition out of military service."

The budget we are putting forward reflects our commitment to the broad range of responsibilities of the military health care system; the medical readiness requirements needed for success on today's battlefield; the medical research and development necessary for success on tomorrow's; the patient-centered approach to care that is being woven through the fabric of the military health care system; the transformative focus we have placed on the health of our population; the public health role we play in our military community and in the broader American community; the reliance we have on our private sector health-care partners who provide indispensable service to our service members and their families; and our responsibility to deliver all of those services with extraordinary quality and care.

The Defense Health Program, the appropriation that supports the MHS, is under mounting financial pressure. The DHP has more than doubled since 2001 from 19 billion to 50.7 billion in

2011. The majority of DOD health spending supports health-care benefits for military retirees and their dependents, not the active force. We projected up to 65 percent of DOD health-care spending will be going towards retirees in fiscal year 2011, up from 45 percent in 2001.

As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option, and they are likely to drop their employer's insurance.

These costs are expected to grow from 6 percent of the Department's total budget in 2001 to more than 10 percent in 2015. Despite these financial challenges, however, the fiscal year 2011 budget request provides realistic funding for projected health-care requirements, and we are grateful to this committee and to the Congress for affirming TRICARE as a qualifying plan under the health reform act.

The unified medical budget, the Department's total request for 2011 is \$50.7 billion. This includes the DHP appropriation, including wounded, ill, and injured care and rehabilitation, military personnel, military construction, and normal cost contributions for Medicare-eligible retiree health care.

For military personnel, the unified budget includes 7.9 billion to support the more than 84,000 military personnel who provide health-care services in military theaters of operations in fixed health-care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response as we recently saw in Haiti.

Funding for the military construction (MILCON) includes a billion dollars to improve our medical infrastructure. We are committed to building new hospitals, using the principles of evidence-based design, and excited to be able to open a national showcase in evidence-based design, the new Fort Belvoir Community Hospital, in 2011.

MILCON funding will also be directed toward infrastructure enhancements at the interagency biodefense campus at Fort Detrick.

Madam Chair, the military health care system continues to provide world-class medical care for a population that demands and deserves the best care anywhere. I am proud to be here on behalf of the men and women who comprise the military health care system, proud to submit to you and your colleagues a budget that is fully funded and that we can successfully execute in the coming year. I look forward to your questions.

Mrs. DAVIS. Thank you.

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

Mrs. DAVIS. General.

**STATEMENT OF LT. GEN. ERIC B. SCHOOMAKER, USA,  
SURGEON GENERAL, U.S. ARMY**

General SCHOOMAKER. Chairwoman Davis and Representative Wilson, distinguished members of the Military Personnel Subcommittee and the full committee, thank you for inviting us to discuss the Defense Health Program and our respective medical service programs.

Now in my third hearing cycle as the Army Surgeon General and the Commanding General of the United States Army's Medical Command, or MEDCOM, I can tell you that these hearings are valuable opportunities for me to talk about the accomplishments and challenges of Army Medicine and to hear your collective perspectives regarding military health promotion and health care. And for the reasons, ma'am, that you mentioned in your opening comments, although closely interrelated, I keep military health promotion and health care somewhat separate issues.

I am pleased to tell you that the President's budget submission for fiscal year 2011 fully funds the Army Medical Department's needs. Your support of the President's proposed budget will be greatly appreciated.

One particular area of special interest to this subcommittee is our comprehensive effort to improve warrior care from the point of injury through evacuation and inpatient treatment to rehabilitation and return to duty. There is nothing more gratifying than to care for these wounded, ill, and injured heroes. We in Army Medicine continue to focus our efforts on our warriors in transition, which is our term for them. And I want to thank the Congress for your unwavering support of these efforts.

The support of this committee especially has allowed us to hire additional providers to staff our warrior transition units, to conduct relevant medical research, and to build healing campuses, the first of which will open in Fort Riley, Kansas very soon.

I am convinced that the Army has made some lasting improvements. The most important improvement will be the change in mindset from a focus on disability to an emphasis on ability and achievement. Each of these warriors has the opportunity and resources to create their own future as soldiers or as productive private citizens.

A second area of special interest for the subcommittee is psychological health. Army Medicine, under the direction of our new Deputy Surgeon General, Major General Patty Horoho who has just relinquished command of the Western Region and has traveled here and is replacing David Rubenstein who is headed to San Antonio, is finalizing a comprehensive behavioral health system of care campaign plan. This comprehensive behavioral health system of care is intended to standardize and synchronize the vast array of activities across the medical command and throughout the Army's force generation cycle, this iterative three-cycle process by which we prepare soldiers and units for deployment, deploy them and support their families back in garrison, bring them back and redeploy them and reintegrate them. I look forward to sharing more information with you over the next few months as we roll out this exciting initiative.

In keeping with our focus on preventing illness and injury, Army leadership is fully engaged in an all-out effort to change the military mindset regarding traumatic brain injury, especially the milder form, or a concussion. Our goal is nothing less than a cultural change in fighter management after potential concussive events. Every warrior requires appropriate treatment to minimize concussive injury and to maximize recovery. And to achieve this goal we are educating the force so that we have trained and prepared soldiers, leaders, medical personnel to provide early recognition, treat-

ment, and tracking of concussive injuries from the moment of the injury on the battlefield, homeward. Ultimately this is designed to protect warrior health. This also further highlights strong efforts by the senior Army and DOD leadership to reduce the stigma associated with seeking help for these injuries and for behavioral health problems which might be present, separately or jointly.

The Army is issuing very direct standards and protocols to commanders and health-care providers. Similar to aviation incident actions, automatic grounding and medical assessments are required for any soldiers meeting specified criteria. The end state of these efforts is that every service member sustaining a possible concussion will receive early detection, state-of-the-art treatment and a return-to-duty evaluation and a long-term digital health record tracking of their management. Treatment of concussive injury is an emerging science. The Army is leading the way, along with the DOD, in implementing these new treatment protocols both for the DOD, and the DOD is leading the nation.

I brought here with me today a brain injury awareness kit that I will share with you and your staff. It contains patient information materials, as well as a very informative DVD, sort of a concussive injury 101.

Mrs. DAVIS. Thank you General. I just ask that that be included in the record by unanimous consent.

[The information referred to is retained in the subcommittee files and can be viewed upon request.]

General SCHOOMAKER. Thank you.

I truly believe our evidence-based directive approach to concussion management will change the military culture regarding head injuries and significantly impact the well-being of the force.

Ma'am, in reference to your comments about cost containment and improvements and health outcomes, the Army Medicine is in its fourth year of the performance-based health-care budget program which incentivizes our commanders and our clinicians for practicing evidence-based medicine and improving individual and community health. It has been a very successful campaign. I am very eager to address any questions that you may have about it.

In closing, I am very optimistic about the next two years. Logic would not predict that we would be doing as well as we are in attracting and obtaining and career-developing such a talented team of uniformed and civilian military medical professionals. I feel very privileged to serve with the men and women of Army Medicine, as soldiers, as Americans, and as global citizens.

Thank you for holding this hearing and for your steadfast support of Army Medicine. I look forward to your questions.

Mrs. DAVIS. Thank you.

[The prepared statement of General Schoomaker can be found in the Appendix on page 61.]

Mrs. DAVIS. Admiral Robinson.

**STATEMENT OF VICE ADM. ADAM M. ROBINSON, USN,  
SURGEON GENERAL, U.S. NAVY**

Admiral ROBINSON. Good afternoon. Thank you, Chairwoman Davis, Representative Wilson, distinguished members of the committee, Representative Heinrich, I want to thank you for your un-

wavering support of Navy Medicine, particularly as we continue to care for those who go in harm's way, their families and all beneficiaries. I am honored to be with you today to provide an update of Navy Medicine.

Navy Medicine, world-class care anytime anywhere. This poignant phrase is arguably the most telling description of Navy Medicine's accomplishment in 2009 and continues to drive our operational tempo and priorities for the coming year and beyond.

Throughout the last year we saw challenges and opportunities, and moving forward I anticipate the pace of operations and demand will continue to increase. We have been stretched in our ability to meet increasing operational and humanitarian assistance requirements, as well as maintaining our commitment to provide care to a growing number of beneficiaries. However, I am proud to say that we are responding to this demand with more flexibility and agility than ever before.

The foundation of Navy Medicine is force health protection, and nowhere is this more evident than in Iraq and Afghanistan. During my October 2009 trip to theater, I saw again the outstanding work of medical personnel. The Navy Medicine team is working side by side with Army and Air Force medical personnel and coalition forces to deliver outstanding health care to troops and civilians alike.

As our wounded warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. We want them to mend in body, mind, and spirit. Our patient- and family-centered concept of care brings together medical treatment providers, social workers, case managers, behavioral health providers and chaplains. We are working closely with our aligned counterparts in Marine Corps wounded warrior regiments, and the Navy's Safe Harbor Program to support the full spectrum recovery process for sailors, Marines, and their families.

An important focus for all of us continues to be caring for our wounded warriors suffering with traumatic brain injury. We are expanding traumatic brain injury training to health-care providers throughout the fleet and Marine Corps. We are also implementing a new in-theater TBI surveillance system and conducting important research. Our strategy is both collaborative and integrated by actively partnering with other services, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Department of Veterans Affairs, and leading academic medical and research centers to make the best care available to our warriors.

We must act with a sense of urgency to continue to help build resiliency among our sailors and Marines, as well as the caregivers who support them. We are aggressively working to reduce the stigma surrounding psychological health and operational stress concerns.

Programs such as Navy Operational Stress Control, Marine Corps Combat Operational Stress Control Focus, Families Overcoming Under Stress, Caregiver Occupational Stress Control, and our Suicide Prevention Programs are in place and maturing to provide the support to personnel and their families.

Mental health specialists are being placed in operational environments and forward deployed to provide service where and when

they are needed. The Marine Corps is sending more mental health teams to the front lines, and Operational Stress Control and Readiness team, also known as OSCAR, will soon be expanded to include the battalion level.

A mobile care team of Navy Medicine mental health professionals is currently deployed to Afghanistan conducting mental health surveillance, consulting with command leadership, and coordinating mental health care for sailors throughout the area of responsibility (AOR).

An integral part of the Navy's maritime strategy is humanitarian assistance and disaster response. In support of Operation Unified Response Haiti, we deployed USNS *Comfort* from her homeport in Baltimore within 77 hours of the order, and ahead of schedule. She was on station in Port-au-Prince five days later.

From the beginning, the operational tempo on board *Comfort* was high and our personnel were challenged professionally and personally. For many, this was a career defining experience, and I was proud to welcome the crew home last month and congratulate them for their outstanding performance.

I am encouraged with our recruiting efforts within Navy Medicine, and we are starting to see the results of new incentive programs. But while overall manning levels for both officer and enlisted personnel are relatively high, ensuring we have the proper specialty mix continues to be a challenge in both active and reserve components. Several wartime critical specialties, as well as advance practice nursing and physician assistant, are undermanned.

We also face shortfalls for general dentists, oral and maxillofacial surgeons, and many of our mental health specialists, including clinical psychologists and social workers. We continue to work hard to meet this demand but fulfilling the requirement among these specialties is expected to present a continuing challenge.

Research and development is critical to Navy Medicine's success and our ability to remain agile to meet the evolving needs of our warfighters. It is where we find solutions to our most challenging problems and, at the same time, provide some of medicine's significant innovations and discoveries. Research efforts targeted at wound management, enhanced wound repair and reconstruction, as well as extremity and internal hemorrhage control, phantom limb pain in amputees present definitive benefit. These efforts support our emerging expeditionary medical operations in aid and support to our wounded warriors.

Clearly, one of the most important priorities for leadership of all the service is the successful transition to the Walter Reed National Medical Center on board the campus of the National Naval Medical Center, Bethesda. We are working diligently with the lead DOD organization, Joint Task Force National Capital Region Medical, to ensure that this significant and ambitious project is executed properly and without any disruption of services to our sailors, Marines, their families, and all of our beneficiaries for whom we are privileged to serve.

In summary, I believe we are an important crossroads for military medicine. Commitment to wounded warriors and their families must never waiver, and our programs of support and hope must be built and sustained for the long haul. And the long haul is the rest

of this century when the young, wounded warriors of today mature into our aging heroes in the years to come. They will need our care and support, as will their families, for a lifetime.

On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support and confidence and also for your leadership. It has been my pleasure to testify before you today and I look forward to your questions. Thank you.

Mrs. DAVIS. Thank you.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 77.]

Mrs. DAVIS. General Green.

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

General GREEN. Chairwoman Davis, Representative Wilson and distinguished members of the committee, thank you for this opportunity to join you today as we address common goals in serving our warriors and their families.

The Air Force is all in to support the joint fight, providing global vigilance reaching power for America. The Air Force medical service does whatever it takes to get coalition wounded warriors home safely.

I have previously shared the case of a British combatant with wounds requiring removal of a lung. It took three airplanes and nearly a thousand people coordinating his movement on heart-lung bypass to get him back to England. Today he is out of the hospital and back to a normal life in Birmingham, England.

You may have seen or heard recent national news reports about an amazing operation that took place last month at the Craig Joint Theater Hospital at Bagram. Air Force Major Dr. John Bini is a seasoned theater hospital trauma surgeon, stationed in Wilfred Hall Medical Center, who is deployed to Bagram. When the radiologist discovered a live explosive round in an Afghan patient's head, Major Bini and his anesthesiologist, Dr. Jeffrey Rengold, put on body armor and went to work. They evacuated the operating room (OR), leaving only themselves and a bomb technician with the patient, because any electrical equipment could detonate the round. They turned to manual blood pressure cuffs and battery-operated heart monitor. Counting drips per minute they administered anesthesia the old-fashioned way. Dr. Bini operated and, within 10 minutes, removed the live round. Miraculously, the patient has been discharged, and is recovering, able to walk, talk, and feed himself.

Dr. Bini told the New York Times that technically it wasn't a very complicated procedure; it is just something we train for, although it is a very uncommon event.

In short, this is what Air Force and Army medics, along with Navy corpsmen, are all about. We are trained and ready as a team to meet the mission wherever, whenever, and however needed, with cutting-edge techniques and equipment, or the most basic of resources if this is our only option. We have the lowest died-of-wounds rate in history because of well-trained, highly skilled, and extraordinary people.

Our country should be very proud of our men and women who put service before self and demonstrate excellence in all we do. We

deeply appreciate all you do to ensure we recruit and retain these very special medics who are devoted to providing trusted care anywhere. We could not achieve our goals of better readiness, better health, better care, and best value, for our heroes and their families, without your support. Thank you.

[The prepared statement of General Green can be found in the Appendix on page 96.]

Mrs. DAVIS. Thank you very much, to all of you, and for all the programs that you have highlighted. We know that there are men and women behind you that are really performing extraordinary feats and have used their education and their experience to work on behalf of the men and women who are serving, and we are certainly very grateful for that.

I wanted Dr. Rice to just pick up with one of the provisions that the National Defense Authorizations Act (NDAA) from 2010, section 721, which basically spoke to the study, and a plan to improve military health-care requirement interim response by the end, actually, of this week. I am just wondering if you know what the status of that response is, whether it is being prepared, sort of what strategic evaluation and planning has gone into that report.

Dr. RICE. Madam Chair, I would be happy to get back to you with the details. It is my understanding that the draft is well underway. Obviously we need to coordinate it with the services who deliver the care, but we anticipate having the report in very shortly.

[The information referred to can be found in the Appendix on page 117.]

Mrs. DAVIS. Thank you. We will be looking forward to that.

In your remarks you mentioned transformative medical care. I wonder if you could—we have heard, certainly from all of you to some extent, on medical homes and more healing communities, issues of that sort, of that kind of transformative look that we are trying to gain, I think, some real progress in today. Is that something that you expect out of the report? And if you could detail for us a little bit more about what is that kind of transformative care that you have in mind, rather than perhaps something that I would think that we are talking about here.

Dr. RICE. Well, as you are well aware from the discussions that the Congress has had for the past year, wrestling with the issues of the delivery of health care while controlling costs and ensuring quality is a challenge for the nation as a whole. The military health care system is not isolated or insulated from that.

As you are aware, we are close to concluding the award of the third-generation TRICARE contracts. Working with Rear Admiral Hunter, the Deputy Director of the TRICARE Management Activity, we have begun discussions on what the fourth generation of TRICARE contracts should look like, so that we work with our purchase care contract support organizations to incentivize individual patients to take responsibility for maintaining and improving their own health and working both within the direct care system as well as in the purchase care system for making care more efficient, more patient-centered, and more successful.

As you may be aware, the Department has adopted, with permission from the Institute for Health Care Improvement, who devel-



oped what they refer to as the “triple aim,” we have modified that slightly for the “quadruple aim,” the four aims that are the experience of care, the quality and safety, an emphasis on population health, doing the very best you can to make care safe, efficient, and cost-effective and all of those surround our core mission which all three of the Surgeons General have alluded to, which is readiness—our responsibility to provide a medically ready force and a ready medical force.

We have just begun those conversations on what the fourth-generation TRICARE contracts will entail, what the underlying philosophy is, and I look forward to coming back to report back to you and seek your guidance on ways that we should be thinking about.

Mrs. DAVIS. When do you anticipate that the contracts would be awarded?

Dr. RICE. We expect it to be imminent. As the committee is undoubtedly aware, there were protests in two of the regions that were upheld by the General Accounting Office (GAO). The contracting officer has agreed with the GAO’s findings, and we are now refining exactly how we will resolve those conflicts. The discussions of that are ongoing within the Department and we hope that we will have that issue resolved very shortly.

Mrs. DAVIS. Thank you very much.

I am going to come back later. I am just thinking about this split of direct cost and essentially bought care. Today we are looking at 33 percent, 67 percent. Do you think that is the right mix? Where do we want to be in five years from now in terms of that breakdown?

I will come back and let my colleague speak, but that would be something that I would like to explore.

Mr. Wilson.

Mr. WILSON. Thank you, Madam Chairwoman. Again, thank all of you for your service. All of us are concerned, facing an asymmetric enemy that seems to have zero morality in terms of attacking military civilians. We are so concerned about the post-traumatic stress disorder, mental health issues. And I want to thank you, General Schoomaker, for your information about traumatic brain injury. This is just so helpful and positive.

Yesterday in a hearing we were discussing a concern that I know that you have, too, and what can be done; and that is to determine for pre-deployment neurocognitive baseline, and also then to have a post-deployment assessment.

For any of who would like to answer that, what is being done and how effective do you feel this is?

General SCHOOMAKER. Well, I will take that on, sir. I would say right now the screening for neurocognitive problems as a tool or as an instrument for getting both baselines and post-appointment is fraught with problems. One of the tools that we first turned to that was jointly developed between the University of Oklahoma and the Army was the Automated Neurocognitive Assessment Model, ANAM. ANAM was never designed as a screening tool. It is designed as a prospective ongoing evaluation of neurocognition to see improvements for people who have neurocognitive problems from all causes, not just concussive injury or more severe forms of brain injury.

And when we have looked at this—in fact I sent a team down range over a year ago to look in a very careful way at cohorts of known concussed soldiers in combat, non-concussed but ill soldiers from other causes, and then soldiers without any problems whatsoever either from concussion or from other illnesses, and discovered in that cohort controlled study, conducted by neurologists and scientists, that the ANAM as a screening tool was basically a coin flip. We would call it an insensitive and nonspecific test, both for non-concussed soldiers as well as for soldiers who received concussion.

So we have turned away from ANAM as a simple screening tool. It still has utility for following longitudinally patients who might have, or soldiers who might have been concussed, but it is not a screen. What we have turned to is what we do every day on sports fields in this country, or following motor vehicle accidents or anything else. If we suspect a soldier, or Marine, or sailor, or airman has had a concussion, we evaluate them at the moment of the concussion, as quickly as we can, and safely. That is what is in that packet there, sir.

Mr. WILSON. I looked at it, and this looks very positive, but it is just obviously is a concern that I have that was expressed yesterday. And you are right; whether it be sports or auto accidents, that is where military medicine is leading the way with prosthetics. I am counting on you all on what can be done for pre-deployment, post-deployment.

Another concern I have has been with the Walter Reed National Medical Center, which is to be concluded September 2011; and that is, will the wounded warrior facilities be adequate and will they be contracted out? Are we really prepared? I know Admiral Robinson used to have a lot of hair until this issue came up, but what is the status of development?

Admiral ROBINSON. Representative Wilson, the status of development is that the Navy, the Army, the Air Force, Joint Task Force (JTF) CapMed, are meeting and developing plans for wounded warriors. I will speak for the National Naval Medical Center—to become the Walter Reed National Military Medical Center. We have gone through a long series of discussions and talks. There will be 350 wounded warriors coming to the National Naval Medical Center, Walter Reed National Naval Medical Center, with their requisite nonmedical attendants and family members, and also with the requisite staff of individuals that will help care for them in terms of all of the personnel and other issues that men and women in the military need to have. So that number will be 350-plus and there will be a tail with that number.

I think that if you look at the average daily census of Walter Reed and Bethesda in terms of their outpatient wounded warriors now, I think you will note there is probably a deficit of some number, between the 350 that I know about and the rest in the National Capital Area. And with that in mind, I think that the JTF CapMed and the services need to make sure that we have a comprehensive plan for whatever that delta may be for those wounded warriors and how they may be in fact cared for in the NCA, National Capital Area.

I think that includes—and during discussions last week that will include several other bases in the area, such as Fort Meade. That may include Fort Belvoir. That will include other areas, and that may include also some reconnoitering of the spaces that we have at National Naval Medical Center, so we may have to do something a little different there, too. But there is a deficit of knowledge regarding that delta of wounded warriors in the National Capital Area.

Mr. WILSON. I appreciate your efforts. Thank you, Madam Chairwoman.

Mrs. DAVIS. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you. And thank you, gentlemen, for being here. Mr. Wilson's opening statement made a comment that there is nothing routine about you all's jobs and about military health care, and we appreciate you all trying to stay ahead of changes that occur in the lives of men and women in uniform and their families.

Dr. Schoomaker, in the information that you handed out, give me the 10-second summary, why are over-the-counter pain medicines like Ibuprofen not recommended for treatment of mild headache associated with concussion?

General SCHOOMAKER. We are very concerned about the use of non-steriodals and aspirin in theater, which would interfere with small-vessel blood clotting—

Dr. SNYDER. Okay.

General SCHOOMAKER [continuing]. When you are at risk for a concussive injury or something that may require a robust clotting system. So we recommend that soldiers going down range suspend the use of aspirin and the non-steroidals.

Dr. SNYDER. That makes sense to me.

Same thing, Doctor. I had this discussion yesterday, and I want to ask you, and it is the issue of—I guess I will say the moderately severe traumatic brain injury patients. I am talking about the group of people that may have been in your rehabilitation facility for several months, have reached the point at which we think there is probably the steady state, but it becomes apparent to the caretakers and the medical team that they are probably going to need to be in a facility that watches them.

I think in the olden days we called it a domiciliary. They may not be able to handle meals or they get lost, a fairly significant injury, but still walk around. Maybe they will do some work under their facility.

How do you handle those kinds of folks as time reaches for them to be discharged from the military? How do we make sure that they are immediately transferred to a place in which we won't lose them for an hour, a day, or a week, or a month while we are trying to find a proper placement for them? Is that an issue that you are having to deal with?

General SCHOOMAKER. Yes, sir. I would explain that, beyond moderate brain injury, I would talk about anyone who had a lingering or an enduring problem. I think Admiral Robinson talks about this passionately in every forum we get to. We are into an era in which we are going to have an enduring requirement to care

for these soldiers and to assist their families for decades and decades to come.

We have been intimately involved with the Veterans Administration since the end of the Vietnam War where the Defense Veterans Brain Injury Program, which has a network of certified centers that are community-based, such as you described, for assisting soldiers with moderate brain injury problems, but for rehabilitation and for assisting them in daily living requirements and location. But by extension, anyone who has an enduring physical or behavioral health problem, we partner very closely with the Veterans Administration. Our warrior transition units have veterans, counselors, embedded within them. And we have a program through the Army Wounded Warrior Program, any soldier with 30 percent disability or greater, with coordination of their care that goes into the Veterans Affairs system and beyond.

So there is a very, very warm handshake now being conducted both into the VA system, as well as other private sector care that is required for these kinds of patients and patients who have other disabilities beyond just brain injury.

Dr. SNYDER. Dr. Rice, in your written statement I think you refer to the fact that we still have—I don't know if you said too high—but too high levels of smoking amongst our men and women in uniform. You also talk about the fact of the retiree issue we will be taking care of in terms of health care expenses for we hope decades and decades to come, when they live long, long lives of being productive Americans after a military career. The reality is the expenses for our country and their quality of life will not do well if they are smoking as young people in the military.

Now, if we can't get that under control, in the controlled situation of the military, I just don't see how we are going to do it. Why are we lagging behind on that?

Dr. RICE. Well, it is a complex issue. As you know, there was an Institute of Medicine Report in 2009 that talked about controlling tobacco use in the DOD and in the VA. The Department has been evaluating that very carefully to see which things the Department can enact and undertake on its own and those things for which it may need assistance from the Congress.

The Navy—Admiral Robinson can correct me if I misstate this—but the Navy has already eliminated tobacco products from its commissaries. The Army and Air Force have yet to take that step. But we still have pricing for tobacco products in the military exchanges that are below the comparable civilian market. That is one factor.

I think by far the most important factor has to do with role modeling for young men and women. Basic training is already a tobacco-free environment. But as soldiers, sailors, airmen, and Marines transition to their first assignments and they see older, particularly non-commissioned officers, who smoke and, by implication, are led to believe that it is okay for them.

As you know, nicotine, tobacco products, are viciously addictive and the Department has—or the Military Health Care System has developed a number of smoking cessation programs, so that we work very hard to get people to stop smoking. This is an effort that will continue for years to come. As I say, there are some areas in which we may need your assistance.

Dr. SNYDER. Are you going to let us know what those areas are?

Dr. RICE. Yes, sir.

Dr. SNYDER. I thank the gentleman.

Mrs. DAVIS. Mr. Fleming.

Dr. FLEMING. I thank you, Madam Chairwoman.

Well, first of all let me say to Admiral Robinson, I was a physician in the Navy some years ago, and served in three stations, enjoyed that, and certainly looked fondly upon those days, certainly in uniform. And then certainly for General Schoomaker and for Admiral Robinson.

I have toured and visited with the wounded warriors at Walter Reed and Bethesda, and I am extremely impressed with the facilities there. You all are taking real good care of our wounded warriors. I appreciate that. I am even more impressed with the warriors themselves, the true warrior spirit. They don't talk about what their service-connected disability will be or what their pension is going to be. I am sure it is appropriate at some point in time or in the future that they will explore that. What they talk about, which inspires me, is when they are going to get back to duty and how they are going to get back to duty, what they are going to do, and what is the best way to do that. So I am extremely impressed with that.

Now for some questions. Dr. Rice, I have two major military installations in my district: Barksdale Air Force Base and Fort Polk Army post. I am finding in our area that the reimbursement to physicians through TRICARE is oftentimes slow and low, and that creates an access issue. It doesn't seem to be quite as much a problem at Barksdale, because it is near a very large, or certainly a medium-size city where there are many physicians in the private marketplace to choose from. But in a more rural area like Leesville, Louisiana, there are some limitations.

So I want to know, as we move forward with new contracts, is that being addressed and how is it being addressed?

Dr. RICE. Dr. Fleming, as you know, the reimbursement level for TRICARE is tied to Medicare rates. And so by law, that has where that is. I am a little surprised and disappointed to hear that perception among the providers is that we are slow to pay. We have always prided ourselves on turning around payments very promptly. So if there is some specific information that you have, I would really be eager to look into that to see if we have a systemic problem that we need to fix. That is not the Department's policy.

Dr. FLEMING. That is more of a perception from history, not necessarily new information. When you say it is tied to Medicare, are you saying it is exactly the same for the same evaluation and management (E&M) codes or the same procedural codes? Or you are saying it is a percent above or a percent less than Medicare reimbursement?

Dr. RICE. I have to check that to make sure, but I believe that it is at the same level as Medicare.

[The information referred to can be found in the Appendix on page 117.]

Dr. FLEMING. Okay, great.

And certainly for the panel at large, if you can answer this, I am very interested in the electronic medical records. I think that is a

very important thing going forward, particularly in terms of quality of care and the special need for continuity of care when you have a worldwide mission such as our military does.

Also, the interactivity or, if you will, the "interfacement" with the VA system. There have been some problems. I am told about the slowness of performance; that is, when you are connecting on the Internet and getting records, information exchanging, sometimes that can be so slow as to be impractical.

There have been some difficulties with the VA and the active duty military systems talking to one another. Can you bring me up to date on that?

Dr. RICE. Yes, sir. As you know, the implementation of an electronic health record is an extremely complex undertaking. Through my civilian academic career, I implemented two intensive care unit-based electronic records and two hospital-based, and I swore I would never do that again, but here I am.

There are two or three challenges. First, with respect to response time, as you and Dr. Snyder know, we as physicians will sit down with a medical chart and spend 15 minutes going through to find the consultation report or the laboratory result that we want. But let the computer screen sit blank for five seconds, and our perception is it is slow.

With that said, there is no question that performance and stability are key issues. Security and scalability are also important issues. We are having an intense effort inside the Department now to examine the underlying architecture for the electronic health record. Then we need to make sure that we build applications that sit on top of that underlying architecture so that they work for the clinicians. Whether it is the nurses, the physicians, the physical therapists, the pharmacists, whatever, it has to work for them. If it does not work for the clinicians, it is not going to work.

I think that is a challenge that we have faced by using a system that was originally developed for other purposes and trying to challenge it towards use as an electronic health record. So it is a subject we are actively and vigorously pursuing and hope to have a very clear vector ahead very shortly.

Dr. FLEMING. Thank you, I yield back.

Mrs. DAVIS. Thank you. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you, and thank you all for being here and for the service you are providing our military men and women. I have had great concerns about the open-air burn pits. And so I wanted to ask you, Dr. Rice, because you did put in your testimony the responsibility for public health for the military. You said they have been there for eight years. And I have received a lot of information over the past year or so about the impact and how soldiers have talked about it and complained about it and gone to health-care clinics and are showing up with skin diseases, blood diseases, neurological problems, et cetera.

And so I know we have worked on it, we have got something into the last NDA authorization and will continue to do that. But it is a puzzle to me about how this could have gone on for so long. I would just ask you if you would tell me, has this been something that has been an issue for all of you and has it been discussed? And are you keeping the records that you need for these men and

women when they return from service and for the next years of their lives, so we can determine if we have had problems with them because of their exposure?

Dr. RICE. Thank you for that question. The environmental impact of burn pits and its impact on our service men and women has been a source of concern. Let me ask General Schoomaker. I think your Public Health Command has taken a keen interest in that problem and has been tracking, which happens; is that right?

General SCHOOMAKER. That is right. We have a Public Health Command, previously known as the Center for Health Promotion and Preventive Medicine, and the Veterinarian Command now have been combining Army Medicine into a single Public Health Command. Brigadier General Tim Adams commands that and has subject matter experts who have been tracking all of the topics that you have described ma'am. And we can take that question for the record and give you a more detail accounting of the burn pits.

[The information referred to can be found in the Appendix on page 117.]

Ms. SHEA-PORTER. Well, I know it is the acknowledgment now that this could be playing a factor in the health problems that some of the service men and women are experiencing. But my concern here is, is there an integrated approach and are we moving fast enough to find ways to substitute some of the products that are being burned in the pits?

For example, we do know that we are still burning the plastics openly, and we could use recyclable materials in the kitchens which are producing a great deal of the plastic refuse each day. So can you step it up? And who are you working with? I know your field is medical, but are you talking to others who are responsible for what is being brought onto the base and how it is being disposed of? Are you fully engaged, in other words, because eight years is a long time and some of our soldiers have been exposed twice, three, and four times to this.

General SCHOOMAKER. Well, ma'am, certainly there is a good linkage between public health monitoring and all the services and the operational commanders, specifics about the items you just talked about. I can't speak with any real knowledge about that, but, again, I am more than happy to take that question for the record and give you a detailed accounting to tell you what we have done to coordinate with the in-theater operators.

Ms. SHEA-PORTER. I thank you, General, and I am not trying to trap you. I am just trying to nudge everybody to get this taken care of as quickly as possible. Thank you, I yield back.

Mrs. DAVIS. Thank you. Ms. Tsongas.

Ms. TSONGAS. Thank you all for your testimony. I appreciate the extraordinary range of issues that you have to contend with for our young soldiers, and I appreciate the efforts that you are putting into it.

I would like to ask a slightly different question, an outgrowth of Defense Authorization Bill. As we were leading into it, we were hearing that we needed to extend Reserve component access to early eligibility TRICARE from 90 to 180 days prior to mobilization. I think this was an issue that had been around for some time, and the purpose, obviously, being to allow service members with

treatable medical conditions access to TRICARE services earlier, in order to decrease the number of medically non-deployable service members.

Can you all explain the implementation plan for providing Reserve component access—to try earlier access to TRICARE services in order to meet the provisions of last year's Defense Authorization Bill?

Dr. RICE. Yes, ma'am. I would be happy to tackle the first part of that question and then ask my colleagues to amplify.

The Assistant Secretary of Defense for Reserve Affairs has the lead on implementing the statutory change, because it is primarily the determination of eligibility. So Reserve Affairs is now preparing the DOD policy and the functional requirements for the system changes have already been developed. So once the personnel have established the eligibility for reservists and updated the Dependent Eligibility Enrollment Reporting System (DEERS) system, the eligibility recording system, then any DEERS-eligible member who presents for care in the military health care system is provided that care.

General SCHOOMAKER. Ma'am, I will just reinforce that to say the Army is very, very reliant on its Reserve, National Guard, and the United States Army Reserve for the conduct of the present conflict. At any one time, tens of thousands of our Reserve component soldiers were mobilized for deployment. And one of the important things in eliminating steps in getting Reserve component soldiers ready to be deployed is medical and dental readiness. We know that there are several factors involved in that identification of problems that need to be reversed in the dental and medical arena. A medical problem that may have a solution before a soldier can be deployed or a dental problem that needs some time for fixing, we find that.

For a large portion of the Reserve component who may not have health insurance is a consequence of their employment or maybe for students don't have programs available. This is an important incentive for them to be engaged in their Reserves, and it allows us the time necessary to get them fixed before they can go out the door.

So, to my knowledge, the program is being implemented and is felt to be a very important adjunct to using the Reserves, as they are being used in the Army today, as an operational reserve rather than a strategic reserve, held only back for the most nation-threatening advance. We currently use them as a very active part of the force.

Admiral ROBINSON. Ditto, from what has been said earlier from the Navy perspective. In addition, as the service member—the Reserve component service member is transitioning back to the private sector, whatever injuries and illnesses that that individual may have sustained will be evaluated before they are discharged. So the service member will stay on the active roles until we understand what the medical or condition is.

From a family point of view, or from the service member transitioning and being able to utilize the TRICARE benefit for the 180 days, that can certainly be given, too. But my point is, if at 180 days there is not an adjudication, there is not some determina-



tion of that, then the service member stays and is fully cared for until we can come up with that.

Obviously, the issue is for those people who we say, We think we have the answer, but the service member says, I don't think you have the answer yet—and there are a few people that fall under that category—we usually default—from the Navy and from our point of view, I default towards the service member and the care. So we usually back off until we thoroughly understand what the issue is. So we care for those individuals until we have a determination of what is in fact happening.

General GREEN. And the Air Force has exactly that same program. We keep people who have medical conditions on active duty until we have resolved what is going on, and then have a transition assistance management program (TAMP) that allows them up to six months post-release from deployment, if they need that.

Your specific question, however, is with regards to 180 days prior. We have tremendous volunteerism in our Guard and Reserve, and actually get great volunteers to serve. I am not as aware of the 180 days prior, and I am not certain that we have the full guidance yet to establish eligibility for that, so I am going to have to take that for the record and get back to you.

[The information referred to can be found in the Appendix on page 118.]

Ms. TSONGAS. Well, thank you all for your testimony. I know that we heard about this issue. I have heard about it quite frequently, and am also hearing that it is not being implemented as quickly as we might have wished. And so I look forward to hearing a little more about your plans to move it forward. Thank you.

Mrs. DAVIS. Thank you. Mr. Heinrich.

Mr. HEINRICH. Thank you, Chairwoman. And first I want to thank Chairwoman Davis and the members of the committee for allowing me to be here today.

Dr. Rice and Surgeons General, as Chairwoman Davis mentioned a little bit ago, I recently introduced H.R. 4923, the TRICARE Dependent Coverage Extension Act. And if this legislation were to pass, it would allow our service men and women the opportunity to provide uninterrupted health care coverage to their children until the age of 26. This is the same opportunity that has been granted to civilians under the recently passed health-care reform legislation that was signed into law last month. And I was hoping that each of you might be able to give me your thoughts on this proposal, and also let me know if the Department of Defense is considering taking any action similar to this legislation that would bring their policies in line with what is now law for civilians.

Dr. RICE. Thank you, Mr. Heinrich. We are well aware of the introduction of H.R. 4923, and have begun thinking through how we would implement it if it becomes law. We do not believe that the Department has statutory authority to extend eligibility up to age 26, absent a change in the law. But if it does become law, we have made preliminary estimates about the number of potential enrollees and the estimated average annual cost for those enrollees.

Mr. HEINRICH. Well, I look forward to getting together with you as well on some of those numbers, because that would be very helpful for us as well.

Are there any other instances that any of you have found, where the rest of the country will have benefits now that are incongruous or inconsistent with what you provide currently under the TRICARE system?

Dr. RICE. No, sir. I am not aware of any others.

Mr. HEINRICH. Thank you very much. I yield back.

Mrs. DAVIS. Thank you. I wanted to go back to my question at the end of the first round and just ask, you know, as we look to the future and we are looking at what makes the best sense for our military health care system, what do you think that mix should be? There is always an ideal. But what is reasonable? Where should we be headed?

Dr. RICE. Well, my own view—

Mrs. DAVIS. Or stay where we are?

Dr. RICE. My own view is, as you identified in your opening comments, the purchase care system was originally intended to fill gaps. And the direct care system, I think many of our beneficiaries, if the system is convenient and accessible to them, many of our beneficiaries clearly prefer to be cared for in the direct care system. The challenge, as you pointed out, has been that during this eight year conflict, their primary care providers are deployed or transferred. And our primary focus has to be on the active duty service members.

The question of what is the right mix is an intriguing one and can be looked at, in my view, from two or three different perspectives. One is, are we thinking about this from a cost perspective? The other is, are we thinking about this from the desire of the beneficiary population, where they would most likely be seen? And the third aspect that has to be considered is, what is the right mix for the training and education of the next generation of active duty—of military providers, whether nurses or physicians. I am not sure there is a single right answer. There is probably an optimum answer. It is one of the things that we hope to influence. I am not sure that we can control it, but we certainly hope to influence it with the next generation of TRICARE contracts.

General SCHOOMAKER. I think we all have pretty strong feelings about this, so I will be as brief as I can. But I think this is one of the central issues that we are all struggling with. And I would point to the recent Military Health System Conference that was conducted in January, in which all three of us and Dr. Rice's predecessor, Ellen Embrey, spoke; and we brought in national experts like Don Berwick, and Jack Wenberg, and John Cortezy and others to talk about the challenges that we face not just in the military health care system, but in the country at large.

And I think that what we in the military are focusing upon are some of the central themes in a real health-care reform package, which is evidence-based practices, which is looking at outcomes of care rather than just processes of care.

And I alluded earlier in my comments to an effort that we have undertaken now into its, probably, fifth or sixth year within Army Medicine, pioneered it in the southeast, of a performance-based budget program that links incentives to outcomes of care, evidence-based practices, and improvements in Healthcare Effectiveness Data and Information Set (HEDIS) measures, the measures of pop-

ulation health, individual health, and compliance with evidence-based practices for such things as diabetes and asthma and the like. And this has shown very positive results. I think that is one that has got to be a major part of the centerpiece of what we do.

We also, I think, universally agree that we need a very robust TRICARE system that is centered around a primary care-based system of the patient- and family-centered medical home process that gives continuity, it gives a site for tailorable, individuated care, and controls the hemorrhage or leak of care into the network. We have got to look very carefully at where that cost is coming from.

Frankly, Army Medicine over the last several years has created more capacity. In the last year and a half or so, we have conducted about 1 million additional appointments. And we are continuing to bring more people into the direct care system run by the uniformed side. The problem that we have is that growth, especially in the white space between large installations and large metropolitan centers where we have a very robust system of health care for the direct care system, demand in that white space is increasing as we use Reserves more and as our TRICARE for Life program grows. So we are working very hard, internal to the services, to accommodate more and provide greater capacity. And I think we all agree very much that maintaining a very robust direct care system is one of the centerpieces based upon real reform of the health care.

Mrs. DAVIS. Thank you.

Admiral ROBINSON. I think that what Dr. Rice and General Schoomaker said is right. I am going to come back to the private sector care and the direct care. It is 67 and 33 percent respectively.

I think that the problem is, to some extent, that there is a wall between the two care systems. The problem is that there is the direct care system and the private sector care system that TRICARE Management Activity (TMA) helps to build through our networks, and the network providers do an excellent job, but we are separated. We need a care system in which the direct care, the uniformed services are directly aided by the private sector care. They are actually a part of our system. And we can utilize them not only around our medical centers and hospitals, but in the white spaces, too. And the white space is the one area that is harder to get to, so I recognize that private sector care may be the method.

We can still do a lot with the private sector care and how we process TRICARE, the types of forms that we use. If we could standardize in terms of, you know, a military medical health care formed by the different forms that we use.

But I will get back to this to only say that the direct care system and the private sector care system are separate now in the sense that the monies that go into private sector care must pay bills from the health affairs perspective. I don't disagree with that. But there is not a lash-up between the two systems that really help us provide the care that we need. I think that is the biggest thing that the new contracts—and I am thinking in terms of the T-4—could possibly do that would be revolutionary, in my opinion, for military medicine.

Mrs. DAVIS. General Green, did you want to add anything?

General GREEN. I would. Actually, the reality of our situation is we are the most distributed system of any, with 75 bases and about 80 clinics out there. As medicine has changed over the years and we have seen higher technology and, therefore, larger populations in order to support different specialties, what we have seen is we couldn't always maintain hospitals in these small areas. Average wing for us is about 6,000 people, with families maybe 12,000 to 15,000. It is very difficult to support specialty mix.

And so the TRICARE contractors in those areas where we have small populations are really the only way to seek that care. In other areas where we have larger populations and where we have military bases with hospitals, I would love for us to get 100 percent of that care. And that is what Admiral Robinson is talking to, where we try to bring some of the people who are in surrounding areas to our facilities.

I think that it is unreasonable for us to think that we would ever be able to provide primary care perhaps to 100 percent of that population, but there are ways that we can reduce federal costs by working arrangements with HMOs, with the VA, even with university partners, wherein either we bring our patients back to our facilities if we are in the area, or, in many cases we take our professionals and work in their facilities so that we can actually maintain skills and be ready for wartime missions.

And so I guess I would tell you that it is a mix. In places where we are in rural settings, we really rely on the TRICARE contractors and the network. And so the mix is going to be different. In places where we have hospitals, we should be trying to bring everything that we possibly can back into the hospital to maintain currency. So my goal would be in larger population centers where we have hospitals, to gain 100 percent of the market; and in places where we have clinics, the mix that you described may be real.

Mrs. DAVIS. I appreciate all of your responses. What is obviously important here is that people are working hard, focusing on this and really trying to address it. And the other reality, of course, is there are a lot of other things people are working on. And we need to look to the Defense Military Affairs and figure out whether we have got the people there that are trying to address these issues. And one of the concerns that I think we have is that there haven't been the kind of political appointees that are there in place, nor are the nominations there.

And I would think that that is a vital part of what we are talking about and that we do need to get moving with those. Dr. Rice.

Dr. RICE. I agree with that.

Mrs. DAVIS. I know you do. Do you have any suggestions? We are open. We are certainly interested. Mr. Wilson.

Mr. WILSON. In fact, Dr. Rice, with all the hats you are wearing, back to your TRICARE hat. My understanding, the number of reservists who have taken advantage of TRICARE Reserve Select, TRS, is lower than the Department of Defense anticipated.

What factors have contributed to the low take rate? What actions has DOD taken to make the program more attractive? Are members of the Reserves, who may want to enroll in TRICARE Reserve Select, having difficulty finding TRICARE standard providers?

Dr. RICE. Let me defer to my colleague, General Schoomaker, who has insight on that.

General SCHOOMAKER. Yes, sir. I can answer that. You are right; we are seeing, overall, a rate of use in the Army of TRICARE Reserve Select of only about six percent or so. But it is growing very quickly. And in part, it is based upon the observation that those that don't have a health-care program, we have been quite reluctant to impose a requirement that they maintain medical readiness as a condition of their employment, even though it is, in the Army regulation, already there.

In other words, if you are in the Reserves, we expect you to be dentally and medically ready to be deployed. In the past, because we could not offer good programs necessarily, or couldn't require someone who may not have an employment health plan—or maybe a student, or be unemployed—to have a plan to cover them, commanders were very reluctant on the Reserve side to impose or hold them to that standard.

I think with the TRICARE Reserve Select program, which is very robustly supported by the military and by Health Affairs, and now with the growing availability of plans under health-care reform and the like, we are putting teeth into that. And I think you will see a growing use of TRICARE Reserve Select as we hold soldiers, appropriately, to the requirement that they be medically fit.

Without abusing my executive privilege here, I just want to respond to one last thing on this last item, because we are also passionate about what we can do to sustain this program that we have. We have a very high-quality program.

To answer Mr. Heinrich's question earlier, I don't see us having a lesser plan. I think we have a superior plan to the average American right now, and we all want to sustain this. But I think historically what we have focused on is business rules to control costs, and most of us now I think feel very firmly that what we have to focus on is good clinical practices and outcomes. And if we focus on that, the cost will be stabilized and possibly even be reduced.

Mr. WILSON. And I want to indeed thank you. I can remember during the debate that we had in the Education and Labor Committee, that as I was working for an amendment to preserve and protect TRICARE, it was brought to my attention—and I can remember very well the organization, it was called the Wilson Institute, and that they had done a study of satisfaction by persons with their health insurance policies, and TRICARE for 9.2 million was at the tops. And of course, I will never forget the Wilson Institute. I was unjustly accused, Madam Chair, of making up an organization, but it actually exists.

Dr. Rice, again, or whoever, the Department of Defense has estimated the resulting savings would be \$12 billion, fiscal years 2010 to 2015, by obtaining federal pricing discounts for TRICARE prescriptions dispensed by retail pharmacies.

Is DOD on track to obtain these estimated savings? Are all drug manufacturers complying with requirements? What steps are underway to ensure that the required federal pricing discounts are obtained?

Dr. RICE. Mr. Wilson, we are on track to realize that outcome. There is still—I think I have this right, and if not, I will certainly

correct it. I believe there is still a pending appeal, but the actions taken thus far have indicated that the drug manufacturers are prepared to comply with the federal pricing, and we anticipate realizing those savings.

Mr. WILSON. It is good to hear something is on track. And in regard to TRICARE in general, any way that I and our subcommittee can be of assistance, we want to work with you. Thank you.

Dr. RICE. Thank you, sir.

Mrs. DAVIS. Thank you very much. Thank you, Mr. Wilson. And perhaps I will just go back to one of the questions he raised earlier.

Do you think there is any confusion or discomfort believing that perhaps the Secretary of Defense is not in charge of Military Health Affairs? Do you have any?

Dr. RICE. I don't think so. I think Secretary Gates has it pretty clearly in his mind that he is. And I certainly have seen some correspondence from Secretary Sebelius where she has indicated that management of the Defense Health Program is under the supervision of the Secretary.

Mrs. DAVIS. Because I know that has been raised in other circles as well, and I appreciate Mr. Wilson raising it.

If I could, just quickly, I know we are going to have votes in a few minutes. The budget was characterized as being fully funded. And if I could go to you first perhaps, General Green, is that an accurate statement from your vantage point?

General GREEN. Yes, it is an accurate statement. We are in very good shape for 2011.

Mrs. DAVIS. Admiral Robinson.

Admiral ROBINSON. Yes. Navy Medicine is fully funded.

General SCHOOMAKER. Yes, ma'am. Nothing crossed.

Mrs. DAVIS. You don't have another list out there somewhere? Okay.

One of the numbers that jumped out at me was just the research and development dollars going down somewhere in the neighborhood of about 61 percent, I believe, partly because there was a reduction in medical research and development (R&D). And I think that reflects dollars, \$125 million, transfer of research to Defense Advanced Research Projects Agency (DARPA). But we don't really see an accompanying increase in DARPA's program to accommodate that.

Dr. RICE. Yes, ma'am, I can speak to that. There is a decrement of 125 million in the research, development, testing and evaluation (RDT&E) priority elements for fiscal year 2010. There were decisions made in the Department in the fall of 2008 which enhanced the medical R&D budget by about \$375 million a year, with the entire new budget going into the Defense Health Program RDT&E budget for fiscal 2010.

There was an additional Department decision for fiscal 2011 and out that was that \$125 million of that annual cost was to be contributed by DARPA, but under their control; that is, not transferred from DARPA to DHP, which reduced the new budget burden to the Department by 125 million. This would mean that DARPA would have to increase their medical RDT&E spending from about 144 million by an additional 125 for fiscal 2011. And this is a com-

pliance issue that is under that defense development research and engineering oversight.

There is programmatic and regulatory risk when the Defense Health Program RDT&E advanced on the portfolio is dependent on the science and technology transitions from another agency within the Department which is more focused on very high-risk and very high-payoff investments. This is under discussion in the Department, but it is that decision that results in the number that you cited.

Mrs. DAVIS. Where would we see the greatest shortfall if somehow this isn't worked through, and what kind of R&D? Prosthetics? Or what kinds of things could that affect?

Dr. RICE. It is not clear to me, at least at this point. It could be in a variety of areas, from basic research to information technology research to advanced battlefield efforts.

Mrs. DAVIS. Okay. Thank you very much.

Just one follow-up question to earlier discussion about electronic records. And the Virtual Lifetime Electronic Record, VLER, was announced by Secretaries Gates and Shinseki together that it would be this single record. But now I understand that the Department submitted a reprogramming request that would take \$42 million from the Defense Health Program to establish the Office of the VLER. So why is the Defense Health Program only paying for that?

Dr. RICE. The VLER is in part an electronic health record, but it also in part has to do with personnel records. So that comes outside of the Defense Health Program.

Mrs. DAVIS. Is there a VA piece to this as well then?

Dr. RICE. I am sorry?

Admiral ROBINSON. The VLER piece would be actually—and I am probably the least information technology (IT) savvy of this group—but there will be a VA piece with this. And the VLER system will work with an electronic health record system, in this instance AHLTA, and with the VA Vista, to hook us to the commercial sector so that we can transpose that record to hospitals that are not DOD. So there are several sections that go with this. And I can't tell you much more, but that I do know.

Mrs. DAVIS. All right. We hope that comes together and that works out.

And I don't really expect you to answer this in any detail, but throughout all of the testimony and through all of the discussions that we know in terms of health care nationwide, the concern about unmanned positions, any number of specialties, practitioners that are needed in this country. Are people thinking out of the box about this enough? Because we know that bonuses are a good idea. We know that there are recruitment strategies, some of which have been very helpful, and I know you addressed that.

But it also feels as if we have a lot of people in our country who would have an interest if we actually did something quite substantive in the country. People may not have agreed with the war on poverty, but at that time there were many, many people, myself included, who were incentivized to go into helping professions. And I am wondering now whether the military plays such a large role in this, and particularly among our men and women who are coming back from the war theater and have great, I think, aptitude to

be able to do this with the right encouragement, there are some programs out there.

Are we spending enough time and effort into trying to really address this problem?

Dr. RICE. With my other hat on, as president of the university, I spend a lot of time thinking about what our health-care system, what our health-care workforce is going to look like 15 or 20 years from now.

We have an enormous challenge in the country as a whole, of which the military system is just a small part. And that is that the science and mathematics and engineering preparation in our middle schools and high schools has not helped focus our young people on careers in science and technology. And there are a number of misperceptions in students.

In my previous job at the University of Illinois, I spent a lot of time going out and talking to middle school and high school students about careers in health care. And there were three things that struck me about what they would say about why they weren't thinking about health care.

The first is that they viewed us as low tech. And at times I was signing very large purchase orders for very expensive pieces of equipment. That didn't resonate quite right to me, but that was their perception.

The second thing is that if you have dealt with teenagers lately, you know that they are not interested in hierarchies. And the provision of health care is, at least as currently practiced, hierarchical.

And the third factor that turned them off was we have schedules. And they are not interested in schedules.

So I think we are going to have to rethink how we deliver health care in a pretty dramatic way, exactly as you allude. We are looking at—by the year 2020, it is estimated we will be 1 million nurses short of what we will need. And as I get into my old age, that becomes more and more of an issue for me. We are looking at a substantial shortfall in the number of physicians. And importing them from other countries is not the answer. That simply is not an ethical or moral approach to solving that problem. So I do think it is an issue that we need to spend a lot of time thinking on.

Mrs. DAVIS. I was just going to mention that in last year's bill there was a provision for undergraduate education and for encouraging more students and scholarships. And I don't know whether that is anything that is moving along.

General SCHOOMAKER. We have a pretty successful and robust program right now that I think is now being very successfully executed. I certainly agree with everything that Dr. Rice—who has a very long and distinguished career in medical education and the provision of the workforce.

We are looking at, I think with the increasing number of women going into medicine and health professions who want to do job sharing, that want to have shifts—and I don't think it is restricted to women only in this perspective—who want to have a career in which they can move in and out of the workforce more agilely. We are looking at a continuum of care between the active component and Reserve component, where you can turn on and turn off that kind of a career.



And, quite frankly, even from my experience among children, you have got to begin engaging children who are going into these technical fields, in middle school and sometimes earlier. So programs that are engaging earlier and earlier and getting mentor programs and the like.

But I would submit in closing, although this really doesn't address the problem of the workforce per se, that the real out-of-the-box thinking that we have to adopt in this country—and we are in the military—is one that shifts the paradigm from treating disease and treating injury after it has occurred, to preventing disease and preventing injury.

I mean at Fort Jackson, South Carolina right now, we pin a hip fracture on a young woman, on average, once a week. Once a week. These are 18- and 19- and 20-year-old women who come into the force, who begin active lives after being sedentary, who are suffering from bone washout from drinking phosphate-rich sodas and being sedentary before they come in. And now we are getting hip fractures in basic training.

We have a problem in this country in the overall health and fitness of the population and with growing childhood obesity, the tobacco problems that you addressed earlier. We have got to shift the paradigm away from one of disease and injury treatment to one that prevents it from the get-go.

Mrs. DAVIS. Admiral Robinson, we have to go vote. But if you have a quick comment, that would be great.

Admiral ROBINSON. One other thing. Actually, this is General Green, and that is, he said something the other day that was so intriguing to me; and that is, take enlisted personnel and actually get them certified to do mental health. So I think—and this happens, this works. But I think my addition to everything else is that we need to think in terms of how we provide the care. It needs to be preventative and wellness, and then we need to think in terms of how that care is given. Thank you very much.

General GREEN. And just very quickly, I really do think we need to think out of the box. We are increasing our number of practitioners and extenders. We are looking at the mix to get the right team, using medical home to do outreach. For non-enrolled care, we think emergency rooms are going to be overrun in the near future because of the lack of primary care. We are preparing fast tracks in acute-care clinics to make sure we are ready for the increased workload.

And I do think we do need to think beyond traditional mental health and look at the licensed medical counselors, to see whether or not we can train some of our enlisted force. Just like we are bringing enlisted to nurses, we may be able to increase our diversity by bringing enlisted into medical schools as they are prepared.

So we are doing a lot of things to try to leverage our enlisted force to try to create new venues of care.

Mrs. DAVIS. Thank you very much. Thank you to all of you. I mentioned earlier, it is the Military Undergraduate Nurse Training, section 525, from the former authorization that I was inquiring about.

Dr. RICE. Yes, ma'am. There is a report due to Congress. The three military nursing chiefs are actively working on that and anticipate having a report to you on time.

Mrs. DAVIS. Great. Thank you very much to all of you. I hope that the hearing was helpful to you as well. It was to us. And we look forward to the next one. Thank you very much.

[Whereupon, at 3:24 p.m., the subcommittee was adjourned.]

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# **A P P E N D I X**

APRIL 21, 2010

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**PREPARED STATEMENTS SUBMITTED FOR THE RECORD**

APRIL 21, 2010

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**OPENING STATEMENT OF THE CHAIR**  
**DEFENSE HEALTH PROGRAM OVERVIEW**

Wednesday, April 21, 2010

Good afternoon. Today the Military Personnel Subcommittee will hold a hearing on the President's Fiscal Year 2011 budget request for the Defense Health Program.

Testifying before us are the senior medical leaders of the Department of Defense. Dr. Charles Rice is the President of the Uniformed Services University of Health Sciences, and is currently Performing the Duties of the Assistant Secretary of Defense for Health Affairs. This office is responsible for the preparation and oversight of the Defense Health budget, as well as the execution of private sector care. We also have with us the service surgeons-general, Lieutenant General Eric Schoomaker from the Army, Vice Admiral Adam Robinson from the Navy, and Lieutenant General Bruce Green from the Air Force, who are responsible for the provision of care in military hospitals and clinics. Gentlemen, welcome.

This year's budget request, much like last year's, lacks many of the objectionable proposals of years past. For example, there are no onerous TRICARE fee increases that seek to place the burden of improving the system on beneficiaries instead of on the Department of Defense. There are no "efficiency wedges", an interesting term that meant, "We think the services are spending too much, but we don't know exactly where, so we are just going to cut their budgets and let them figure it out." There are no proposed conversions of military medical positions to civilian medical positions. The absence of these things from the proposed budget is a good start.

However, this budget request, while devoid of major negatives, is also light on positives. We continue to see little if any evidence of a comprehensive, multi-faceted strategy for moving the military health system forward. For the past few years, Congress has been pushing the Department of Defense to improve the health status of the beneficiary population and improve the cost-effectiveness of the care provided to our beneficiaries by adopting proven practices. The Fiscal Year 2009

National Defense Authorization Act contained many initiatives to improve preventive and wellness care, but eighteen months after it was signed into law, we are still waiting for most of them to be fully implemented. That same bill also gave the Department great latitude and authority to conduct demonstration projects to test other methods of improving health while reducing costs. We would like to hear today how the department plans to take advantage of that authority.

Further, the Fiscal Year 2010 National Defense Authorization Act contained a requirement for the Department to undertake actions to enhance the capability of the military health system and improve the TRICARE program. Congress felt that such action was needed because private sector care, which was originally intended to be and is still described by the Department as a program to fill gaps in the direct care system, is projected to account for 67 percent of Department of Defense health care expenditures in FY11, versus 65 percent this year. It strains logic to characterize something that accounts for almost 70 percent of a program as a “gap-filler”. We recognize that several factors have contributed to the unintentional growth in private sector care, such as two wars, staffing shortages, and broad reserve mobilization. That said, without appropriate planning, the effect of these factors could be an irreversible trend, placing medical readiness for future contingencies in jeopardy. Congress clearly believes the Department must develop a long-term plan to maximize the capabilities of the direct care system, and we would like to hear from our witnesses today any ideas they may have.

This has been a momentous year for health care in this country. Last month, the Patient Protection and Affordable Care Act, and the companion improvements bill, were signed into law. Further, just last week the Senate unanimously passed the TRICARE Affirmation Act, introduced by the chairman of this committee, Ike Skelton, which had previously passed unanimously in the House. The TRICARE Affirmation Act explicitly states that TRICARE and nonappropriated fund (NAF) health plans meet all of the health care requirements for individual health insurance under the newly enacted health care reform law. TRICARE and the NAF health plans already meet the minimum requirements for individual health insurance coverage in the recently enacted health care bill, and no TRICARE or NAF health plan beneficiary will be required to purchase additional coverage beyond what they already have. However, to reassure our military service members and their families



and make it perfectly clear that they will not be negatively affected by the health care reform law, the TRICARE Affirmation Act explicitly states that TRICARE and the NAF health plans meet the minimum requirements for individual health insurance.

Now that the bills are law, parents across the country will now be able to extend their health coverage to their dependent children up to age 26. Being true to their word, Congressional Democratic leadership ensured that the health reform bills did not involve TRICARE in any way. Since care was taken to guarantee that the Department of Defense health programs under title 10, United States Code, were not touched by the health reform bills, this means that the new law does not allow TRICARE beneficiaries to extend their health coverage to their dependent children. Fortunately, a member of this committee, Mr. Heinrich of New Mexico, quickly crafted and introduced a bill, H.R. 4923, the TRICARE Dependent Coverage Extension Act, that would amend title 10 to precisely match the health reform law to allow TRICARE beneficiaries to extend their health coverage to their dependent children up to age 26. Mr. Heinrich, thank you for introducing this important legislation, and I want to let everyone know that I intend to include Mr. Heinrich's bill in this subcommittee's mark for this year's National Defense Authorization Act in a few weeks.

Finally, and perhaps most importantly, we need to talk about leadership. It is important to note, though it is beyond the control or purview of any of our witnesses, that sixteen months into the new administration, none of the political leadership positions within Health Affairs have been filled. Not one. In fact, a nomination has not yet even been made for the Assistant Secretary of Defense for Health Affairs, let alone the confirmation process that will follow, which we of course hope will be expeditious.

These facts call into question the priority placed by the Department of Defense on the military health system. This is the most challenging time for military health care in decades: we are fighting two wars; approaching the finish line of the 2005 round of BRAC, the centerpiece of which is the consolidation of two of our top military hospitals at the new Walter Reed National Military Medical Center at Bethesda; starting the most expensive burst of medical military construction in

history; continuing to improve wounded warrior care; and contending with rapidly escalating health care costs. Given these realities, the continued lack of political leadership within Health Affairs is cause for serious concern. This committee sincerely hopes that the administration quickly fills these positions so that it we may start working with them to address the myriad of challenges facing the military health system.

Opening Remarks – Congressman Wilson  
Military Personnel Subcommittee Hearing  
Defense Health Program—an Overview  
April 21, 2010

Thank you, Chairwoman Davis. Today the Subcommittee meets to hear testimony on the Defense Health Program for Fiscal Year 2011. Although we routinely have an annual hearing on the Defense Health Program, I believe there is nothing routine about the military health system and the extraordinary care it provides to our service members and their families. I have first hand knowledge of these remarkable military and civilian medical professionals from my son, Addison, who is an orthopedic resident in the Navy.

The subcommittee remains committed to ensuring that the men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. I would like to express my deep appreciation to all of the military health system leadership and personnel who are responsible for delivering the highest quality healthcare during these most challenging times.

To begin, I want to commend the Department of Defense for sending us a budget that does not rely on raising TRICARE fees to help finance the Defense Health Program. It appears the Defense Health Program is fully funded; however, I remain concerned a portion of the funding is based on projected savings from several programs that may not be fully realized. I would like to know how the Department of Defense plans to cover any unexpected shortfalls in the Defense Health Program if the savings from initiatives such as Federal Pricing for pharmaceuticals doesn't materialize.

With that, I am anxious to hear from our witnesses today about the progress the Department has made in developing a comprehensive approach to providing world class health care to our beneficiaries while at the same time controlling costs. I would like to know how the Military Health System is meeting the medical needs of our beneficiaries today and what process you use for determining the medical requirements of future beneficiaries. I am interested in knowing how you have included the stakeholders in military health care in the discussions about providing world class health care and the future of the Military Health System.

Further, I would like to hear from the witnesses on how the Defense Health Program supports the critical mental health services needed by our service members and their families, particularly the National Guard and reserve members who rely primarily on TRICARE Standard.

I would also like to better understand from our military Surgeons General whether the Defense Health Program will fully support their responsibility to maintain medical readiness, provide healthcare to eligible beneficiaries, provide battlefield medicine to our brave men and women in Iraq and Afghanistan and care for our combat veterans through the long recovery process when they become injured and wounded.

Finally, with regard to TRICARE, which is now regarded as a health care delivery system worthy of emulation, I quite frankly don't understand why the Department of Defense would not want to explicitly protect it from any unintended consequences that may arise from the health care reform law. Congress has already acted to make clear and explicit what the recent health care reform bill did not – that TRICARE meets the statutory requirement for minimum essential health care. The Department of Defense did not object to that recent Congressional action. Now it's time to

make explicit in law what President Obama promised would be explicit in the health care reform – the Secretary of Defense would remain in control of the DOD health care program. No one should object to Congress making that control explicit in law. While some may feel that this is an unnecessary precaution, we owe our military that clearly stated protection.

With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I look forward to your testimony.

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STATEMENT BY

CHARLES L. RICE, M.D.

PRESIDENT, UNIFORMED SERVICES UNIVERSITY OF THE HEALTH  
SCIENCES, PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF  
DEFENSE, HEALTH AFFAIRS AND ACTING DIRECTOR, TRICARE  
MANAGEMENT ACTIVITY

REGARDING

THE MILITARY HEALTH SYSTEM: BUDGET OVERVIEW

BEFORE THE

HOUSE COMMITTEE ON ARMED SERVICES  
SUBCOMMITTEE ON MILITARY PERSONNEL

April 21, 2010

**FOR OFFICIAL USE ONLY**  
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Madam Chairwoman, Members of the Committee, thank you for the opportunity to discuss the Military Health System (MHS)'s priorities and budget for Fiscal Year (FY) 2011.

We have enduring obligations to the men and women of our Armed Forces, and to their families who serve with them, and to the millions of retired military personnel who have served us in the past.

This obligation begins the moment a recruit walks through our doors. In our budget for the coming year, we acknowledge that lifetime commitment we have to those who serve today or have served in the past, and to their families.

For those service members who honorably conclude their service before reaching military retirement, we have an obligation to ensure their medical experience is fully captured and easily shared with the Department of Veterans Affairs (VA) or with their own private physician. For those who retire from military service, our obligation to them and their families often extends for a lifetime.

And, for those who have borne the greatest burden, through injury or disease suffered in our nation's conflicts, we have an even higher obligation to the wounded and their families. As Secretary Gates stated with the introduction of the Defense budget, "Recognizing the strain that post-9/11 wars have put on so many troops and their

families, the department will spend more than \$2 billion for wounded warrior initiatives, with a special focus on the signature ailments of current conflict, such as post-traumatic stress disorder (PTSD) and traumatic brain injury. We will sustain health benefits and enlarge the pool of medical professionals. We will broaden electronic information-sharing between the Department of Defense (DoD) and VA for wounded warriors making the transition out of military service.”

The budget we are putting forward reflects our commitment to the broad range of responsibilities of the MHS – the medical readiness requirements needed for success on today’s battlefield; the medical research and development necessary for success on tomorrow’s; the patient-centered approach to care that is being woven through the fabric of the MHS; the transformative focus we are placing on the health of our population; the public health role we play in our military community and in the broader American community; the reliance we have on our private sector health care partners who provide indispensable service to our service members and families; and our responsibility to deliver all of these services with extraordinary quality and service.

As our military forces in Afghanistan are engaged in combat operations to expand the security, governance, and development environment for the people of Afghanistan; as we continue with the careful hand-off of responsibilities to the elected leaders of Iraq; and, as Marines provide security and the joint medical team provides care for the people of Haiti,



we are mindful of the trust and investment that the American people have made in military medicine. We will continue to honor that trust.

### **MHS Mission and Strategic Plan**

The MHS overarching mission remains as in years past: to provide optimal health services in support of our nation's military mission – anytime, anywhere.

Over the last twelve months, the Office of the Assistant Secretary of Defense for Health Affairs has worked with our Service Surgeons General and the entire Joint MHS leadership team to update and refine the MHS Strategic Plan.

In the process, we sought the expertise and advice from leaders both within our system and external to the MHS, to include renowned experts at the Mayo Clinic, Kaiser Permanente, Geisinger Health System, the Cleveland Clinic, Intermountain Health, and the Institute for Healthcare Improvement.

This effort resulted in unanimous support for adopting “The Quadruple Aim” as the foundation for our strategic plan in the coming years.

The Quadruple Aim borrows liberally (and with permission) from the Institute for Healthcare Improvement's (IHI) “Triple Aim,” and is further tailored to the unique mission of the MHS. The four core components of the Quadruple Aim are:

- Readiness – Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including combat support, defense support to civil authorities, and humanitarian assistance/disaster relief missions as we witnessed most recently in Haiti.
- Population Health – Improving the health of our population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.
- Experience of Care – Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, evidence-based, and always of the highest quality.
- Cost – Creating value by focusing on measuring and enhancing quality healthcare; eliminating inefficiencies; reducing unwarranted variation; and emphasizing investments in health that reduce the burden and associated cost of preventable disease in the long term.

The outcome of this strategic planning effort is more than the plan itself. The values and strategies we have articulated in our plan are reflected in our proposed budget.

Whereas we take great pride in the past accomplishments of the joint MHS team, the overview we provide in the following pages for our fiscal year 2011 strategic priorities is forward-looking, not merely a reflection of past accomplishments. By aligning this

testimony with our strategic plan, we link our budget proposal and priorities to our strategic focus inherent in the four core components of the Quadruple Aim.

### **Readiness**

A fit, healthy, and protected force is the starting point in ensuring a medically ready force. We have a core set of individual medical readiness (IMR) measures that inform both our line commanders and our medical teams about the individual preparedness of a service member to deploy.

We will continue to use our monitoring systems so that we reduce the rate of deployment limiting conditions. We will also focus on disparities between the Active and Reserve Components in terms of IMR, and improve the medical readiness of the Total Force.

A critical companion strategic matter for the Department is the psychological health of our people. Between 20-30% of our service members who have deployed to Operation Iraqi Freedom or Operation Enduring Freedom (OIF/OEF) have reported some form of psychological distress. As has been widely noted, suicide rates in the Armed Forces have also been rising. DoD and the individual Services are studying every suicide or suicide attempt closely, and we have collectively introduced a number of new programs and initiatives to reduce the occurrence of suicide. We are engaging commanders, the medical research community and fellow service members in a multi-tiered effort to understand and implement effective strategies to deter suicide; to reduce the stigma of

seeking professional help and counseling; and to ensure there are adequate personnel resources to meet a clear and growing demand for mental health services.

We remain focused on accelerating our research into and the adoption of evidence-based care treatments for personnel with PTSD and traumatic brain injury. Secretary Gates continues to be personally interested in seeing us move information from the research realm to the field in a much more rapid manner.

We are proposing another \$669 million to support our requirements in meeting these critical needs in support of psychological health. Significant funds are also directed to other critical battlefield medical research and development needs.

In addition, our investments in Defense Centers of Excellence and the Defense and Veterans Brain Injury Center are funded and poised for delivering world-class care and service to our military and veteran populations.

Finally, in FY 2010 and FY 2011, we will be undertaking actions to expand our measures of “readiness.” Specifically, we will be assessing how to better measure “family readiness.” There is no question that the health and resiliency of the entire family is tied to the readiness of the individual Soldier, Sailor, Airman, and Marine. Our efforts will be directed toward measures that help us proactively identify and address health risks within a family prior to deployment.

**Population Health**

There are few organizations in the world that compare to the DoD in having the right incentives to truly invest in population health efforts. A significant number of military personnel and their families will have their health care managed by DoD or other federal and private sector partners for their lifetimes. Accordingly, we will continue to develop and employ the best tools and programs to transform our culture to one focused not just on expertly treating disease and injury, but to one focused on sustaining the health and well-being of our population.

There are a number of tools and programs at our disposal to improve overall population health. The Department will continue to invest deeply in our preventive service programs. We will improve our provider support tools so that opportunities for education or preventive treatment can be engaged at all patient-provider opportunities.

We will closely track our performance in delivering preventive services using the Health Employer Data Information System (HEDIS) measures. HEDIS allows us the opportunity to compare ourselves among each Service or MTF, but equally importantly, to compare ourselves against our private sector counterparts. In 2009, we witnessed impressive gains in preventive service delivery as compared to both national norms and national benchmarks, particularly in the Army and Navy, after introducing pay for performance incentive programs.

We recognize, however, that not all measures are moving in the right direction. For example, we are seeing continued high levels of tobacco usage among our youngest service members. We are also seeing rising rates of obesity in our non-active duty population (along with the related morbidities, particularly diabetes).

As an aspect of our strategic imperatives, we are seeking to more directly and more personally engage patients to take a more active role in managing their health. We will seek to influence behaviors through increased positive actions (better nutrition and increased physical activity) and reduced negative habits (tobacco use and excessive alcohol intake).

Our efforts to improve the overall health status of our population do not operate in a vacuum. Improvements are made one patient at a time; one patient visit at a time. In this regard, our efforts in this strategic arena are directly tied to our efforts at the individual level with their experience with the care received -- and the topic of the next section.

### **Experience of Care**

One of our foremost and sustained priorities is to improve the experience of care for those who are most intimately interacting with our MHS every day – the wounded, ill, and injured from our current conflicts who are moving through the joint patient evacuation system, from point of injury in the theater of operations, to the point of

definitive care in the United States, where many are recovering at our flagship military medical centers in the National Capital Area and other medical centers around the country.

We remain grateful for the support of the Congress, and especially this Committee, to ensure we have the resources to provide the very best health care for our forces and their families, and in particular for the wounded, ill, and injured.

We propose a budget of more than \$670 million to support the spectrum of services for the wounded, ill, and injured – services which include enhanced case management, improvements to our Disability Evaluation System, and greater data sharing with the VA and other private sector medical organizations.

Central to our efforts is the obligation to expedite the administrative elements of our disability cases, and work to get our Wounded Warriors to the best possible location to facilitate their recovery. We are expediting our Medical Evaluation Board (MEB) process toward a goal of completing all MEBs within 30 days.

We have also successfully piloted efforts with the VA to have both Departments' medical examination requirements completed in a single exam—which increases the timeliness of processing and increases satisfaction with the entire experience for the service member.

Enhancing the care experience is not limited, however, to our wounded warriors. It is imperative that we offer solutions and improvements for our entire beneficiary population we serve.

The overriding issue in our system has historically been and continues to be “access to care.” Simply put, access is about getting the right care for the right patient at the right time.

Our efforts to improve access in the coming year will be focused on expanding our “Medical Home” initiatives. The Patient Centered Medical Home provides patients with a known provider or small team of providers, who will get to know that patient and her or his medical problems. The continuity of care offered by this model, when coupled with enhanced access to the provider through telephone messaging or secure electronic communication and timely appointing, will enhance the quality and safety of care and improve the patient experience. This model has been endorsed by professional medical societies (the American Academy of Pediatrics and the American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association), several large third party payers, employers, and health plans. Its adoption in the MHS reflects the continuation of a journey toward improving patient access and satisfaction.

We will be providing our enrolled population with clear communications about how to access the appropriate level of medical care to meet their needs at any time, 24 hours a



day - seven days a week. We will offer our patients with multiple modes of accessing care, to include expansion of telephone access, and secure, web-based patient-provider messaging service.

**Per Capita Cost Control**

We are proposing a fully funded budget for FY 2011. The MHS serves 9.5 million beneficiaries, to include active duty members and their families, members of the Reserve Component and their families, and retired military personnel and their families. It is important to note that this number that has grown with the increased active duty end strength as well as the expansion of health benefits to members of the Reserve Component. Thus, while real cost growth will continue to rise, we, nonetheless, will be focused on controlling per capita costs within our system.

Our primary and most strategically important bulwark against unmanaged cost growth for the coming year is quality. Our efforts to develop, proliferate and adhere to evidence-based guidelines will have the most dramatic effect on our costs. In this instance, we will again compare ourselves against each other and against private sector data using the Dartmouth Atlas as our guide. Our goal is to reduce inappropriate variation in the utilization of services.

The urgency of addressing costs in FY 2011 is clear from our budget request. A major increase in the budget request includes \$1.2 billion for private sector care costs due to an increase in users of TRICARE and an increase in utilization of the TRICARE benefit.

We recognize that this focus on quality and utilization does not diminish the need for wise and informed management actions to also control costs. In FY 2011, we will also:

- continue implementation of Federal Ceiling Pricing of retail pharmaceuticals;
- continue implementation of the Outpatient Prospective Payment System, which reduces the reimbursement paid for outpatient care at inpatient private sector care facilities;
- standardize medical supply chain management across the full range of military health care operations;
- increase efforts to identify and detect fraud, waste, abuse, and overpayments to civilian medical providers; and
- pursue the first fully integrated Joint DoD/VA healthcare collaboration consisting of the North Chicago Veterans Affairs Medical Center and the Navy Health Clinic, Great Lakes, Illinois.

Through improved access to care from the medical home initiative and adherence to evidence-based care guidelines, we are hoping to reduce the need for referrals to private sector sources wherever possible, and to decrease utilization of emergency room services (when used as a source for non-emergent primary care).

We recognize that the MHS is not immune from the cost growth challenges faced by our private sector peers. And, the ever-increasing value of the TRICARE benefit against private sector plans and premiums will likely place additional pressure on the MHS budget. Yet, along with the civilian and military leadership of the Department, we are mindful of the trade-offs being made every day to sustain this system of care.

### **Learning and Growth**

Fiscal Year 2011 promises to be both exciting and challenging, as many of the Department's most significant health efforts will be advanced in bold and meaningful ways. The 2005 Base Realignment and Closure actions, which impact medical facilities in multiple joint medical markets, the joint Medical Education and Training Campus, and co-location of medical headquarters, will come to fruition in September 2011. Additionally, work on the Electronic Health Record (EHR) will continue on the trajectory toward improved system effectiveness and interoperability. And the Department will continue to address and resolve governance issues related to emerging requirements to organize, execute, and oversee Joint peacetime health care activities.

In this dynamic environment, supporting the Quadruple Aim is an objective that must continue to grow and support the people who serve the MHS. Our major initiatives for this year center on (1) furthering the MHS; contribution to medical science, (2) delivering information to enable better healthcare decisions, and (3) ensuring a fully capable workforce most prepared to support our strategic initiatives.

Our medical research program continues to grow, with the leadership of Secretary Gates and the ongoing support of Congress. Significant funding has been dedicated to TBI and psychological health; battlefield medicine; threats from the full range of chemical, biological, radiobiological and nuclear threats. Our EHR continues to serve a vital function in support of our clinicians and patients. The incredibly rich clinical data repository is capturing care delivered throughout our system, to include outpatient services in the combat theaters. And, in each successive year, we are able to transfer more health information more easily with our counterparts in the VA.

Yet, our EHR has not been without its technical challenges. For FY 2011, we are proposing a total of \$875 million for modernization efforts and to enable data interoperability with the Virtual Lifetime Electronic Record (VLER), being jointly led by DoD and the VA. VLER is an ambitious and needed undertaking to integrate medical, personnel benefits, and financial information in a single virtual record for veterans.

Finally, vital to our ability to deliver a high quality, accessible and cost-effective health system is a workforce that is trained and ready to operate in a fast-paced environment. We are investing in recruitment and retention programs to sustain our system. We have proposed legislation that will allow us to offer post-graduate scholarships for MHS civilians. We are partnering with universities, marketing our job opportunities to their graduates. Outreach activities include attending job fairs, speaking at professional

conferences, and marketing through our MHS website. Partnering with the VA has allowed us to share recruiting opportunities, improving our mutual ability to recruit scarce medical professionals. In all, our MHS human capital programs will continue to allow us to extol the benefits of public service while supporting our strategic initiatives.

We are proud to serve with the talented, dedicated and resourceful team of public servants and military volunteers who comprise the MHS. And, we are committed to enhancing their professional experience in service to the country.

#### **UNIFIED MEDICAL BUDGET REQUEST FOR FY 2011**

The Defense Health Program (DHP), the appropriation that supports the MHS, is under mounting financial pressure. The DHP has more than doubled since 2001 – from \$19 billion to \$50.7 billion in FY 2010.

The majority of DoD health spending supports health care benefits for military retirees and their dependents, not the active force. We project that up to 65 percent of DoD healthcare spending will be going toward retirees in FY 2011 – up from 45 percent in FY 2001. As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option and they are likely to drop their employer's insurance. These costs are expected to grow from 6 percent of the Department's total budget in FY 2001 to more than 10 percent in FY 2015.

Despite these fiscal challenges, the FY 2011 budget request provides realistic funding for projected health care requirements.

The Unified Medical Budget, the Department's total request for healthcare in FY 2011, is \$50.7 billion. This includes the DHP appropriation, including Wounded, Ill and Injured Care and Rehabilitation; Military Personnel, Military Construction, and normal cost contributions for the Medicare-Eligible Retiree Healthcare.

#### **Defense Health Program**

The largest portion of the request, or \$30.9 billion, will be used to fund the DHP, which is comprised of Operation & Maintenance (O&M), Procurement and Research, Development, Test & Evaluation (RDT&E). A little over \$29.9 billion is for O&M, which funds most day-to-day operational costs of healthcare activities;

#### **Military Personnel and Construction**

For Military Personnel, the Unified Medical Budget includes \$7.9 billion to support the more than 84,000 military personnel who provide healthcare services in military theaters of operations and fixed health care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard, and undersea medicine, and global humanitarian assistance and response.

Funding for medical Military Construction (MILCON) includes \$1.0 billion to improve our medical infrastructure. We are committed to building new hospitals using the principles of Evidence-Based Design (EBD). We are excited to be able to open a national showcase in EBD, the new Fort Belvoir Hospital, in 2011.

MILCON funding will also be directed toward infrastructure enhancements at the National Interagency Biodefense Campus at Fort Detrick, Maryland – a vital resource for the nation.

**DoD Medicare-Eligible Retiree Health Care Fund**

The estimated normal cost of the Medicare-Eligible Retiree Health Care Fund in FY 2010 is \$10.9 billion. This funding includes payments for care in MTFs, to private health care providers, and to reimburse the Services for military labor used in the provision of healthcare services.

**CONCLUSION**

Madam Chairwoman, the Military Health System continues to provide world-class medical care for a population that demands and deserves the best care anywhere. I am proud to represent the men and women who comprise the MHS. I am proud to submit to you and your committee members a budget that is fully funded and that we can successfully execute in the coming year.

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I am pleased that I am able to provide you a budget with a direct and specific link to our strategic planning efforts of the last year.

Thank you again, Madam Chairwoman, for the opportunity to be with you today. I look forward to your questions.

[END]



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STATEMENT BY

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AND COMMANDER, US ARMY MEDICAL COMMAND

COMMITTEE ON ARMED SERVICES  
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 111<sup>TH</sup> CONGRESS

FY2011 DEFENSE HEALTH PROGRAM

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COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Representative Wilson, and distinguished members of the Military Personnel Subcommittee, thank you for inviting us to discuss military medicine and our respective Service medical programs. Now in my third Congressional hearing cycle as the Army Surgeon General and Commanding General, US Army Medical Command (MEDCOM), I can tell you that these hearings are valuable opportunities for me to talk about the accomplishments and challenges of Army Medicine and to hear your collective perspectives regarding military healthcare. You and your staff members ask some difficult questions, but these questions help keep us focused on those we serve--the Soldiers, Sailors, Marines, Airmen, Coast Guardsmen, Family members, and Retirees as well as the American public. I hope you also find these hearings beneficial as you review the President's budget submission, which this year fully funds the Army Medical Department's needs, and determine priorities and funding levels for the next fiscal year.

The US Army Medical Department is a complex, globally-deployed, and world class team. My command element alone, the MEDCOM, is an \$11 billion international health improvement, health protection, emergency response and health services organization staffed by 70,000 dedicated Soldiers, civilians, and contractors. I am in awe at what these selfless servants have done over the past years—their accomplishments have been quietly, effectively, powerfully successful. While we have experienced our share of crises and even tragedies, despite eight years of continuous armed conflict for which Army Medicine bears a heavy load, every day our Soldiers and their Families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in cutting-edge fashion when prevention fails; and are supported by an extraordinarily talented medical force to include those who serve at the side of the Warrior on the battlefield. We mourn the loss of 26 teammates in the Fort Hood shootings—six dead and 20 wounded—but are inspired by the resolve shown by their units to continue their missions and the exemplary

performance of the 467<sup>th</sup> and 1908<sup>th</sup> Medical Detachments serving in Afghanistan today.

One area of special interest to the Congress is our comprehensive effort to improve warrior care from point of injury through evacuation and inpatient treatment to rehabilitation and return to duty. I am convinced the Army has made some lasting improvements, and I was recently heartened to read the comments of a transitioning Warrior that reinforced these perceptions. She commented:

As I look back in the past I am able to see with a reflective eye...the people that have helped me fight this battle, mostly my chain of command, who have always stood beside me instead of in front of me. They have gone out of their way to do what was best for me and I cannot say I would be here still if I hadn't had such wonderful support.... This is my story at the WTB and all in all, I just had to make aware to everyone that has helped that I am very grateful and I truly appreciate all of the work you have done for me.

There is nothing more gratifying than to care for these wounded, ill, and injured heroes. We in Army Medicine continue to focus our efforts on our Warriors in Transition and I want to thank Congress for its unwavering support. The support of this committee has allowed us to hire additional providers, staff our warrior transition units, conduct relevant medical research, and build healing campuses. In the remainder of my testimony today, I will discuss how we are providing optimal stewardship of the investment the American public and this Committee has made in Army Medicine.

We lead and manage Army Medicine through the Kaplan & Norton Balanced Scorecard performance improvement framework that I introduced to you in last year's testimony. The Scorecard balances missions and resources across a broad array, while ensuring that near-term measures of success are aligned with longer-term, more strategic results. This balancing is depicted on the Scorecard's Strategy Map, which shows how we marshal our resources, train and develop our people, and focus our internal processes and efforts so as to balance competing goals. Ultimately our means, ways, and ends contribute

toward accomplishing our mission and achieving our strategic vision. The five strategic themes that guide our daily efforts are:

- Maximize Value in Health Services
- Provide Global Operational Forces
- Build the Team
- Balance Innovation with Standardization
- Optimize Communication and Knowledge Management

Although distinct themes, they inevitably overlap and weave themselves through everything we do in Army Medicine.

The first strategic theme--**Maximize Value in Health Services**-- is built on the belief that providing high quality, evidence-based services is not only the right for our Soldiers and Families; it results in the most efficient use of resources within the healthcare system, thus delivering value to not only our patients, but indeed, the Nation. In fact, what we really want to do is move from a healthcare system to a system for health.

We have resisted simply inventing a new process, inserting a new diagnostic test or therapeutic option *in vacuo* or adding more layers of bureaucracy but are truly adding value to the products we deliver, the care we provide, and the training of our people. This requires focusing on the clinical outcome for the patient and the community and maintaining or even reducing the overall resource expenditure needed to achieve this objective. It has occurred through adoption of evidence-based practices and reducing unwarranted practice variation--even "unwarranted administrative practice variation" for the transactional processes in our work. As one example of this, Army Medicine is expanding upon our Performance Based Budget model to link resources to clinical and quality outputs. The Healthcare Effectiveness and Data Information Set (HEDIS<sup>®</sup>) is a tool used by more than 90% of America's health plans (> 400 plans) to measure performance on important dimensions of care, namely, the prevention of disease and evidence-based treatments for some of the most common and onerous chronic illnesses. The measures are very specifically

defined, thus permitting comparison across health plans. Since 2007, we have been providing financial incentives to our hospitals, clinics and clinicians for superior compliance in key HEDIS measures. Currently, we track nine measures and compare our performance to national benchmarks. Our performance has improved on each measure, in one case by 63%. We have demonstrated that these incentives work to change organizational behavior to achieve desired outcomes in our health system. Put quite simply, our beneficiaries, patients and communities are receiving not only better access to care but better care—objectively measured.

As the DoD budget and health-/healthcare-related costs come under increasing scrutiny, this element of our strategy will be even more critical for us. As the United States struggles to address improvements in health and healthcare outcomes while stabilizing or reducing costs of our national system of care, we in Army Medicine and the Military Health System will surely keep the goal of maximizing value in our cross-hairs...or we will find our budgets tightening without a way to measure the effects on our patients' and our communities' health and well-being.

All of these remarkable achievements would be without meaning or importance to our Soldiers, their Families, and our patients if we do not provide access and continuity of care, especially within the direct care system of our medical centers, community hospitals, health centers, and clinics. I am looking carefully at my commanders' leadership and success in ensuring that their medical and dental treatment facilities provide timely access and optimize continuity of care. We have undertaken major initiatives to improve both access and continuity—this is one of the Army Chief of Staff's and my top priorities. After conducting thorough business case analyses, Army Medicine is expanding product lines in some markets and expanding clinical space in others. At 14 locations, we are establishing Community Based Primary Care Clinics by leasing and operating clinics located in off-post communities that are close to where active duty Families live, work, and go to school. These clinics will provide a patient-centered medical home for Families and will provide a range of benefits:

- Improve the readiness of our Army and our Army Family
- Improve access to and continuity of care
- Reduce emergency room visits
- Improve patient satisfaction
- Implement Best Practices and standardization of services
- Increase physical space available in military treatment facilities (MTFs)
- Improve physical and psychological health promotion and prevention

Along with the rest of the Military Health System, Army Medicine is embracing the Patient-Centered Medical Home concept, which is a recommended practice of the National Committee for Quality Assurance and is endorsed by a number of medical associations, several large third-party payers, and many employers and health plans. The Patient-Centered Medical Home improves patient satisfaction through its emphasis on appropriate access, continuity and quality, and effective communication. The goal is simple: consult with one consistent primary care provider-nurse team for all your medical needs. The seven core features of the Medical Home are:

- Personal Primary Care Provider (primary care manager/team)
- Primary Care Provider Directed Medical Practice (the primary care manager is team leader)
- Whole Person Orientation (patient centered, not disease or provider centered)
- Care is Coordinated and/or Integrated (across all levels of care)
- Quality and Safety (evidenced-based, safe medical care)
- Enhanced Access (meets access standards from the patient perspective)
- Payment Reform (incentivizes the development and maintenance of the medical home)

I look for 2010 to be the year Army Medicine achieves what we set out to improve two years ago in access and continuity, key elements of our covenant with the Army Family, led by our Chief of Staff and Secretary of the Army.

Unlike civilian healthcare systems that can focus all of their energy and resources on providing access and continuity of care, the Military Health System has the equally important mission to **Provide Global Operational Forces**.

The partnership between and among the medical and line leadership of Operations Iraqi Freedom and Enduring Freedom, Central Command, Army Forces Command, US Army Reserve Command, National Guard Bureau, Army Medical Department Center & School, Medical Research and Materiel Command, Army G3/5/7, and others has resulted in a dynamic reconfiguration of the medical formations and tactics, techniques, and procedures required to support the deployed Army, joint and coalition force. Army Medicine has never missed movement and we continue to achieve the highest survivability rate in the history of warfare. Army Medicine leaders have never lost sight of the need to first and foremost make a difference on the battlefield.

This will not change—it will even intensify in 2010 as the complexity of the missions in Afghanistan increases. And this is occurring even while the need to sustain an Army and joint force which is responsibly withdrawing from Iraq puts more pressure on those medics continuing to provide force health protection and care in Operation Iraqi Freedom. This pressure on our All-Volunteer Army is unprecedented. Healthcare providers, in particular, are subject to unique strains and stressors while serving in garrison as well as in deployed settings. The MEDCOM has initiated a defined program to address provider fatigue with current efforts focused on sustaining the healthy force and identifying and supporting higher risk groups. MEDCOM has a healthy healthcare workforce as demonstrated by statistically significant lower provider fatigue and burnout than: The Professional Quality of Life Scale (ProQol) norming sample of 1187 respondents; and Sprang, Clark and White-Woosley's study of 222 civilian behavioral health (BH) providers. But as our Chief of Staff of the Army has told

us: this is not an area where we just want to be a little better than the other guy—we want the healthiest and most resilient healthcare provider workforce possible.

The Provider Resiliency Training (PRT) Program was originally designed in 2006, based on Mental Health Advisory Team findings. The US Army Medical Department Center and School (AMEDDC&S) developed a military-specific model identifying “provider fatigue” as the military equivalent of compassion fatigue. In June of 2008, MEDCOM implemented a mandated PRT program to educate and train all MTF personnel to include support staff on the prevention and treatment of signs and symptoms of provider fatigue. The stated goal of PRT is to mitigate the negative effects of exposure to combat, to deployment, to secondary trauma from caring for the casualties of war as well as the unremitting demand for healthcare services and from burnout. All will ultimately improve organizational effectiveness. The AMEDDC&S currently offers three courses in support of the MEDCOM PRT: the Train the Trainer Course; the Professional Resiliency Resident Course; and the PRT Mobile Training.

None of our goals and themes would be achievable without the right mix of talented professionals within Army Medicine and working with Army Medicine; what our Balanced Scorecard refers to as **Build The Team**: a larger, more inclusive joint medical team; an adaptive & responsive interagency team (VA, DHS, DHHS/NIH/NIAID, CDC, USDA, etc.); an effective coalition team; and a military-civilian/academic-operational team. The teams we build must be aligned with the Army, Defense, and National Military Strategy and long-term goals, not based solely on personalities and the arcane interests of a few. My Deputy Surgeon General, subordinate leaders, and others have been increasingly more deliberate and disciplined in how we form and sustain these critical partnerships.

Effective joint, interagency and coalition team-building has been a serious challenge for some time now. I see the emphasis on our ability to craft these teams grow in 2010. The arrival of September 15, 2011--the deadline for the 2005 BRAC--will be one of the key milestones and tests of this skill. My regional commanding generals in San Antonio and Washington, DC have taken lead roles



in this endeavor. Let there be no question among those who underestimate our collective commitment to working as a team and our shared vision to serve the Nation and protect and care for the Warriors and his or her Family—we are *One Team!*

In addition to building external teams, we need to have the right mix and quality of personnel internal to Army Medicine. In Fiscal Year 2010 (FY10) and continuing into FY11 the Army requested funding for programs to improve our ability to attract and retain the professional workforce necessary to care for our Army. Our use of civilian hiring incentives (Recruiting, Retention, & Relocation) increased in FY10 by \$90M and should increase by an additional \$30M in FY11. In FY11, civilian hiring incentives will equate to 4.8% of total civilian pay. We have instituted and funded civilian recruiting programs at the MEDCOM, regional, and some local levels to seek qualified healthcare professionals. For our military workforce, we are continuing our successful special salary rates, civilian nurse loan repayment programs, and civilian education training programs. Additionally, our Health Professional Scholarship Program and loan repayments will increase in FY10 by \$26M and continue into FY11. This program supports 1,890 scholarships and 600 participants in loan repayments—it is as healthy a program as it has ever been. Let me point out that our ability to educate and train from within the force—through physician, nursing, administrative, medic and other programs in professional education—is a vital capability which we cannot permit to be degraded or lost altogether. In addition to providing essential enculturation for a military healthcare provider, administrator and leader, these programs have proven to be critical for our retention of these professionals who are willing to remain in uniform, to deploy in harm's way and to assume many onerous duties and assignments in exchange for education in some of the Nation's best programs. Army and Military Graduate Medical, Dental, Nursing and other professional education has undoubtedly played a major role in our remaining a viable force this far into these difficult conflicts.

The theme of evidence-based practice runs through everything we do in Army Medicine and is highlighted throughout our Balanced Scorecard. Evidence-based practices mean integrating individual clinical expertise with the best available external clinical evidence from systematic research. Typical examples of evidence-based practices include implementation of clinical practice guidelines and dissemination of best practices. I encourage my commanders and subordinate leaders to be innovative, but across Army Medicine we **Balance Innovation with Standardization** so that all of our patients are receiving the best care and treatment available. Standardization efforts include:

- The MEDCOM AHLTA Provider Satisfaction (MAPS) initiative
- Care of combat casualties through the Joint Theater Trauma System (JTTS), enabled by the use of a Joint Theater Trauma Registry (JTTR)—both of which I will discuss further below—which examines every casualty's care and outcome of that care, including en route care during medical evacuation (MEDEVAC) with an eye toward standardizing care around the best practices
- The Virtual Behavioral Health Pilot (aka Comprehensive Behavioral Health Integration) being conducted at Schofield Barracks and Ft. Richardson
- Our initiative to reduce Ventilator Associated Pneumonia events in our ICUs by adopting not only industry best practices, but sending out an expert team of MEDCOM professionals to evaluate our own best practices and barriers to success
- Our standardized events-driven identification and management of mild TBI/concussion on the battlefield coupled with early diagnosis and treatment of Post-Traumatic Stress Reactions/Acute Stress Reactions as close in time and space to the events which lead to these reactions

Programs which are in the process of maturing into best practices for more widespread dissemination are:

- The Confidential Alcohol Treatment & Education Pilot (CATEP)

- The standardized and now automated Comprehensive Transition Plan for Warriors In Transition in our WTUs and CBWTUs
- A standardized program to "build trust in Army Medicine" through hospitality and patient/client/customer service in our medical, dental, and veterinary treatment facilities and throughout the MEDCOM
- Standardized support of our Active, National Guard, and Reserve forces engaged in the reiterative, cyclic process of the Army Force Generation Model (ARFORGEN) including but not restricted to preparation for combat medics and medical units, Soldier Readiness Processing of deploying units, ensuring full medical readiness of the force, restoration of dental and behavioral health upon redeployment, support of the total Army Family while Soldiers are deployed, and provision of healthcare for mobilized and demobilizing Reserve Component Soldiers and their Families.

These and many other standardized efforts reflect a change in how we do the business of Army Medicine. We can no longer pride ourselves on engaging in a multiplicity of local "science projects" being conducted in a seemingly random manner by well-meaning and creative people but without a focus on added value, standard measures of improved outcomes, and sustainability of the product or process. Even the remarkably agile response to the behavioral health needs-assessment and ongoing requirements at Fort Hood following the tragic shooting were conducted in a very deliberate and effective fashion which emphasized unity of command and control, alignment of all efforts and marshalling of resources to meet a well-crafted and even exportable community behavioral health plan.

The emphasis which Army Medicine leaders have placed on disciplining these innovative measures so as to harvest best practices, subject them to validation at other sites, and rapidly proliferate them across the MEDCOM and Army in a standard fashion has been remarkable. It is the essence of **Optimizing Communication and Knowledge Management**.

Many of our goals, internal processes and enablers, and resource investments are focused on the knowledge hierarchy: collecting data; coalescing it into information over time and space; giving it context to transform it into knowledge; and applying that knowledge with careful outcome measures to achieve wisdom. This phenomenon of guiding clinical management by the emergence of new knowledge is perhaps best represented by Dr. Denis Cortese, former President and Chief Executive Officer of the Mayo Clinic. He laid out this schematic earlier this year after participating in a set of workshops which centered on healthcare reform. We participated to explore how the Federal system of care might contribute to these changes in health improvement and healthcare delivery.

What Dr. Cortese depicted is a three-domain ideal representation of healthcare delivery and its drivers. We share this vision of how an ideal system should operate. His notion is that this system of care should focus on optimizing individual health and healthcare needs, leveraging the knowledge domain to drive optimal clinical practices. This transition from the knowledge domain to the care delivery domain now takes 17 years. The clinical practice domain then informs and drives the payer domain to remunerate for effective clinical outcomes. What occurs too often today is what I call “widget-building” or “turnstile” medical care which chases remuneration for these encounters—too often independent of whether it is the best treatment aimed at the optimal outcome. To transform from a healthcare system to a system for health, we need to change the social contract. No longer should we be paid for building widgets (number of clinic visits or procedures), rather, we should be paid for preventing illness and promoting healthy lifestyles. And when bad things happen to good people—which severe illness and injury and war continuously challenge us with—we should care for these illnesses, injuries and wounds by the most advanced evidence-based practices available, reducing unwarranted variation in practice whenever possible.

Our Military Health System is subtly different in that we have two practice domains—garrison and battlefield. Increasingly, we leverage the clinical domain

to provide feedback into the knowledge domain—with the help of the electronic health record—AHLTA—and specialized databases. We do this in real time and all under the umbrella of the regulatory domain which sets and enforces standards.

The reengineering of combat trauma care borne of rapid turnaround of new-found, data-driven knowledge to new materiel and doctrinal solutions is one of the premier examples of this concept. The simplest example is our continuous re-evaluation of materials and devices available to Soldiers, combat life savers, combat medics and the trauma team at the point of injury and in initial trauma management and the intellectual framework for their application to rapidly improve outcomes from combat-injured Warriors.

After making the first major change in 40 years to the field medical kit—the Improved First Aid Kit (IFAK)—we have modified the contents of the kit at least three times since May 2005 based upon ongoing reviews of the effectiveness of the materials and head-to-head comparisons to competing devices or protocols. In like fashion, we have modified protocols for trauma management through active in-theater and total systemic analyses of the clinical outcomes deriving from the use of materials and protocols.

The specialized system in this endeavor is a joint and inter-agency trauma system which creates the equivalent of a trauma network available for a major metropolitan area or geographic region in the US but spread across three continents, 8000 miles end-to-end—the Joint Theater Trauma System (JTTS). Staffed and led by members of the Army, Navy, Marine Corps and Air Force, it is truly a joint process. It is centered on the US Army Institute of Surgical Research in San Antonio, Texas. The specialized database in this effort and an essential element of the JTTS is the Joint Theater Trauma Registry (JTTR)—a near-comprehensive standardized database which has been developed for each casualty as soon as possible in the treatment evacuation chain—usually at level II or III healthcare in theater. One of the most important critical applications of the JTTS and JTTR at present is the ongoing analysis of MEDEVAC times and the casualties being managed during evacuation. This is our effort to minimize

the evacuation time for casualty in a highly dispersed force which is subjected in Afghanistan to the "tyranny of terrain and weather."

The decisions about where and how many trauma teams should be placed around the theater of operation as well as where to place MEDEVAC crews and aircraft is a delicate balancing act—one which balances the risk of putting care providers and MEDEVAC crews and helicopters at risk to the enemy and the elements with the risk of loss of life and limb to Warriors whose evacuation may be excessively prolonged. The only way to fully understand these competing risks is to know the outcomes of care and evacuation by injury type across a wide range of MEDEVAC missions. This analysis will help us understand if we still require a "Golden Hour" for every casualty between initial management at the point of injury and arrival at a trauma treatment site (like an Army Forward Surgical Team, the Marine Forward Resuscitative Surgical System or a Combat Support Hospital) or whether we now have a "Platinum 15 Minutes" at the point of injury which extends the Golden Hour.

This methodology and these casualty data are being applied to the next higher level of inquiry: how do we prevent injury and death of our combatants from wounds and accidents at the point of potential injury? Can we design improved helmets, goggles, body armor, vehicles and aircraft to prevent serious injuries? These questions are answered not only through the analysis of wound data, both survivable and non-survivable, through the JTTS and data from the virtual autopsy program of the Office of the Armed Forces Medical Examiner, but also by integrating these data with information from the joint operational, intelligence, and materiel communities to enable the development of improved tactics, techniques, and procedures and materiel improvements to protective equipment worn by the Warriors or built into the vehicles or aircraft in which they were riding. This work is performed by the Joint Trauma Analysis and Prevention of Injury in Combat program, a component of the DoD Blast Injury Research Program directed by the National Defense Authorization Act for 2006. To date it has been an effective means of improving the protection of Warriors and

preventing serious injury and death even as the enemy devises more lethal and adaptive weapons and battlefield tactics, techniques, and procedures.

We in Army Medicine are applying these knowledge management tools and approaches to the improvement of health and the delivery of healthcare back home as well. We are coupling these knowledge management processes with a funding strategy which incentivizes our commanders and clinicians to balance productivity—providing episodes of care—with optimal outcome: the right kind of prevention and care.

Among our greatest team achievements in 2009 was our effort to better understand how we communicate effectively with our internal and external stakeholders, patients, clients and customers. We adopted a formal plan to align our messages--ultimately all tied to Army goals and those on our Balanced Scorecard. Our creation of a Strategic Communications Directorate to ensure alignment of our key messages, to better understand and use social media, to expedite cross-talk and learning among such diverse groups as the Office of Congressional Liaison, Public Affairs, Protocol, Medical History, the Borden Institute, the AMEDD Regiment and others speaks directly to these efforts.

While we are still in the "advanced crawl/early walk" phase of knowledge management, we know from examples such as the Joint Theater Trauma System and the Performance Based Budget Model that we can move best practices and newly found evidence-based approaches into common or widespread use if we aggressively coordinate and manage our efforts and promote transparency of data and information and the knowledge which derives from it. We have begun a formal process under the Strategy & Innovation Directorate to move the best ideas in both clinical and transactional processes into standard practices across the MEDCOM in a timely way. This will be achieved through a process to identify, validate, and transfer best practices. We endeavor to be more agile and adaptive in response to a rapidly changing terrain of US and Federal healthcare and operational requirements for a Nation at war.

In closing, I am very optimistic about the next two years. We have weathered some serious challenges to trust in Army Medicine. Logic would not predict that we would be doing as well as we are in attracting, retaining and career developing such a talented team of uniformed and civilian medical professionals. However, we continue to do so year after year--a tribute to all our Officer Corps, the leadership of our Non-Commissioned Officers, and our military and civilian workforce. The results of our latest Medical Corps Graduate Medical Education Selection Board and the Human Capital Distribution Plan show continued strength and even improvements over past years. The continued leadership and dedicated service of officers, non-commissioned officers, and civilian employees are essential for Army Medicine to remain strong, for the Army to remain healthy and strong, and for the Nation to endure. I feel very privileged to serve with the men and women of Army Medicine during this historic period as Army Medics, as Soldiers, as Americans and as global citizens.

Thank you for holding this hearing and your unwavering support of the Military Health System and Army Medicine. I look forward to working with you and your staff and addressing any of your concerns or questions.



**Not for Publication until released by  
the House Armed Services Committee**

**Statement of**

**Vice Admiral Adam M. Robinson, Jr., MC, USN**

**Surgeon General of the Navy**

**Before the**

**Subcommittee on Military Personnel**

**of the**

**House Armed Services Committee**

**Subject:**

**The State of Navy Medicine**

**21 April 2010**

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**Introduction**

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

Navy Medicine – World Class Care ... Anytime, Anywhere. This poignant phrase is arguably the most telling description of Navy Medicine's accomplishments in 2009 and continues to drive our operational tempo and priorities for the coming year and beyond. Throughout the last year we saw challenges and opportunities; and moving forward, I anticipate the pace of operations and demands placed upon us will continue to increase. Make no mistake: We have been stretched in our ability to meet our increasing operational and humanitarian assistance requirements, as well as maintain our commitment to provide Patient and Family-Centered care to a growing number of beneficiaries. However, I am proud to say to that we are responding to this demand with more flexibility and agility than ever before. We are a vibrant, world-wide health care system fully engaged and integrated in carrying out the core capabilities of the Maritime Strategy around the globe. Regardless of the challenges ahead, I am confident that we are well-positioned for the future.

Since becoming the Navy Surgeon General in 2007, I have invested heavily in our strategic planning process. How we accomplish our mission is rooted in sound planning, sharp execution and constructive self-assessment at all levels of our organization. I

challenged our leadership to create momentum and establish a solid foundation of measurable progress. It's paying dividends. We are seeing improved and sustained performance in our strategic objectives. Just as importantly, our planning process supports alignment with the Department of Navy's Strategic Plan and Operations Guidance.

Navy Medicine's commitment to Patient and Family-Centered Care is also reflected in our resourcing processes. An integral component of our Strategic Plan is providing performance incentives that promote quality and directly link back to workload and resources. We are evolving from a fiscal planning and execution process rooted in historical data, to a system which links requirements, resources and performance goals. This transformation to Performance Based Budgeting properly aligns authority, accountability and financial responsibility with the delivery of quality, cost-effective health care

The President's budget for FY11 adequately funds Navy Medicine to meet its medical mission for the Navy and Marine Corps. The budget also provides for the maintenance of our facilities. We appreciate the Committee's strong support of our resource requirements.

### **Force Health Protection**

The foundation of Navy Medicine is Force Health Protection. It's what we do and why we exist. In executing our Force Health Protection mission, the men and women of Navy Medicine are engaged in all aspects of expeditionary medical operations in support of our warfighters. The continuum of care we provide includes all dimensions of physical and psychological well-being. This is our center of gravity and we have and

will continue to ensure our Sailors and Marines are medically and mentally prepared to meet their world-wide missions.

Nowhere is our commitment to Force Health Protection more evident than in our active engagement in military operations in Iraq and Afghanistan. As these overseas contingency operations evolve, and in many respects become increasingly more dangerous, we are seeing burgeoning demand for expeditionary combat casualty care in support of joint operations. I recently returned from a trip to Afghanistan and I again saw the outstanding work of our medical personnel. The Navy Medicine team is working side-by-side with Army and Air Force medical personnel and coalition forces to deliver outstanding health care to our troops and civilians alike.

We must continue to be innovative and responsive at the deckplates and on the battlefield. Since the start of Operation ENDURING FREEDOM and Operation IRAQI FREEDOM, the Marine Corps has fielded new combat casualty care capabilities which include: updated individual first aid kits with combat gauze, advanced tourniquets, use of Tactical Combat Casualty Care principles, troop training in Combat Lifesaver, and the use of Factor VII - a blood clotting agent used in trauma settings. In addition, Navy Fleet Hospital transformation has redesigned expeditionary medical facilities that are lighter, modular, more mobile, and interoperable with other Services' facilities.

Our progress is also evident in the innovative work undertaken by a Shock Trauma Platoon (STP) two years ago in Afghanistan. This team, comprised of two physicians, two nurses, a physician assistant and 14 corpsmen, essentially created a mobile emergency room - a seven-ton truck with a Conex container and welded steel plates - that went into combat to administer more expedient and effective care in austere

settings. This prototype led to the creation of the Mobile Trauma Bay (MTB), a capability that both Marine Corps and Navy Medicine leadership immediately recognized as vital to the warfighter and an unquestionable life-saver on the battlefield. MTB use has already been incorporated into our Afghanistan shock trauma platoon operations, and they are already positively impacting forward resuscitative and stabilization care. We understand that the Marine Corps has fully embraced the MTB concept and is planning to add additional units in future POM submissions.

#### **Humanitarian Assistance and Disaster Response**

An integral part of the Navy's Maritime Strategy is humanitarian assistance and disaster response. In the wake of the devastating earthquake in Haiti earlier this year, our Nation moved forward with one of the largest relief efforts in our history to save lives, deliver critically needed supplies and provide much-needed hope. The response was rapid, as Navy deployed ships and expeditionary forces, comprised of more than 10,000 personnel, to provide immediate relief and support for the Haitian people. In support of Operation UNIFIED RESPONSE, Navy Medicine answered the call. We deployed USNS COMFORT (T-AH 20) from her homeport in Baltimore within 77 hours and ahead of schedule – going from an industrial shipboard site to a ready afloat Naval hospital, fully staffed and equipped. She was on station in Port-au-Prince five days later and treating patients right away. From the beginning, the operational tempo onboard USNS COMFORT has been high with a significant trauma and surgical caseload. Medical teams from the ship are also ashore to help in casualty evaluation, triage crush wounds, burn injuries and other health issues. Providing care around the clock, our

personnel were challenged both professionally and personally. For many, this was a career-defining experience and certainly reflects the Navy's commitment as a "Global Force for Good." I spoke to the crew as they were preparing to get underway, and personally related just how important this mission is and why it is a vital part of the Navy's Maritime Strategy.

Navy Medicine provided additional support that included the deployment of a Forward Deployed Preventive Medicine Unit (FDPMU) and augmented Casualty Receiving and Treatment Ship (CRTS) medical staff capabilities onboard USS BATAAN (LHD 5). We also recognized the potential psychological health impact on our medical personnel involved in this humanitarian assistance mission and ensured we had trained Caregiver Occupational Stress Control (CgOSC) staff onboard.

The ship departed Haiti on 10 March 2010. Prior to getting underway, the crew gathered for a memorial ceremony in honor of the people of Haiti. The men and women of USNS COMFORT, and all involved in this mission, saved lives, alleviated suffering, and brought hope in the midst of devastation. Their performance and spirit of caring was exemplary.

Navy Medicine is inherently flexible and capable of meeting the call to support multiple missions. I am proud of the manner in which the men and women of Navy Medicine leaned forward in response to the call for help. In support of coordination efforts led by the Department of State and the U.S. Agency for International Development, and in collaboration with nongovernmental organizations, both domestic and international, our response demonstrated how the expeditionary character of our

Naval and Marine forces are uniquely suited to provide assistance during interagency and multinational efforts.

### **Concept of Care**

Navy Medicine's Concept of Care is Patient and Family-Centered Care. It is at the epicenter of everything we do. This concept is elegant in its simplicity yet extraordinarily powerful. It identifies each patient as a participant in his or her own health care and recognizes the vital importance of the family, military culture and the military chain of command in supporting our patients. My goal is for this Concept of Care – this commitment to our patients and their families – to resonate throughout our system and guide all our actions. It is enabled by our primary mission to deliver force health protection and a fully ready force; mutually supported by the force multipliers of world class research and development, and medical education. It also leverages our emphasis on the health and wellness of our patients through an active focus on population health.

### **Caring for Our Heroes**

When our Warriors go into harm's way, we in Navy Medicine go with them. At sea or on the ground, Sailors and Marines know that the men and women of Navy Medicine are by their side ready to care for them. There is a bond of trust that has been earned over years of service together, and make no mistake, today that bond is stronger than ever. Our mission is to care for our wounded, ill and injured, as well as their families. That's our job and it is our honor to have this opportunity.

As our Wounded Warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. We want them to mend in body, mind and spirit. Our focus is multidisciplinary-based care, bringing together medical treatment providers, social workers, case managers, behavioral health providers and chaplains. We are working closely with our line counterparts with programs like the Marine Corps' Wounded Warrior Regiments and the Navy's Safe Harbor to support the full-spectrum recovery process for Sailors, Marines and their families.

Based on the types of injuries that we see returning from war, Navy Medicine continues to adapt our capabilities to best treat these conditions. When we saw a need on the West Coast to provide expanded care for returning Wounded Warriors with amputations, we established the Comprehensive Combat and Complex Casualty Care (C5) Program at Naval Medical Center, San Diego, in 2007. C5 manages severely injured or ill patients from medical evacuation through inpatient care, outpatient rehabilitation, and their eventual return to active duty or transition from the military. We are now working to expand utilization of Project C.A.R.E – Comprehensive Aesthetic Recovery Effort. This initiative follows the C5 model by ensuring a multidisciplinary approach to care, yet focuses on providing state-of-the-art plastic and reconstructive surgery for our Wounded Warriors at both Naval Medical Center San Diego and Naval Medical Center Portsmouth, with potential future opportunities at other treatment facilities.

We have also significantly refocused our efforts in the important area of clinical case management at our military treatment facilities and major clinics serving Wounded



Warriors to ensure appropriate case management services are available to all who need them. The Clinical Case Management Program assists patients and families with clinical and non-clinical needs, facilitating communication between patient, family and multi-disciplinary care team. Our clinical case managers collaborate with Navy and Marine Corps Recovery Care Coordinators, Federal Recovery Coordinators, Non-Medical Care Managers and other stakeholders to address Sailor and Marine issues in developing Recovery Care Plans. As of January 2010, 192 Clinical Case Managers are assigned to Military Treatment Facilities and ambulatory care clinics caring for over 2,900 Sailors, Marines and Coast Guardsmen.

#### **Psychological Health and Post-Traumatic Stress**

We must act with a sense of urgency to help build resiliency among our Sailors and Marines, as well as the caregivers who support them. We recognize that operational tempo, including the number and length of deployments, has the potential to impact the psychological health of service members and their family members. We are aggressively working to reduce the stigma surrounding psychological health and operational stress concerns which can be a significant barrier to seeking mental health services for both military personnel and civilians. Programs such as Navy Operational Stress Control, Marine Corps Combat Operational Stress Control, FOCUS (Families Overcoming Under Stress), Caregiver Occupational Stress Control (CgOSC), and our suicide prevention programs (A-C-T Ask-Care-Treat) are in place and maturing to provide support to personnel and their families.

The Navy Operational Stress Control program and Marine Corps Combat Operational Stress Control program are the cornerstones of the Department of the Navy's approach to early detection of stress injuries in Sailors and Marines and are comprised of:

- Line led programs which focus on leadership's role in monitoring the health of their people.
- Tools leaders may employ when Sailors and Marines are experiencing mild to moderate symptoms.
- Multidisciplinary expertise (medical, chaplains and other support services) for more affected members.

Decreasing the stigma associated with seeking psychological health care requires a culture change throughout the Navy and Marine Corps. Confronting an ingrained culture will take time and active leadership support. Stigma reducing interventions span three major fronts: (1) education and training for individual Sailors and Marines that normalizes mental health care; (2) leadership training to improve command climate support for seeking mental health care; and (3) encouragement of care outreach to individual Sailors, Marines, and their commands. This past year saw wide-spread dissemination of Operational Stress Control (OSC) doctrine as well as a Navy-wide education and training program that includes mandatory Navy Knowledge Online courses, instructor led and web-based training.

Navy Medicine ensures a continuum of psychological health care is available to service members throughout the deployment cycle – pre-deployment, during deployment, and post-deployment. We are working to improve screening and surveillance using

instruments such as the Behavior Health Needs Assessment Survey (BHNAS) and Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA).

Our mental health specialists are being placed in operational environments and forward deployed to provide services where and when they are needed. The Marine Corps is sending more mental health teams to the front lines with the goal of better treating an emotionally strained force. Operational Stress Control and Readiness (OSCAR) teams will soon be expanded to include the battalion level, putting mental health support services much closer to combat troops. A Mobile Care Team (MCT) of Navy Medicine mental health professionals is currently deployed to Afghanistan to conduct mental health surveillance, command leadership consultation, and coordinate mental health care for Sailors throughout the AOR. In addition to collecting important near real-time surveillance data, the MCT is furthering our efforts to decrease stigma and build resilience.

We are also making mental health services available to family members who may be affected by the psychological consequences of combat and deployment through our efforts with Project FOCUS, our military treatment facilities and our TRICARE network partners. Project FOCUS continues to be successful and we are encouraged that both the Army and Air Force are considering implementing this program. We also recognize the importance of the counseling and support services provided through the Fleet and Family Support Centers and Marine Corps Community Services.

Beginning in 2007, Navy Medicine established Deployment Health Centers (DHCs) as non-stigmatizing portals of care for service members staffed with primary care

and psychological health providers. We now have 17 DHCs operational. Our health care delivery model supports early recognition and treatment of deployment-related psychological health issues within the primary care setting. Psychological health services account for approximately 30 percent of all DHC encounters. We have also increased mental health training in primary care, and have actively partnered with Line leaders and the Chaplain Corps to develop combat and operational stress control training resources. Awareness and training are keys to our surveillance efforts. Over 4,000 Navy Medicine providers, mental health professionals, chaplains and support personnel have been trained to detect, screen and refer personnel who may be struggling with mental health issues.

We must continue to recognize the occupational stress on our caregivers. They are subject to the psychological demands of exposure to trauma, loss, fatigue and inner conflict. This is why our Caregiver Occupational Stress Control programs are so important to building and sustaining the resiliency of our providers. We cannot overlook the impact on these professionals and I have directed Navy Medicine leadership to be particularly attuned to this issue within their commands.

### **Traumatic Brain Injury**

While there are many significant injury patterns in theater, an important focus area for all of us remains Traumatic Brain Injury (TBI). Blast is the signature injury of OEF and OIF – and from blast injury comes TBI. The majority of TBI injuries are categorized as mild, or in other words, a concussion. Yet, there is much we do not yet know about these injuries and their long-term impacts on the lives of our service members.

The relative lack of knowledge about mild TBI amongst service members and health care personnel represents an important gap that Navy Medicine is seriously addressing. We are providing TBI training to health care providers from multiple disciplines throughout the fleet and the Marine Corps. This training is designed to educate personnel about TBI, introduce the Military Acute Concussion Exam (MACE) as a screening tool for mild TBI, inform providers about the Automated Neurocognitive Assessment Metric (ANAM) test, and identify a follow-up for assessment including use of a repeatable test battery for identification of cognitive status. We have recently established and are now expanding our TBI program office to manage the implementation of the ANAM as a pre-deployment test for service members in accordance with DoD policy. This office will further develop models of assessment and care as well as support research and evaluation programs.

All the Services expect to begin implementation of a new in-theater TBI surveillance system which will be based upon incident event tracking. Promulgated guidelines will mandate medical evaluation for all service members exposed within a set radius of an explosive blast, with the goal to identify any service member with subtle cognitive deficits who may not be able to return to duty immediately.

Navy Medicine has begun implementing the ANAM assessment at the DHCs and within deploying units as part of an Assistant Secretary of Defense (Health Affairs) mandate. We have also partnered with Line leadership, or operational commanders, to identify populations at risk for brain injury (e.g., front line units, SEAL units, and Navy Explosive Ordnance Disposal units). In addition, an in-theater clinical trial for the

treatment of vestibular symptoms of blast-exposure/TBI was completed at the USMC mTBI Center in Al Taqqadum, Iraq.

Both our Naval Health Research Center and Navy-Marine Corps Public Health Center are engaged with tracking TBI data through ongoing epidemiology programs. Goals this year include the establishment of a restoration center in-theatre to allow injured Sailors and Marines a chance to recover near their units and return to the fight.

Additionally, the National Naval Medical Center's Traumatic Stress and Brain Injury Program provides care to all blast-exposed or head-injured casualties returning from theatre to include patients with an actual brain injury and traumatic stress. Navy Medicine currently has TBI clinics at San Diego, Portsmouth, Camp Pendleton and Camp Lejeune with plans for further expansion reflecting our commitment to the treatment of this increasingly prevalent injury.

We are employing a strategy that is both collaborative and integrative by actively partnering with the other Services, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Department of Veterans Affairs, and leading academic medical and research centers to make the best care available to our Warriors afflicted with TBI.

#### **Excellence in Research and Development (R&D)**

Research and development is critical to Navy Medicine's success and our ability to remain agile to meet the evolving needs of our warfighters. It is where we find solutions to our most challenging problems and, at the same time, provide some of

medicine's most significant innovations and discoveries. Our R&D programs are truly force-multipliers and enable us to provide world-class health care to our beneficiaries.

The approach at our research centers and laboratories around the world is straightforward: Conduct health and medical research, development, testing, evaluation and surveillance to enhance deployment readiness. Each year, we see more accomplishments which have a direct impact on improving force health protection. The contributions are many and varied, ranging from our confirmatory work in the early stages of the H1N1 pandemic, to the exciting progress in the development of a malaria vaccine. Research efforts targeted at wound management, including enhanced wound repair and reconstruction as well as extremity and internal hemorrhage control, and phantom limb pain in amputees, present definitive benefits. These efforts also support our emerging expeditionary medical operations and aid in support to our Wounded Warriors.

#### **The Navy Medicine Team**

Navy Medicine is comprised of compassionate and talented professionals who continue to make significant contributions and personal sacrifices to our global community. Our team includes our officers, enlisted personnel, government civilian employees, contract workers and volunteers working together in a vibrant health care community. All have a vital role in the success of our enterprise. Our priority is to maintain the right workforce to deliver the required medical capabilities across the enterprise, while using the appropriate mix of accession, retention, education and training incentives.

Overall, I am encouraged with our recruiting efforts within Navy Medicine and we are starting to see the results of new incentive programs. But while overall manning levels for both officer and enlisted personnel are relatively high, ensuring we have the proper specialty mix continues to be a challenge. Several wartime critical specialties including psychiatry, family medicine, general surgery, emergency medicine, critical care and perioperative nursing, as well as advanced practice nursing and physician assistants, are undermanned. We are also facing shortfalls for general dentists, oral maxillofacial surgeons, and many of our mental health specialists including clinical psychologists and social workers. We have increasing requirements for mental health professionals as well as for Reserve Component Medical Corps, Dental Corps, Medical Service Corps and Nurse Corps officers. We continue to work hard to meet this demand, but fulfilling the requirements among these specialties is expected to present a continuing challenge.

I want to also reemphasize the priority we place on diversity. We are setting the standard for building a diverse, robust, innovative health care workforce, but we can do more in this important area. Navy Medicine is stronger and more effective as a result of our diversity at all levels. Our people are our most important resource, and their dignity and worth are maintained through an atmosphere of service, professionalism, trust and respect.

#### **Partnerships and Collaboration**

Navy Medicine continues to focus on improving interoperability with the Army, Air Force, Department of Veterans Affairs (VA), as well other federal and civilian partners to bring operational efficiencies, optimal technology and training together in



support of our patients and their families, our missions, and the national interests. Never has this collaborative approach been more important, particularly as we improve our approaches to ensuring seamless transitions for our veterans.

We remain committed to resource sharing agreements with the VA and our joint efforts in support of improving the Disability Evaluation System (DES) through the ongoing pilot program at several MTFs. The goal of this pilot is to improve the disability evaluation process for service members and help simplify their transitions. Together with the VA and the other Services, we are examining opportunities to expand this pilot to additional military treatment facilities. Additionally, in partnership with the VA, we will be opening the James A. Lovell Federal Health Care Center in Great Lakes, Illinois – a uniquely integrated Navy/VA medical facility.

We also look forward to leveraging our inter-service education and training capabilities with the opening of the Medical Education and Training Campus (METC) in San Antonio in 2010. This new tri-service command will oversee the largest consolidation of service training in DoD history. I am committed to an inter-service education and training system that optimizes the assets and capabilities of all DoD health care practitioners yet maintains the unique skills and capabilities that our hospital corpsmen bring to the Navy and Marine Corps – in hospitals, clinics at sea and on the battlefield.

Clearly one of the most important priorities for the leadership of all the Services is the successful transition to the Walter Reed National Military Medical Center onboard the campus of the National Naval Medical Center, Bethesda. We are working diligently with the lead DoD organization, Joint Task Force – National Capital Region Medical, to

ensure that this significant and ambitious project is executed properly and without any disruption of services to our Sailors, Marines, their families, and all our beneficiaries for whom we are privileged to serve.

### **The Way Forward**

I believe we are at an important crossroads for military medicine. How we respond to the challenges facing us today will likely set the stage for decades to come. Commitment to our Wounded Warriors and their families must never waver and our programs of support and hope must be built and sustained for the long-haul – and the long-haul is the rest of this century when the young Wounded Warriors of today mature into our aging heroes in the years to come. They will need our care and support as will their families for a lifetime. Likewise, our missions of cooperative engagement, through humanitarian assistance and disaster response, bring opportunities for us, our military and the Nation. It is indeed a critical time in which to demonstrate that the United States Navy is truly a “Global Force for Good.”

Navy Medicine is a vibrant, world-wide health care system comprised of compassionate and talented professionals who are willing to make contributions and personal sacrifices. This team - our team - including officer, enlisted, civilians, contractors, and volunteers work together as a dynamic health care family. We are all essential to success.

Navy Medicine will continue to meet the challenges ahead and perform our missions with outstanding skill and commitment. On behalf of the men and women of Navy Medicine, I want to thank the Committee for your tremendous support, confidence

and leadership. It has been my pleasure to testify before you today and I look forward to your questions.

## United States Air Force

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Presentation



Before the House Armed Services Committee,  
Subcommittee on Military Personnel

### ***Medical Programs***

Witness Statement of Lieutenant General (Dr.)  
Charles B. Green, Air Force Surgeon  
General

April 21, 2010

NOT FOR PUBLICATION UNTIL RELEASED  
BY THE COMMITTEE ON ARMED SERVICES  
UNITED STATES HOUSE OF REPRESENTATIVES

Chairwoman Davis, Representative Wilson and distinguished members of the Committee, it is an honor and a privilege to appear before you representing the Air Force Medical Service and our 60,000 Total Force medics. I'm looking forward to working with you during my tenure as Air Force Surgeon General. I pledge to do all in my power to support the men and women of the Armed Forces and this great country. Thank you for your immeasurable contributions to the success of our mission.

"Trusted Care Anywhere" is the Air Force Medical Service's vision for 2010 and beyond. In the domain of Air, Space and Cyberspace, our medics contribute to the Air Force, Joint, and coalition team with world class medical capabilities. Our 60,000 high performing Total Force medics around the globe are trained and ready for mission success. Over 1,600 Air Force medics are now deployed to 40 locations in 20 countries, building partnership capability and delivering state of the art preventive medicine, rapid life-saving care, and critical air evacuation. In all cases, these efforts are conducted with joint and coalition partners. At home, our health care teams assure patient-centered care to produce healthy and resilient Airmen, and provide our families and retirees with full spectrum health care.

Today's focus is on world-class health care delivery systems across the full spectrum of our operations. From theater hospitals in Balad and Bagram, to the efforts of humanitarian assistance response teams, to the care of our families at home, we put patients first. We are transforming deployable capabilities, building patient-centered care platforms, and investing in our people, the foundation of our success. We are expanding collaboration with joint and coalition partners to collectively strengthen rapid response capabilities. Globally, Air Force medics are diligently working to balance the complex demands of multiple missions in current and expanding areas of operations.

We are committed to advancing capabilities through education and training, research, and infrastructure recapitalization. Recent efforts in these areas have paid huge dividends, establishing new standards in virtually every major category of full spectrum care including humanitarian assistance. The strategic investments assure a trained, current, and deployable medical force today and tomorrow. They reinforce a culture of learning to quickly adapt medical systems and implement agile organizations to produce healthier outcomes in diverse mission areas.

While we've earned our Nation's trust with our unique capabilities and the expertise of our people, we constantly seek to do better! I would like to highlight our areas of strategic focus and share some captivating examples of Air Force medics in action.

#### **Transforming Expeditionary Medicine and Aeromedical Evacuation Capabilities**

Our success on the battlefield underscores our ability to provide "Trusted Care, Anywhere." The joint and coalition medical teams bring wounded warriors from the battlefield to an operating room within an unprecedented 20 to 40 minutes! This rapid transfer rate enables medics to achieve a less than 10 percent died-of-wounds rate, the best survival rate ever seen in war.

In late July, a British soldier sustained multiple gunshot wounds in Afghanistan. After being stabilized by medical teams on the ground, who replaced his blood supply more than 10 times, doctors determined the patient had to be moved to higher levels of care in Germany. It took two airplanes to get the medical team and equipment in place, another aircraft to fly the patient to Germany, three aircrews and many more personnel coordinating on the ground to get this patient to the next level of care. Every member of the joint casualty care and aeromedical

evacuation teams selflessly gave their all to ensure this soldier received the compassionate care he deserved. After landing safely at Ramstein Air Base in Germany, the soldier was flown to further medical care at a university hospital by helicopter. This case highlights the dedication and compassion our personnel deliver in the complex but seamless care continuum. This tremendous effort contributes to our unprecedented survival rate.

As evidenced in this story, our aeromedical evacuation system (AE) and critical care air transport teams (CCATT) are world-class. We mobilize specially trained flight crews and medical teams on a moment's notice to transport the most critical patients across oceans. Since November 2001, we have transported more than 70,000 patients from Afghanistan and Iraq.

We are proud of our accomplishments to date, but strive for further innovation. As a result of battlefield lessons learned, we have recently implemented a device to improve spinal immobilization for AE patients that maximizes patient comfort and reduces skin pressure. We are working toward an improved detection mechanism for compartment syndrome in trauma patients. The early detection and prevention of excess compartment pressure could eliminate irreversible tissue damage for patients. In February 2010, a joint Air Force and Army team will begin testing equipment packages designed to improve ventilation, oxygen, fluid resuscitation, physiological monitoring, hemodynamic monitoring and intervention in critical care air transport.

#### **Information Management/Information Technology**

Our Theater Medical Information Program Air Force (TMIP AF) is a software suite that automates and integrates clinical care documentation, medical supplies, equipment, and patient movement. It provides the unique capabilities for in-transit visibility and consolidated medical

information to improve command and control and allow better preventive surveillance at all Air Force deployed locations. This is a historic first for the TMIP AF program.

Critical information is gathered on every patient, then entered into the Air Force Medical Service (AFMS) deployed system. Within 24 hours, records are moved and safely stored at secure consolidated databases in the United States. During the first part of 2010, TMIP AF will be utilized in Aeromedical Evacuation and Air Force Special Operations areas.

#### **Expeditionary Medicine and Humanitarian Assistance**

We have also creatively developed our Humanitarian Assistance Rapid Response Team (HARRT), a Pacific Command (PACOM) initiative, to integrate expeditionary medical systems and support functions. The HARRT provides the PACOM Commander with a rapid response package that can deploy in less than 24 hours, requires only two C-17s for transport and can be fully operational within hours of arrival at the disaster site. This unique capability augments host nation efforts during the initial stages of rescue/recovery, thus saving lives, reducing suffering, and preventing the spread of disease. So far, HARRT successfully deployed on two occasions in the Pacific. Efforts are underway to incorporate this humanitarian assistance and disaster relief response capability into all AFMS Expeditionary Medical System (EMEDS) assets.

Air Force medics contribute significant support to the treatment and evacuation of Haiti earthquake victims. The Air Force Special Operations Command sent 47 medics to support AFSOC troops on the ground within 12 hours following the disaster to perform site assessments, establish preventive public health measures, and deliver life-saving trauma care to include surgical and critical care support. This team was also instrumental in working with Southern Command and Transportation Command to establish a patient movement bridge evacuating individuals from Haiti via air transport.



As part of the U.S. Air Force's total force effort, we sent our EMEDS platform into Haiti and rapidly established a 10-bed hospital to link the hospital ship to ground operations. The new EMEDS includes capabilities for pediatrics, OB/GYN and mental health. Personnel from five Air Force medical treatment facilities (MTFs) are supporting Operation Unified Response, as well as volunteers from the Air Reserve Forces.

### **Build Patient-Centered Care and Focus on Prevention to Optimize Health**

We are committed to achieving the same high level of trust with our patients at home through our medical home concept. Medical home includes initiatives to personalize care, and to improve health and resilience. We are also working hard to optimize our operations, reduce costs and improve patient access. We partner with our federal and civilian colleagues to continuously improve care to all our beneficiaries.

#### **Family Health Initiative**

To achieve better health outcomes for our patients, we implemented the Family Health Initiative (FHI). FHI mirrors the American Academy of Family Physicians' "Patient Centered Medical Home" concept and is built on the team-approach for effective care delivery. The partnership between our patients and their health care teams is critical to create better health and better care via improved continuity, and reduce per capita cost.

Our providers are given full clinical oversight of their care teams and are expected to practice to the full scope of their training. We believe the results will be high quality care and improved professional satisfaction. Two of our pilot sites, Edwards AFB, CA., and Ellsworth AFB, SD, have dramatically improved their national standings in continuity, quality, access to care, and patient satisfaction. Eleven other bases are implementing Medical Home, with an additional 20 bases scheduled to come on-line in 2010.

We are particularly encouraged by the results of our patient continuity data in Medical Home. Previous metrics showed our patients only saw their assigned provider approximately 50 percent of the time. At Edwards and Ellsworth AFBs, provider continuity is now in the 80-90 percent range.

We still have work to do, such as developing improved decision support tools, case management support, and improved training. Implementing change of this size and scope requires broad commitment. The Air Force Medical Service has the commitment and is confident that by focusing on patient-centered care through Medical Home, we will deliver exceptional care in the years ahead.

The Military Health System's Quadruple Aim of medical readiness, population health, experience of care and per capita cost serves us well. Patient safety remains central to everything we do. By focusing on lessons learned and sharing information, we continually strive to enhance the safety and quality of our care. We share our clinical lessons learned with the Department of Defense (DoD) Patient Safety Center and sister Services. We integrate clinical scenarios and lessons learned into our simulation training. We securely share de-identified patient safety information across the Services through DoD's web-based Patient Safety Learning Center to continuously improve safety.

**Improving Resilience and Safeguarding the Mental Health of Our Airmen**

Trusted care for our beneficiaries includes improving resilience and safeguarding their mental health and well-being. We are engaged in several initiatives to optimize mental health access and support.

Air Force post-deployment health assessment (PDHA) and post-deployment health re-assessment (PDHRA) data indicates a relatively low level of self-reported stress. However, about 20-30 percent of service members returning from OIF/OEF deployments report some form of psychological distress. The number of personnel referred for further evaluation or treatment has increased from 25 percent to 50 percent over the past four years, possibly reflecting success in reducing stigma of seeking mental health support. We have identified our high-risk groups and can now provide targeted intervention and training.

We recently unveiled "Defenders Edge," which is tailored to security forces Airmen who are deploying to the most hostile environments. This training is intended to improve Airmen mental resiliency to combat-related stressors. Unlike conventional techniques, which adopt a one-on-one approach focusing on emotional vulnerability, "DEFED" brings the mental health professional into the group environment, assimilating them into the security forces culture as skills are taught.

Airmen who are at higher risk for post traumatic stress are closely screened and monitored for psychological concerns post-deployment. If treatment is required, these individuals receive referrals to the appropriate providers. In addition to standard treatment protocols for post traumatic stress disorder (PTSD), Air Force mental health professionals are capitalizing on state-of-the-art treatment options using Virtual Reality. The use of a computer-generated virtual Iraq in combination with goggles, headphones, and a scent machine allow service members to receive enhanced prolonged exposure therapy in a safe setting. In January 2009, 32 Air Force Medical Service therapists received Tri-Service training in collaboration with the Defense Center of Excellence at Madigan Army Medical Center. The system was deployed

to eight Air Force sites in February 2009 and is assisting service members in the treatment of PTSD.

Future applications of technology employing avatars and virtual worlds may have multiple applications. Service member and family resiliency will be enhanced by providing pre- and post-deployment education; new parent support programs may offer virtual parent training; and family advocacy and addiction treatment programs may provide anger management, social skills training, and emotional and behavioral regulation.

#### **Rebuilding Our Capabilities by Recapturing Care and Reducing Costs**

Our patients appropriately expect AFMS facilities and equipment will be state-of-the art and our medical teams clinically current. They trust we will give them the best care possible. We are upgrading our medical facilities and rebuilding our capabilities to give patients more choice and increase provider satisfaction with a more complex case load. In our larger facilities, we launched the Surgical Optimization Initiative, which includes process improvement evaluations to improve operating room efficiency, enhance surgical teamwork, and eliminate waste and redundancy. This initiative resulted in a 30 percent increase in operative cases at Elmendorf AFB, Alaska, and 118 percent increase in neurosurgery at Travis AFB, California.

We are engaged in an extensive modernization of Wright-Patterson Air Force Base Medical Center in Ohio with particular focus on surgical care and mental health services. We are continuing investment in a state-of-the-art new medical campus for SAMMC at Lackland AFB, TX. Our ambulatory care center at Andrews AFB, MD, will provide a key capability for the delivery of world-class health care in the National Capital Region's multi-service market.

By increasing volume, complexity and diversity of care provided in Air Force hospitals, we make more care available to our patients; and we provide our clinicians with a robust clinical

practice to ensure they are prepared for deployed operations, humanitarian assistance, and disaster response.

#### **Partnering With Our Private Sector and Federal Partners**

Now more than ever, collaboration and cooperation with our private sector and federal partners is key to maximizing resources, leveraging capabilities and sustaining clinical currency. Initiatives to build strong academic partnerships with St. Louis University, Wright State University (Ohio); University of Maryland; University of Mississippi; University of Nebraska-Lincoln; University of California-Davis and University of Texas-San Antonio, among others, bolster research and training platforms and ultimately, ensures a pipeline of current, deployable medics to sustain Air Force medicine.

Our long history of collaborating with the Veterans Administration (VA) also enhances clinical currency for our providers, saves valuable resources, and provides a more seamless transition for our Airmen as they move from active duty to veteran status. The Air Force currently has five joint ventures with the VA, including the most recent at Keesler AFB, MS. Additional efforts are underway for Buckley AFB, CO, to share space with the Denver VA Medical Center, which is now under construction.

The new joint Department of Defense-Veterans Affairs disability evaluation system pilot started at Malcolm Grow Medical Center at Andrews AFB, MD in November 2007. It was expanded to include Elmendorf AFB, AK; Travis AFB, CA and Vance AFB, OK; and MacDill AFB, FL, in May 2009. Lessons learned are streamlining and expediting disability recovery and processing, and creating improved treatment, evaluation and delivery of compensation and benefits. The introduction of a single comprehensive medical examination and single-sourced

disability rating was instrumental to improving the process and increasing the transparency. Services now allow members to see proposed VA disability ratings before separation.

We continue to work toward advances in the interoperability of the electronic health record. Recent updates allow near real-time data sharing between DoD and Veterans Affairs providers. Malcolm Grow Medical Center, Wright-Patterson Medical Center, and David Grant Medical Center are now using this technology, with 12 additional Air Force military treatment facilities slated to come online. New system updates will enhance capabilities to share images, assessment reports, and data. All updates are geared toward producing a virtual lifetime electronic record and a nationwide health information network.

#### **Warrior and Survivor Care**

Our unwavering commitment to our wounded, ill, and injured Airmen and their families remains strong and we have hired 17 Recovery Care Coordinators (RCCs) at locations throughout the United States, with plans to add another 11 RCCs this year. RCCs have proven to be an invaluable asset to our wounded, ill, and injured Airmen and their families. Their development of comprehensive recovery plans to guide our Airmen through recovery, rehabilitation, and reintegration have been effective in helping our Airmen and their families adapt to the life-altering challenges they face as a result of service to our Nation. Our goal is to ensure RCCs are available to serve seriously wounded, ill, and injured Airmen throughout the country whether active duty, Air National Guard, or Air Force Reserve Airmen.

The Air Force has also changed personnel policies to reflect a more abilities-based approach with regards to assignments, retention, promotions, and retraining of our wounded Airmen. Our first priority is to offer combat wounded Airmen the opportunity to remain on active duty, should they desire. TSgt Del Toro, one of our most severely wounded Airmen,

reenlisted in February of this year and is now serving as a Tactical Control Recruiter and orientation instructor at Lackland Air Force Base. We have found that the combat experience of our heroic wounded Airmen is an asset we need to treasure and use to educate our Airmen.

The Air Wounded Warrior Program (AFW2) provides support and assistance to over 650 combat-injured Airmen, with a commitment of lifetime support. AFW2 consultants assist in a wide-variety of issues including transition assistance, benefits advisory service, employment counseling, and job placement services in the Air Force. The AFW2 program is growing by approximately 18 Airmen per month, and we plan to staff the program accordingly to ensure our Airmen continue to receive the best possible service and support.

Serious wounds, illness, and injuries to our Airmen are life-altering events for entire families. The Air Force philosophy is to provide the best possible care and service to the family structure that is affected by these life-altering events. We have a lifetime commitment to our Airmen and their families. Our medical and personnel communities work closely together to ensure we are meeting that commitment.

#### **Year of the Air Force Family**

This is the "Year of the Air Force Family," and we are working hand in hand with Air Force personnel and force management to ensure our Exceptional Family Member Program (EFMP) beneficiaries receive the assistance they need.

In September 2009, the Air Force sponsored an Autism Summit where educational, medical, and community support personnel discussed challenges and best practices. In December 2009, the Air Force Medical Service provided all Air Force treatment facilities with an autism tool kit. The kit provided educational information to providers on diagnosis and

treatment. Also, Wright-Patterson AFB, OH is partnering with Children's Hospital of Ohio in a research project to develop a comprehensive registry for autism spectrum disorders, behavioral therapies, and gene mapping.

The Air Force actively collaborates with sister Services and the Defense Center of Excellence for Psychological Health and Traumatic Brain injury (DCoE) to offer a variety of programs and services to meet the needs of children of wounded warriors. One recent initiative was the "Family Connections" website with Sesame Street-themed resources to help children cope with deployments and injured parents. In addition, DoD-funded websites, such as *afterdeployment.org*, providing specific information and guidance for parents/caregivers to understand and help kids deal with issues related to deployment and its aftermath.

Parents and caregivers also consult with their child's primary care manager, who can help identify issues and refer the child for care when necessary. Other resources available to families include counseling through Military OneSource, Airman and Family Readiness Centers, Chaplains, and Military Family Life Consultants--all of whom may refer the family to seek more formal mental health treatment through consultation with their primary care manager or by contacting a TRICARE mental health provider directly.

## **Investing in Our People: Education, Training, and Research**

### **Increased Focus on Recruiting and Retention Initiatives**

To gain and hold the trust of our patients, we must have highly trained, current, and qualified providers. To attract those high quality providers in the future, we have numerous efforts underway to improve recruiting and retention.



We've changed our marketing efforts to better target recruits, such as providing Corps-specific DVDs to recruiters. The Health Profession Scholarship Program remains vital to attracting doctors and dentists, accounting for 75 percent of these two Corps' accessions. The Air Force International Health Specialist program is another successful program, providing Air Force Medical Service personnel with opportunities to leverage their foreign language and cultural knowledge to effectively execute and lead global health engagements, each designed to build international partnerships and sustainable capacity.

The Nursing Enlisted Commissioning Program (NECP) is a terrific opportunity for Airmen. Several Airmen have been accepted to the NECP, completed degrees, and have been commissioned as Second Lieutenant within a year. To quote a recent graduate, 2<sup>nd</sup> Lt. April C. Barr, "The NECP was an excellent way for me to finish my degree and gave me an opportunity to fulfill a goal I set as a young Airman...to be commissioned as an Air Force nurse."

For our enlisted personnel, targeted Selective Reenlistment Bonuses, combined with continued emphasis on quality of life, generous benefits, and job satisfaction have positively impacted enlisted recruiting and retention efforts.

#### **Increasing Synergy to Strengthen GME and Officer/Enlisted Training**

We foster excellence in clinical, operational, joint and coalition partner roles for all Air Force Medical Service personnel. We are increasing opportunities for advanced education in general dentistry and establishing more formalized, tiered approaches to Medical Corps faculty development. Senior officer and enlisted efforts in the National Capital Region and the San Antonio Military Medical Center are fostering Tri-Service collaboration, enlightening the Services to each others' capabilities and qualifications, and establishing opportunities to develop and hone readiness skills.

The Medical Education and Training Campus (METC) at Fort Sam Houston, Texas, will have a monumental impact on the Department of Defense and all military services. We anticipate a smooth transition with our moves completed by summer 2011. METC will train future enlisted medics to take care of our service members and their families and will establish San Antonio as a medical training center of excellence.

Our Centers for the Sustainment of Trauma and Readiness Skills at St. Louis University, University of Maryland-Baltimore Shock Trauma and University of Cincinnati College of Medicine remain important and evolving training platforms for our doctors, nurses and medical technicians preparing to deploy. We recently expanded our St. Louis University training program to include pediatric trauma. Tragically, this training became necessary, as our deployed medics treat hundreds of children due to war-related violence.

Partnerships with the University Hospital Cincinnati and Scottsdale, AZ, trauma hospitals allow the Air Force's nurse transition programs to provide newly graduated registered nurses 11 weeks of rotations in emergency care, cardiovascular intensive care, burn unit, endoscopy, same-day surgery, and respiratory therapy. These advanced clinical and deployment readiness skills prepare them for success in Air Force hospitals and deployed medical facilities, vital to the care of our patients and joint warfighters.

#### **Setting Clear Research Requirements and Integrating Technology**

Trusted care is not static. To sustain this trust, we must remain agile and adaptive, seeking innovative solutions to shape our future. Our ongoing research in procedures, technology, and equipment will ensure our patients and warfighters always benefit from the latest medical technologies and clinical advancements.

Air Force Medical Service vascular surgeons, Lieutenant Colonels Todd Rasmussen and William “Darrin” Clouse, have completed 17 research papers since 2005 and edited the vascular surgery handbook. On January 10, 2009 a U.S. Marine sustained bilateral posterior knee dislocations with subsequent loss of blood flow to his lower legs following an improvised explosive device attack in the Helmand Province. Casualty evacuation delivered the Marine to our British partners at Camp Bastion, a level II surgical unit within an hour. At Bastion, British surgeons applied knowledge gained from combat casualty care research and restored blood flow to both legs using temporary vascular shunts. Medical evacuation then delivered the casualty to the 455<sup>th</sup> Expeditionary Medical Group at Bagram. Upon arrival, our surgeons at Bagram performed definitive vascular reconstruction and protected the fragile soft tissue with negative pressure wound therapy. The Marine is currently recovering at the National Military Medical Center in Bethesda and is expected to have functional limbs.

In another example, a 21-year-old Airman underwent a rare pancreatic autotransplantation surgery at Walter Reed Army Medical Center (WRAMC) to salvage his body’s ability to produce insulin. The airman was shot in the back three times by an insurgent at a remote outpost in Afghanistan. The patient underwent two procedures in Afghanistan to stop the bleeding, was flown to Germany, then to WRAMC. Army surgeons consulted with University of Miami’s Miller School of Medicine researchers on transplantation experiments. The surgeons decided to attempt a rare autotransplantation surgery to save the remaining pancreas cells. WRAMC Surgeons removed his remaining pancreas cells and flew them over 1,000 miles to the University of Miami Miller School of Medicine. The University of Miami team worked through the night to isolate and preserve the islet cells. The cells were flown back

to WRAMC the next day and successfully implanted in the patient. The surgery was a miraculous success, as the cells are producing insulin.

These two cases best illustrate the outcome of our collaborations, culture of research, international teamwork, innovation, and excellence.

### **Shaping the Future Today Through Partnerships and Training**

Under a new partnership with the University of Illinois at Chicago, we are researching directed energy force protection, which focuses on detection, diagnosis and treatment of directed energy devices. We are exploring the discovery of biomarkers related to laser eye injuries, development of films for laser eye protection and the development of a “tricorder” prototype capable of laser detection and biomarker assessment. Additional efforts focus on the use and safety of laser scalpels and the development of a hand-held battery operated laser tool to treat wounds on the battlefield.

We continue our seven-year partnership with the University of Pittsburgh Medical Center to develop Type II diabetes prevention and treatment programs for rural and Air Force communities. Successful program efforts in the San Antonio area include the establishment of a Diabetes Center of Excellence, “Diabetes Day” outreach specialty care, and efforts to establish a National Diabetes Model for diabetic care.

Another partnership, with the University of Maryland Medical Center and the Center for the Sustainment of Trauma and Readiness Skills (C-STARS) in Baltimore is developing advanced training for Air Force trauma teams. The project goal is to develop a multi-patient trauma simulation capability using high fidelity trauma simulators to challenge trauma teams in rapid assessment, task management, and critical skills necessary for the survival of our wounded

warriors. A debriefing model is being developed to assist with after action reviews for trauma team members.

Radiofrequency technology is contributing to medical process improvements at Keesler AFB, MS. Currently, Keesler AFB is analyzing the use of automatic identification and data capture (AIDC) in AFMS business processes. The AIDC evaluation focuses on four main areas: patient tracking, medication administration, specimen tracking, and asset management. Further system evaluation and data collection is ongoing in 2010 with an expansion of AIDC use in tracking automated data processing equipment.

### **Conclusion**

As a unique health system, we are committed to success across the spectrum of military operations through rapid deployability and patient-centered care. We are partnering for better outcomes and increasing clinical capacity. We are strengthening our education and training platforms through partnerships and scanning the environment for new research and development opportunities to keep Air Force medicine on the cutting edge.

We will enhance our facilities and the quality of health care to ensure health and wellness of all entrusted to our care. We do all this with a focus on patient safety and sound fiscal stewardship. We could not achieve our goals of better readiness, better health, better care and reduced cost without your support, and so again, I thank you.

In closing, I share a quote from our Air Force Chief of Staff, Gen. Norton A. Schwartz, who said, "I see evidence every day the Medical Service is *"All In,"* faithfully executing its mission in the heat of the fight, in direct support of the warfighter, and of families back home as well." I know you would agree that "All in" is the right place to be.



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**WITNESS RESPONSES TO QUESTIONS ASKED DURING  
THE HEARING**

APRIL 21, 2010

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#### **RESPONSE TO QUESTION SUBMITTED BY MRS. DAVIS**

Dr. RICE. The initial report on progress made in undertaking actions to enhance the Military Health System (MHS) and improve the TRICARE program as required in Section 721 of the National Defense Authorization Act for Fiscal Year 2010 has been drafted and is in the coordination process.

A high-level working group was formed to address the report requirements and included representatives from a number of MHS entities. The initial report describes the progress made and future plans for improvement of the MHS. DoD senior leadership provided further guidance to the subject matter experts working on the areas Congress requested DoD study and consider planning to improve access to care.

Note: Representatives from MHS entities include:

- Chief, Policy and Operations Branch, TRICARE Policy and Operations Directorate (TPOD)
- Director, DoD/VA Program Coordination Division
- Chief, Purchased Care Systems Integration Branch, TPOD
- Deputy Chief, Human Capital Office OASD(HA)
- Program Director, Health Budgets and Financial Plans OASD(HA)
- Director, Operations Division, TPOD
- Director, Strategic Communications and Transformation OASD(HA)
- Director, Population Health and Medical Management, Office of the Chief Medical Officer
- Chief, Program Evaluation Branch, TPOD
- Chief, TRICARE Operations Center
- Deputy Chief, TRICARE Division
- Army Medical Department (AMEDD) One Staff
- Offices of the Service Surgeons General

[See page 12.]

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#### **RESPONSE TO QUESTION SUBMITTED BY MS. SHEA-PORTER**

General SCHOOMAKER. Surveillance documents, laboratory data, and field notes are available for future use to investigate the occupational and environmental health risks of respective burn pits. The US Army Public Health Command (Provisional) is the designated DoD lead agent for archiving all deployment occupational and environmental health (OEH) surveillance data for US military operations. It maintains the DoD OEH surveillance documents in Internet-based unclassified and classified document libraries identified as the deployment OEH surveillance data portal. US Army Public Health Command (Provisional) has a separate DoD database for archiving all of the laboratory data and associated field notes for deployment samples (e.g., air, water, soil) sent to the Army Public Health Command for analysis. This sample database is identified as the Defense Occupational and Environmental Health Readiness System—Environmental Health Module. [See page 19.]

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#### **RESPONSE TO QUESTION SUBMITTED BY DR. FLEMING**

Dr. RICE. By law, Title 10 United States Code Section 1079(h)(1), TRICARE's payment for a charge for services by an individual health care professional must be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services by Medicare. Statute permits TRICARE reimbursement rates to be less than Medicare rates when providers have agreed to give network discounts. In addition, there is statutory authority to set TRICARE rates above Medicare rates if necessary

to obtain an adequate network of providers or to prevent severe access to care deficiencies. [See page 17.]

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**RESPONSE TO QUESTION SUBMITTED BY MS. TSONGAS**

General GREEN. Based on my understanding of NDAA 2010, Section 702, when Guard/Reserve members receive federal delayed-effective-date active duty orders for more than 30 consecutive days in support of a contingency operation, the service member and their family are eligible for TRICARE. TRICARE coverage will begin the date the order was issued or 180 days prior to activation date, whichever is later. Current TRICARE coverage is for 90 days prior to activation date.

As Dr. Rice mentioned, Reserve Affairs will be sending out the DOD policy to enforce this change. Although eligibility determination belongs to Air Force Manpower & Personnel (AF/A1), the Air Force Medical System (AFMS) will work with AF/A1 to ensure full compliance across the Air Force. We have verified that the implementation date is projected for 1 Oct 10.

Once implemented, Guard/Reserve members will need to register their family members and their records in the Defense Enrollment Eligibility Reporting System (DEERS) through the nearest service personnel office, ID card-issuing facility or DEERS Support Office. Once eligibility verification is made by AF/A1 and is accurately reflected in DEERS, the AFMS is prepared to provide the medical care to all eligible members and their dependents. [See page 21.]

