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THE STATE OF THE MILITARY HEALTH CARE SYSTEM

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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THE STATE OF THE MILITARY HEALTH CARE SYSTEM

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Tuesday, March 27, 2007.

The subcommittee met, pursuant to call, at 9:05 a.m., in room 2212, Rayburn House Office Building, Hon. Vic Snyder (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, CHAIRMAN, MILITARY PERSONNEL SUBCOMMITTEE

Dr. SNYDER. The hearing will come to order.

I want to welcome our guests today and folks attending. We obviously have Major General Pollock, the Acting Surgeon General of the Army, Vice Admiral Arthur, Surgeon General of the Navy, and Lieutenant General—I need you to pronounce your last name for me.

General ROUDEBUSH. Yes, sir, Roudebush.

Dr. SNYDER. Roudebush. I thought that is what it was.

General ROUDEBUSH. Yes, sir.

Dr. SNYDER. But you and I had been friends long enough, I thought I didn't want to mess it up here.

General ROUDEBUSH. Thank you, sir.

Dr. SNYDER. Lieutenant General Roudebush, Surgeon General of the Air Force.

We appreciate you all being here.

This is General Pollock's first appearance before this committee in this role. And we appreciate you being here today, General.

And this may be Admiral Arthur's last time, although the full committee not long ago bid goodbye to General Schoomaker, and he returned, like, two weeks later.

So this may be your last time here. We certainly appreciate your years of service to your country and to the Navy.

And, of course, we can't discuss the current state of the military health care system without acknowledging the events of the last few weeks. The stories that have come, the reports out of Walter Reed Army Medical Center showed our failure to properly care for all of our wounded warriors in the way that we all want. And when I say "our," it is a joint problem for this country. It is all of our issue and all of our responsibility.

In order to have an open and honest dialogue, we need to understand both the challenges the system faces and the solutions the Department of Defense (DOD) and the services have proposed. Our military medics face growing requirements as far into the future as

we can see. They will continue to support operations in Iraq, Afghanistan, and the global war on terror. They will also need to support the expansion of the Army and Marine Corps.

While they are doing all of these things, however, the military medical departments are being required to cut costs. They are being tasked to find "efficiencies" in the system to the tune of $248 million in fiscal year 2008. They are further required to convert military medical positions to civilian ones, frequently reducing the overall number of medical professionals in the process.

We have no doubt that our dedicated military personnel will devote all of their efforts to accomplish their assigned missions. But there is concern that they are not being given the resources they need, not want, but need to fully support our Nation's military forces.

And we appreciate you being here. You are the first of two panels today.

I also want to introduce David Kildee, who this is his first time in this staff position sitting here.

And please prepare to fire off red flares, Mr. McHugh, if you and I get in trouble and he doesn't know what to do. So Jeanette will come racing over here to——

Mr. MCHUGH. I hope you have got a lot of them. [Laughter.]

Dr. SNYDER. A lot of them.

And with that, I would like to yield to Mr. McHugh for any comments he would like to make.

STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE FROM NEW YORK, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. MCHUGH. Thank you, Mr. Chairman. And I would ask my entire statement be entered into the record in its entirety.

Dr. SNYDER. Without objection.

Mr. MCHUGH. I certainly want to add my words of welcome to our distinguished guests.

I think, Mr. Chairman, you said an appropriate potential farewell to the good admiral. But whether it is his last or not, I will certainly add to your comments about our deep appreciation for all that he has done.

And a word of special welcome to General Pollock, who not only joins us in her first hearing as the new surgeon general for the United States Army, but also comes, I am told by Jeanette James, who was the general's successor as the Medical Department Activity (MEDAC) medical commander up at Fort Drum for the 10th Mountain Division, she is also the first nurse to work her way and earn her way into this esteemed position.

Although, general, very challenging times, we certainly congratulate you on your appointment and look forward to your progress and cooperation and participation in this partnership, as the chairman said, in the days ahead.

Mr. Chairman, I would echo as well your comments about the broad range of challenges we face. You mentioned efficiency wedges, a fine phrase, if you will, for cuts. And it is really just the proverbial tip of the iceberg. If you look at the expected or anticipated savings placed against other costs in the medical system, we

are looking at over $2 billion in efficiency wedges and cuts and savings that all mean we have got a great uphill battle to meet the demands of the budget.

Civilian conversions from military positions—there are funds for an additional 2,700-plus positions for conversion at a time when we have already converted over 5,500. And I think it is appropriate, we begin to wonder what effect this is going to have on our ability to continue to provide a robust military health system carry out its mission. And certainly given our witnesses' expertise in their medical professions, we look forward to their perspective on those kinds of things.

And last, Mr. Chairman, you are absolutely right. We need to focus all of our abilities and resources on Walter Reed and the larger medical hold, medical holdover system in the medical care system for all of our wounded warriors. None of us, no American, wants to see these brave heroes who have given all of us so much to get anything less than the quality care that we expect them to be treated with.

So with that, we look forward to the panels here today. And, Mr. Chairman, I would yield back.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 65.]

Dr. SNYDER. Thank you, Mr. McHugh.

What we will do, I am going to have David put the five-minute clock on. But that is just to give you an idea where you are at. When you see that red light go on, if you have still got more things that you think we need to know, you go ahead and continue.

We will begin with General Pollock and then go to Admiral Arthur and then to General Roudebush.

So, General Pollock, the floor is yours.

STATEMENT OF MAJ. GEN. GALE S. POLLOCK, ACTING SURGEON GENERAL, DEPARTMENT OF THE ARMY, U.S. ARMY

General POLLOCK. Mr. Chairman, Congressman McHugh, and distinguished members of the subcommittee, thank you for the opportunity to discuss the current posture of the Army Medical Department.

Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, and reassuring them that the health of their families is also secure.

Army medicine is an integral part of Army readiness. Army medics are deployed around the world supporting our Army in combat, participating in humanitarian assistance missions, and training throughout the world. Like the rest of the Army, this operations tempo is beginning to take its toll on the people and equipment who are vital to its success.

The toll has been high in terms of cost and human sacrifice. Army medics have earned 220 awards for valor and more than 400 Purple Hearts. One hundred and two Army Medical Department (AMEDD) personnel have given their lives in Iraq or Afghanistan. These men and women are truly the best our Nation has to offer

and will make any sacrifice in defense of their nation and most importantly, for the care of their patients.

We recently hosted a human capital strategy symposium to address growing concerns within Army medicine about accessions, retention, and including well-being issues, which have a direct impact on morale. We have established a 180-day deployment policy for select specialties, established a physician assistant critical skills retention bonus, increased the incentive special pay for certified registered nurse anesthetists, and expanded the use of the health professions loan repayment program.

Fiscal year 2006 presented Army medicine with challenges in recruiting health care providers. The Army fell short of its goals for awarding health profession scholarships in both the medical corps and dental corps. These scholarships are by far the most important source of accessions for physicians and dentists. And this presents a long-term manning challenge beginning in fiscal year 2009.

The Reserve Office Training Corps, or ROTC, is a primary accession source for the Army Nurse Corps. In recent years, ROTC has had challenges in meeting the required number of nurse corps accessions. And as a consequence, the U.S. Army Recruiting Command was asked to recruit a larger number of direct accession nurses to fill the gap. This has been extremely difficult in a difficult and competitive market. In fiscal year 2006, recruiting command achieved only 84 percent of its mission for Army Nurse Corps officers.

The reserve components provide over 60 percent of Army medicine's force structure. And we have relied heavily on these citizen soldiers during the last four years. And they have performed superbly.

But accessions and retention in the Army National Guard and Reserve continue to be a challenge. Working with the chief of the Army Reserve and director of the Army National Guard, we continue to explore ways to improve reserve component accessions and retention for this important group.

We seek to quickly integrate lessons learned from the battlefield into health care training and doctrine, not only in military medicine, but throughout civilian facilities as well. Army medicine continues to lead the Nation in adopting new trauma casualty management techniques. Since 2003, we have provided rapid fielding of improved tourniquets, new pressure dressings, and the use of hemostatic bandages that promote clotting.

I know you are aware that traumatic brain injury (TBI) has emerged as a common blast-related injury. TBI is a broad grouping of injuries that range from mild concussions to penetrating head wounds. An overwhelming majority of TBI patients have mild and moderate concussion syndromes with symptoms not different from those experienced by athletes with a history of concussion. Many of these symptoms are similar to post-traumatic stress symptoms (PTSD), especially the difficulty concentrating and irritability.

Through your continued support, we will quickly develop a better understanding of TBI from scientific research, including acute diagnosis, treatment, and long-term rehabilitation. You are well-aware of the challenges involved in managing this health care delivery

system, as highlighted in the recent *Washington Post* articles about conditions at Walter Reed Army Medical Center.

The *Post* series highlighted brick-and-mortar problems that should have been identified and fixed by our leaders at Walter Reed. But more challenging, the *Post* series articulated soldiers' frustration with a bureaucratic disability evaluation system that truly needs an overhaul.

We have not waited to correct the problems identified at Walter Reed. I have a tiger team out assessing all of our facilities to ensure that there is not another Building 18 out there and that any other concerns are identified and quickly resolved.

Within two weeks of the *Washington Post* series, every soldier who had been living in Building 18 had been moved out. And the Corps of Engineers was awarded a contract to replace the roof on the building. We will evaluate future uses of the building before we decide to invest on additional renovations.

We are improving the transition from in-patient care to out-patient care for our warriors at Walter Reed and across Army medicine. We quickly established a wounded warrior transition brigade led by experienced combat veterans to focus on the unique command and control requirements of patient management as opposed to the day-to-day command of soldiers assigned to the staff at Walter Reed. The leadership of this brigade down to the platoon sergeant level is supported by the line Army so that now the medics at Walter Reed can focus on patient care responsibilities they were assigned to Walter Reed to perform.

We took the painful lessons learned at Walter Reed and implemented an Army-wide action plan for improvement. This plan includes a wounded soldier and family hotline, an 800 number which began operations last Monday on the 19th. As of the 25th, we had received 315 calls detailing 179 issues ranging from medical care to personnel to finance.

We have already researched and resolved 29 of the 56 complaints received about Army Medical Command areas of responsibility. Seven of those calls were for information only. But these issues are quickly elevated to the Army leaders. And calls are returned by an expert in the topic area within 24 hours.

We are also implementing a one-stop soldier and family assistance center at Walter Reed. This center combines case managers, family coordinators, personnel and finance experts, and representatives from key support and advocacy organizations such as the Army Wounded Warrior Program, the Red Cross, Army Community Services, the Army Relief Fund, and the Department of Veterans Affairs. We are also hiring patient advocates across the AMED and establishing an ombudsmen program, first at Walter Reed and then across the Army.

We are revamping the administrative processes of evaluating and adjudicating our soldiers' disabilities. Our goal is to streamline the process to eliminate confusion among soldiers and families. As we make these changes, we must not compromise the quality of medical care received or the soldiers' right to a full and thorough medical evaluation.

We will need Congress's support to make some of the necessary changes. As we identify those areas that need legislative change,

we will bring them forward for your consideration. We will ensure that soldiers no longer feel that when they leave the resources and attention of our health care system behind, when they are discharged from the hospital, that people don't care.

I am grateful to the Congress for the concern and attention paid to soldiers and their families. And I will keep Congress informed as we improve these processes.

In closing, let me emphasize that the service and sacrifice of our soldiers and their families cannot be measured with dollars and cents. The truth is we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss.

Thanks to your support, we have been very successful in developing and sustaining a health care delivery system that honors the commitment our soldiers, retirees, and their families make to our Nation.

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

[The prepared statement of General Pollock can be found in the Appendix on page 68.]

Dr. SNYDER. Thank you, General Pollock.

Admiral Arthur.

STATEMENT OF VICE ADM. DONALD C. ARTHUR, SURGEON GENERAL, DEPARTMENT OF THE NAVY, U.S. NAVY

Admiral ARTHUR. Yes, good morning.

Dr. SNYDER. Good morning.

Admiral ARTHUR. And, Dr. Snyder, Ranking Member McHugh, other distinguished members of the panel, thank you very much for your kind wishes on my announced retirement in August. It has been an honor to serve for these 33 years and to come and represent the Navy in this committee.

I joined the Navy in the 1970's when we had some significant problems with health care quality. We had a draft service. We had the Berry plan. We had other plans that brought into our service the top health care providers that we have today.

We suffered through some of those problems in the 1980's. The best of our people stayed and made what I think is the best health care enterprise in the world today. Both Army, Navy, and Air Force systems, I think, have the highest quality we can have.

In our Medical Treatment Facility (MTF), you can get quality care that is focused on the patient. I like to say that we never ask our patients how sick they can afford to be because we give the right care every single time. And what a pleasure it has been to have a patient population that is composed of 100 percent patriots.

We have some of the greatest graduate medical, dental, and nursing education programs in the United States ranking in the top ten for many of our programs. The quality of the care, the quality of the education is extraordinarily high.

We also deliver the best care in the world where it counts the most, in combat service support. We have the lowest disease and non-battle injury rate in history. That is the rate of illnesses and injury in a combat zone that are not due to combat but to other illnesses and injuries. We are also resuscitating people from injuries that in prior wars would have been fatal. The average stay for

a casualty who comes back to Bethesda in the intensive care unit is 7.5 days. The average time in a hospital is 109 days.

How people that badly injured are able to get off a battlefield and survive their injuries is nothing short of miraculous. It is due to many factors: the quality of care that we have, the surgeons far up front, the nursing staff that are right there on the battlefield.

But I would say the overwhelming reason why we have the resuscitation rate that we do is the Navy, corpsmen and by extension, the Air Force and Army's medics who are on the field and give the first level of care. They have either seen a Marine or soldier who has been injured or they have trained another Marine or soldier to deliver that combat care.

Unless a wounded veteran gets to a surgeon with a heartbeat, he will not survive. And it is our corpsmen and by extension the medics who ensure that. They are the best they have ever been.

I want to say a special warm thanks to the Air Force's critical care air transport teams that make it possible to get all of these critically injured patients from the battlefield to Landstuhl and then Landstuhl back to the states. And a special thank you to the Army's wonderful facility at Landstuhl, which we are proud to have one-quarter of the staff as Navy personnel. This was a recent addition to their armamentarium.

I want to especially recognize Landstuhl because unlike Walter Reed, Bethesda, and all of our other facilities back at Continental United States (CONUS), the folks at Landstuhl get to see all of the casualties in their newly injured states. They don't have the advantage of seeing them walk out, see their families reunited, and to see the wonderful cures. They day after day see injured sailors, Marines, airmen and soldiers and, I think, have extraordinary challenges. My hat is off to the staff of the Landstuhl Army Regional Medical Center.

We do have special challenges, as General Pollock mentioned, especially in traumatic brain injury, post-traumatic stress. When I first took this job, someone gave me a brief that said 15 percent of people who go into combat are significantly affected by the experience. And I said, "That is wrong. One hundred percent of people who are in combat are significantly affected by the experience."

The closer you are to combat, the closer you are to the actual fighting, the breaking in of the doors at Fallujah, the more affected you are. And we have to recognize that this is a debt that all of these young men and women are gaining in combat that we need to repay by paying attention to their needs as they come home.

Traumatic brain injury is an especially difficult entity for us to define right now. We are just coming to the realization that blast injuries, the concussive injuries, especially multiple concussive injuries, have an affect on the brain, on cognitive function that we had not anticipated before and that we have to now define what that is. It is similar to, but not exactly like, the concussive injury in sports players and other people who have a direct blow to the head. These concussive injuries can give you very subtle symptoms that often are not amenable to diagnosis with standard tests.

They can be difficulty with memory, difficulty with mood, inability to make a decision on a menu. And we have veterans who get lost in supermarkets from their traumatic brain injury effects. We

need to do a better job of defining it, to following these people, to being able to give them the right treatment based on their symptoms.

As good as we are today, we can be better. I think a unified or joint approach to health care would benefit us all so that we have common financial systems, common logistics, common communication, common doctrine. And we are working toward that, but I think we have a long way to go. And we could certainly do better.

Another area where we are working very hard and I think we are making great strides is with DOD and the Department of Veterans Affairs (VA) interface for our veterans. And one of the examples I would give is the facility at Great Lakes. The Naval Hospital and the VA facility at Great Lakes have combined. They have combined their leadership, their clinical staffs, their laboratory, their X-ray. And we now have as close as we can get at the moment a joint facility with the Veterans Administration.

We do have some challenges that I would be happy to discuss.

Dr. Snyder, you mentioned the efficiency wedges. We have other wedges and reductions. And by what other name you want to call them, they are reductions in our funding. For us in fiscal year 2008 is $343 million out of a $2.7 billion budget.

We have challenges in personnel. We have program budget decision 712 that you know well, that has asked us to make military to civilian conversions. We are only able to make about 83 percent of those conversions at the moment, despite an intense effort to do so.

We also have the program decision memorandum number 4 that mandated 901 additional cuts, not conversions. And this year, we will have 489 people that we will cut from our roles beginning October 1, 2007. In addition to those cuts, the budget wedges, efficiencies, reductions will necessarily result in a decrease in our contracting funds, further adding to our challenges with providing the right personnel to staff our facilities and be ready to support combat operations.

We have gone through the quadrennial defense review and its medical readiness requirements review. And in that process, many of our future requirements were minimized, especially in areas of homeland defense and humanitarian assistance. That concerns me.

We also addressed fatigue of our deployers. We have a great number of our corpsmen, doctors, nurses, dentists who are deploying and not just once or twice, but three, four times. And this operational tempo for a very combat trauma resuscitative, intensive war does cause fatigue in our providers.

Mr. Chairman, thank you very much for the honor of being here today. It has been a pleasure to serve. And I thank you for allowing me to give my statement.

[The prepared statement of Admiral Arthur can be found in the Appendix on page 84.]

Dr. SNYDER. Thank you, Admiral Arthur.

General Roudebush.

STATEMENT OF LT. GEN. (DR.) JAMES G. ROUDEBUSH, SURGEON GENERAL, DEPARTMENT OF THE AIR FORCE, U.S. AIR FORCE

General ROUDEBUSH. Mr. Chairman, Congressman McHugh, distinguished members of the committee, it is really a privilege and honor for me to be here today to tell you about Air Force medicine on the battlefield and at home station.

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

We build a healthy, fit force fully prepared to execute the mission from each of our bases whether deployed or here in the states because every Air Force base is, in fact, an operational platform.

Whether launching bombers from Whiteman Air Force Base or sitting alert in a missile control facility at F.E. Warren Air Force Base, or providing close air support from Balad Air Base in Iraq, we protect our power for our joint forces and provide sovereign options for our national leadership from our bases. Air Force medicine supports that warfighting capability at each of our bases and is, in fact, designed to prevent casualties and sustain our fighting strength. The result is the lowest disease non-battle injury rate in the history of warfare.

But when there are casualties, whether they be airmen, soldiers, sailors or Marines, your Air Force medics are there with worldclass care. In the deployed arena, our medical teams operate closer to the front than ever before allowing us to provide our warfighters advanced medical care within minutes. Underpinning this worldclass health care for our joint warfighters is our system of joint en route care.

It begins with a Navy corpsman or an Army medic providing life-saving first aid at that point of injury. The casualty is then moved to the next level of care for us at our theater hospital at Balad Air Base, the hub of the joint theater trauma system where life-saving damage control surgery is performed by Air Force surgeons and on occasion, teaming with Army surgeons. The casualty is then prepared for safe and rapid movement in our Air Force air medical evaluation system to Landstuhl, an Army hospital manned by Army, Navy, and Air Force medics.

Re-triage and restabilization is accomplished. And the casualty is prepared for air evacuation back to definitive care at Walter Reed, Bethesda, Wolford Hall, Book Army, Navy Balboa, or perhaps a VA hospital. These capabilities combined to create an average patient movement time of three days from battlefield to stateside care.

That is truly remarkable when compared to the 10 to 14 days required during the Gulf War or an average of 45 days it took in Vietnam. And it is especially remarkable when you consider the severity and complexity of the wounds that our forces are sustaining.

In short, Air Force medicine is a key and central player in the most effective joint casualty care and management system in military history. Having just returned from Afghanistan and Iraq, I have personally observed this capability from that far forward care all the way home to the states. And it is truly life-saving care.

As our casualties move back through Landstuhl and on to our stateside military medical centers, our Air Force casualties are followed closely by their unit through an assigned family liaison officer, a member of their unit, to ensure that the needs of the casualty and their family are met. And if going through the disability evaluation process is the next step for our wounded airmen, the Air Force HEART program ensures the commander, the medics and the family liaison officer continue, eyes on and hands on, throughout the disability process.

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

And as we focus on care for our warfighters, I believe it is also very important to note that caring for the families of our airmen is a mission critical factor. Knowing that their loved ones are well-cared for back at home gives our airmen the peace of mind to do a critical job in a stressful and dangerous environment.

The care we provide is a very important factor in building that trust that is fundamental to attracting and retraining an all-volunteer force. This demanding operations tempo at home and deployed also means that we have to take care of our Air Force medics. This requires finding a balance between these extraordinarily demanding duties, time for personal recovery and growth, and time for family.

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

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

Globally, we have provided compassionate care to 1.5 million people on humanitarian missions over the past six years. And at home station we continue to provide high-quality health care for three million patients every year.

It is clear that we have challenges. But these challenges represent an opportunity. And we have the responsibility to step up to that opportunity to assure that our processes and our capabilities are precisely what those who go in harm's way both need and deserve and that we take care of their families as well.

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

Thank you.

[The prepared statement of General Roudebush can be found in the Appendix on page 103.]

Dr. SNYDER. Thank you, General Roudebush.

What we will do now is David is going to put the five-minute clock on us, and Mr. McHugh and I follow it pretty closely. And we will just go down the line here. But I suspect we will go at least two, if not a third round. So when we get to Ms. Shea-Porter, your day is not over. We will come back and start over again.

I would like to start.

We appreciate your testimony.

Admiral, you brought up this issue of efficiencies. You had such an artful sentence in your written statement on page two, in which you state, "Fiscal year 2008"—you need to put the clock on now, David—"Fiscal year 2008 provides funding challenges in that the efficiency wedge increases in certain assumptions regarding savings opportunities may not be borne out in execution."

I thought that was a very artfully crafted sentence that I think if I am an enlisted guy or a junior officer and I read that, I think we are going to get screwed. Something bad is going to happen. And you brought that up. And I appreciate you acknowledging it is a problem this committee, as Mr. McHugh articulated very well, has been very concerned about.

The question for us is, what do we do? You know, we usually say we are here to help you do your job. But you all are receiving some mandates, not from us, but from others that are making your mission difficult.

So, I mean, we are here on this committee heading into the defense bill. This is a great committee. We are short some Republican members. They are having a conference, a very important meeting today. But we are all unified in our efforts to help you. So what is our response?

I mean, what do you suggest for us, Admiral Arthur, in terms of how do we deal with this? In fact, you upped the ante. We thought it was $248 million. And you said it is $343 million that we are looking at. That is a lot of pressure on the folks at the lower end of the chores that you want to get done.

Admiral ARTHUR. Yes, sir. My figure is we have $147 million in what is called an efficiency wedge, which has no granularity to it. It is a rough figure that health affairs has given us. We have——

Dr. SNYDER. I don't know what you mean by no granularity. Do you mean it is not any detail, nobody has come and just said do this?

Admiral ARTHUR. No, no. Correct. There is a requirement to fund the private-sector care. And funds are being removed from the direct care system to fund the private-sector care. Now, the law was created by this forum to prohibit money from going from direct care to private-sector care during the year of execution. However, this is a creative way to do it in the Program Objective Memorandum (POM).

So in the POM this year we have $147 million in an efficiency wedge. And it is interesting that whenever we highlight efficiencies, they are taken off and the efficiency wedge still remains in its $147 million form. We have a reduction in pharmacy services of $127 million, facility renovation and upkeep reductions of $422 million, and a reduction in our end strength, which results in a

900-person cut in our staffing over the next few years. This year will be $47 million.

So the total for us is $343 million out of our $2.7 billion budget this year. We cannot maintain the present level of services with a funding cut that is about 16 percent of our total budget.

Dr. SNYDER. But, I mean, you are heading out the door. Who is going to get you? But you are being told that you can. Correct? I mean, somebody must think—I mean, I have no doubt that there are patriots all the way up and down the line in the Pentagon. But somebody thinks that you can do this without that money. Is that a fair statement?

Admiral ARTHUR. Well, somebody thinks we can be a whole lot smaller than we are today and get the job done.

Dr. SNYDER. Yes.

Admiral ARTHUR. And if we are going to make these kinds of cuts, we will be delivering care to active-duty only. We will be having pharmacy services that are provided not in our military treatment facilities, but in the private-sector care. And this, in my opinion, will increase the bill overall.

Dr. SNYDER. Right.

Admiral ARTHUR. Because it will force more care out into the private sector where on the margin it is more costly to provide. And the only mechanism that the Pentagon has to influence private-sector care is a bill because there aren't the kind of programs and efficiencies that we can enact within the MTFs that we can display in the private-sector care.

Dr. SNYDER. The point you just made concerns me because on your list was some maintenance monies. Is that correct?

Admiral ARTHUR. $22 million in facility maintenance.

Dr. SNYDER. I think the Air Force was doing this a few years ago overall. And it is shortsighted budgeting because things that you ignore in maintenance bites you sometime down the line. And, I mean, any home owner knows that. You ignore the small leak, and pretty soon you are replastering walls. So that seems pretty shortsighted.

With regard of the personnel cuts or conversions, is it also fair to say—I mean, General Roudebush doesn't submit an invoice for the overtime hours he has worked last month. A civilian employee is obligated. I mean, you are obligated to pay those kinds of fees. It does not become a one to one conversion. Is that a fair statement?

Admiral ARTHUR. That is fair. And at Bethesda this week I was told of the problem with overtime pay given to the civilians that we have had on conversion because they are——

Dr. SNYDER. So it is already an issue?

Admiral ARTHUR. They are no nights, no weekends, 40 hours a week, no deployments.

Dr. SNYDER. Yes.

Admiral ARTHUR. And they take the place and sit right beside a lesser-paid active-duty member who is doing the same job.

This year in fiscal year 2008 we will convert 1,036 billets, positions. And if we keep the 83 percent rate that we are able to fill them currently, that means a decrease of 176 more people.

Dr. SNYDER. Mr. McHugh.

Mr. MCHUGH. Thank you, Mr. Chairman.

I think it is fair to say what happens on capital costs and maintenance costs is Walter Reed. There were contract problems there and continuity of contracts, I understand. But certainly, if you don't have dollars to maintain facilities, including those places where the soldiers are housed while under care, those are the kinds of problems you have.

The good admiral kind of highlighted the concerns he has about the beginning of the military to civilian conversion plan. I want to broaden that a little bit. You know, as I mentioned in my opening comments, we have already converted thousands of these positions, including at this point 152 physicians, 349 nurses, and 208 dental positions. And at the same time, this Congress is actively enhancing the recruiting and retention through the medical health care professional program to try to bring more of these people in.

It just seems kind of at odds to me that we are having trouble, as General Pollock said, finding some health care specialties and yet we are cutting them out. I don't know.

Do either General Pollock or General Roudebush want to comment a little bit about the concerns you may or may not have with respect to the military to civilian transition program on the medical health care professions, particularly nurses and physicians?

General? Either general?

General ROUDEBUSH. Yes, sir, it is a concern. As we attempt to find the right balance within our capabilities—and there are opportunities where we can, in fact, use some civilian physicians in order to provide the capabilities both for our active-duty and our family members. That is not a bad thing in and of itself. It is the extent to which we are being asked to go in terms of making those conversions that causes us great concern.

In the Air Force, we have done a thorough review of our deployable requirements and our active-duty requirements, identified a body of positions that we thought could make sense to convert and then did a business case analysis on it to see if, in fact, those capabilities were present, were they cost-effective and could we acquire them.

We can go that far. But we are concerned about going any further than that because it very quickly gets into the issues that Admiral Arthur describes where we can, in fact, or cannot, in fact, meet the mission in some regard. So we do have concerns in that area.

Mr. MCHUGH. I appreciate it.

And if I may add before we will have comments from General Pollock, beyond, I would argue—and I would like your feedback on this—what the chairman said. And I agree with him totally.

I mean, you have an overtime situation in the civilian sector you don't have under normal circumstances, at least in the military sector. You have also got a deployability, availability to deployability issue, which I think would be a big issue for all of you, certainly, but particularly for the Navy and the—well, no, all of you, all of you, General, across the board.

So, you know, it is kind of a two-edged sword that cuts you both ways, it seems to me.

General.

General ROUDEBUSH. Yes, sir. In fairness, though, I could say we have tried to convert those billets that are not deploying billets such as radiation therapists for cancer. We don't have any deploying billets for them, so we will convert them to civilian positions.

Mr. MCHUGH. Yes, I understand that. And I appreciate that. And I understand what you are trying to do. But you can only try to do so much.

General ROUDEBUSH. Yes, sir.

Mr. MCHUGH. And you noted you are able to fill 83 percent. So try as you might, you have got some real problems there.

General ROUDEBUSH. Yes, sir.

Mr. MCHUGH. That is my point. Thank you.

General.

General POLLOCK. Sir, when the original plans were made, we did not take into consideration that we could truly be in a long war. And some of the eliminations that we have done are for staff now that we realize are absolutely critical. You addressed the physician and nurse issues. I am also concerned about our enlisted soldiers that have been converted to civilians.

Mr. MCHUGH. Yes.

General POLLOCK. We are unable to get the mental health specialists that we are able to train and use as part of that care team. We have not been able to do the hiring—even those positions were eliminated—for a number of the nursing positions because of the national nursing shortage and the challenges that we have in hiring because of the Office of Personnel Management (OPM) restrictions on how we can hire a nurse.

Very, very difficult for us to bring professional nurses back into our organization. And then when we add the significant pay difference between what a civilian would receive and then the overtime compensation compared to the enlisted or junior officer salaries that are available to them, that is definitely a morale buster.

Mr. MCHUGH. Yes. I appreciate your expanding on that. And you are absolutely right. It is a critical issue beyond just the health care professionals. There are other positions that are staffed that are equally important. So thank you for filling that in.

And, Mr. Chairman, I appreciate it. I yield back.

Dr. SNYDER. Thank you.

I think this line of questions is going to continue here through the day, I think.

Ms. Davis.

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. Chairman.

And thank you all for being here. You obviously are here at such a critical time in this discussion.

On the conversion issue, if I can just continue with my colleagues, are we at really a critical point in this? Should we be rethinking what we are doing?

General POLLOCK. We have asked the Army and the Department of Defense to hold on any additional conversions so that we can do a renewed look because of the issues that we hadn't taken into consideration when we made the original suggestions back in 2003 and 2004 for who we thought we could convert. Because the reality is although we selected specialties that we thought we would be able

to hire in the civilian world, we are discovering that we really can't.

Mrs. DAVIS OF CALIFORNIA. Yes.

General POLLOCK. And we would like to have that reassessed so that we are making better decisions and not breaking health care as a result of a personnel change.

Mrs. DAVIS OF CALIFORNIA. Do you see impacts as well in terms of individuals who might be in a pool, so to speak, to be moving into military health provider positions who perhaps would see the conversions and not consider those positions for the future? Is it impacting folks in that way?

General POLLOCK. Ma'am, would you be so kind as to ask me the question again? I am not sure I followed you.

Mrs. DAVIS OF CALIFORNIA. I am just wondering by virtue of a lot of the conversions that we have made—I am wondering. You mentioned some of the corpsmen, the tremendous role that they are playing, the skills that they have developed. I am just wondering whether in some ways we are not cutting off those opportunities for them in the future by virtue of what we have done in these conversions, whether that somehow somebody looking at that would say, "Well, why would I bother?"

General POLLOCK. Well, we certainly have concerns with that because as we decrease the number of our junior enlisted in different specialties, then that also decreases the number of non-commissioned officers (NCO). And as you then become top heavy in those NCO ranks, they stop being promoted.

So then again there is one of those second and third order effects that people hadn't anticipated that then people who are then midterm, you know, mid-career NCOs are going, "Well, if I can't get promoted and I have to go start at the bottom of a new specialty, should I stay in the Army?" And that is a concern for us.

I have been working since I took over the position to start to address these concerns.

Mrs. DAVIS OF CALIFORNIA. Yes. I want to turn for a second to the mental health area because of one of great concern to me personally, but obviously to all of us. And I know that we are going to have testimony in the second panel from TRICARE.

But I wonder if you have concerns we are cutting—there is a 5.8 percent decrease in behavioral health provider reimbursements. And do you see that as having an impact?

Obviously, as you are saying, we are not able to even find the people that we need. And now we are going to be cutting back and in some ways, discouraging people from treating those who really need it right now. Can you comment on that?

General ROUDEBUSH. Ma'am, in the Air Force, we have paid close attention to that. First, training our providers in terms of PTSD, what to look for, how to identify it, how to support that individual and treat them as they go through.

And in addition, we have brought on 32 additional mental health providers to put in those areas where we have the most returning Air Force airmen that have been deployed that could potentially require that capability. So we are paying close attention to that in order to maintain the capacity that we need.

Mrs. DAVIS OF CALIFORNIA. You are not necessarily seeing any negative impacts of that decrease at this time?

General ROUDEBUSH. Because of the steps that we have taken, we have not seen any impacts.

Mrs. DAVIS OF CALIFORNIA. You are not seeing any.

General ROUDEBUSH. However, we continue to watch that very closely because as we get into this sustained conflict—and I think we are going to be in this conflict for a very long time—I think the likelihood and the necessity for continuing to both maintain and perhaps increase our capabilities will be very real.

Mrs. DAVIS OF CALIFORNIA. Yes.

Admiral ARTHUR. Ma'am, there is a military health—a mental health task force that is looking at this in a very comprehensive way from start to finish, involving the service members and their families, military and civilian mental health services. It should report out to the Secretary of Defense on the 15th of May.

Last week I was made the military chairman of that effort after General Kiley's retirement. He was the co-chair before me. So we are going to look at this.

I have read the material that they have collected so far. And they are looking at a very broad-based approach to mental health, not just starting at the time when we identify people who need treatment, but before that and building resilience in our service members and their families anticipating some of the stresses of combat and other stresses of military life.

Mrs. DAVIS OF CALIFORNIA. Yes.

General POLLOCK. The concern I would have, ma'am, is we have forward deployed many more members of the behavioral health team to assist the folks who are deployed. And then as we have requirements for the soldiers as they have returned or their families, we are dependent on the civilian sector for that support. Mental health has not been a robust practice arena in the United States.

Although there is demand, we have certainly are under-resourced across the country. And many of us could speak to the challenges that we have for a child or adolescent behavioral health care around the Nation and how difficult it is.

I remember when I was up at Fort Drum how difficult it could be to move a child perhaps to another state before we were able to get in-patient care if he needed it. This is certainly an area that is a national issue, not just one for the military.

Mrs. DAVIS OF CALIFORNIA. Yes. Thank you.

Thank you, Mr. Chairman. I know I certainly want to address the women in the military issue as well with PTSD. Thank you.

Dr. SNYDER. General Pollock, I need to have you clarify your first answer to Ms. Davis in which you—I forgot how you phrased it, but you have asked your senior folks to revisit a certain decision on their military conversion. Did I understand correctly? Would you repeat what you said?

General POLLOCK. Yes, yes.

Dr. SNYDER. I thought you had an October 1, 2008, timeline that you have to meet.

General POLLOCK. Yes, sir, we have the 2008 conversions broken into different phases. And I have gone back and asked if we could please relook those to see whether or not we are actually going to

be able to hire the folks that we had anticipated that we could when we did that original assessment.

Dr. SNYDER. And specifically, whose decision is that?

General POLLOCK. That goes up through the Army G–1. And then it also goes to the Tricare Management Activity (TMA) up to Department of Defense.

Mr. MCHUGH. Mr. Chairman, if I may?

Dr. SNYDER. Yes, Mr. McHugh?

General POLLOCK. Thank you. Admiral Arthur reminded me it is for the under secretary for personnel and readiness.

Mr. MCHUGH. Yes. When Dr. Winkenwerder appeared before this subcommittee in response to a question I had posed, he had said that they are certainly willing. I don't think he made a hard commitment they were. But he said they certainly were willing to reevaluate both the efficiency wedges and the military to civilian conversions. But I don't think a decision has been made on that. And until a decision is unmade, it remains, it seems to me.

Dr. SNYDER. Ms. Boyda.

Mrs. BOYDA. Thank you, Mr. Chairman.

Let me just say my dad was a medic on a submarine in World War II. So I have always had good medical care at home where he thought was he still was, you know, still from 60 years ago. And thank you very, very much for your service.

May I just ask a question? Did you say you have lost 102 of your medics? Did I hear you say that?

General POLLOCK. Yes, 102. It is across the health care professions. It is medics. It is physicians. It is physician assistants. It is medical service corps officers.

Mrs. BOYDA. That was in the Army or it was in the armed services?

General POLLOCK. That is within the Army. That is the Army medical department.

Mrs. BOYDA. I had no idea. I am sure all of our condolences on behalf of everyone here.

After the Walter Reed, I went to both of the VA hospitals in my district and then to Irwin Army Hospital there at Fort Riley, came back and reported that there is some really ugly green tile in our VAs, but they are clean and they are safe, which is not surprising.

When I went to Irwin, the guy—and I am going to tear up. The staff virtually teared up at how much they take care of their soldiers, how much of a team they are and the concept that we are just turning these into civilian, you know, jobs just alarms me like no other.

And I am a freshman here. Can you explain how we got here, how the decision was made, when it was made? I really don't have the background. When was this decision made?

Admiral ARTHUR. For the military to civilian conversion?

Mrs. BOYDA. Yes.

Admiral ARTHUR. Every four years we have a quadrennial defense review. And that review takes into consideration all of the policies and all of the plans that we have to conduct operations in DOD. And part of that is a medical readiness requirements review where the Department says these will be the requirements over the

next foreseeable future for combat operations and here is how the medical piece will fit into that support.

They calculate what operations they will have, what number of casualties, what kind of casualties. And then they plot what the support will have to be to ensure that those casualties are well-trained. They take into consideration the garrison care, that is the corpsmen, the doctors on the submarines, the ships and with the Marines every day. And they roll it all into a figure, and they tell us that this is what we require of your medical department.

Mrs. BOYDA. Who is "they"?

Admiral ARTHUR. The Under Secretary of Defense for Personnel and Readiness through his plans, analysis and evaluations program, the PA&E, as we call it.

Mrs. BOYDA. Does that come back through Congress then for any kind of funding or any kind of—again, I am trying to figure out—and it doesn't sound like—it is just——

Admiral ARTHUR. No, it does not.

Mrs. BOYDA. And when was this one done then?

Admiral ARTHUR. This one was done just within the last year. They have taken minimal casualty requirements for future warfighting scenarios, minimal deployment and redeployment, almost no humanitarian assistance, disaster relief or homeland security.

Mrs. BOYDA. So this conversion—I hate to interrupt, but this conversion that we are talking about that is going to be finished on October of 2008 was actually directed in what year?

Admiral ARTHUR. Yes. This past year. Well, actually, there are two components. There is the program budget decision 712. And that was several years ago. And we are on the track to convert that number of billets that we had in many ways agreed to.

Mrs. BOYDA. So this conversion started when, again, if you would?

Admiral ARTHUR. In fiscal year 2006 and will continue to fiscal year 2011.

Mrs. BOYDA. I guess what I am trying to ask is—and I just sometimes continue to be appalled at some of the decisions that we are making. This move to convert actually happened while we were at war?

Admiral ARTHUR. Yes, ma'am.

Mrs. BOYDA. Well, did they start looking at doing this maybe a few years back?

Admiral ARTHUR. No, this was in the last two or three years.

Mrs. BOYDA. And I am going to have to go to an Ag hearing meeting. So I am going to go to a different subject right now.

And, you know, we hear that funding for TBI research has been cut back. Can you address that? Do you know anything about that? Is that true? And is there something that Congress can do to—sometimes what you read in the paper doesn't actually reflect reality. I know that shocks us all.

General POLLOCK. I am glad that someone else thinks that, ma'am. What I would like to do is provide you a written response to that question. I am new enough in the job that I can't remember all of those numbers for the research. And I would like to make sure that what I provide you is correct.

[The information referred to can be found in the Appendix beginning on page 218.]

Mrs. BOYDA. Are you concerned that funding has been cut? Is that something that is on your list of things to worry about? Or if you would like to get back, that is fine.

General POLLOCK. Yes, I am concerned about it because with the fact that TBI and PTSD are seeming to be connected in some analyses, I think it is very important that we continue that research so we know exactly how to provide the care so we can return these men and women to their absolute highest level of functioning.

Admiral ARTHUR. This is a newly emerging entity, a new realization for us. And unless we get the research correct, we are not going to get the longitudinal studies that tell us whether we are doing the right thing or not, we are not going to be able to follow the members and their families.

Mrs. BOYDA. Data are good.

Admiral ARTHUR. Yes, ma'am, data are plural.

Mrs. BOYDA. Thank you very much. And thank you for your service, Admiral.

Admiral ARTHUR. Yes, ma'am. It is an honor.

Mrs. BOYDA. And, General, congratulations and good luck with your challenges ahead.

General POLLOCK. Thank you.

Mrs. BOYDA. Thank you.

Dr. SNYDER. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you, Mr. Chairman.

I would like to pursue that direction that my colleague was going in. My husband was stationed at Fitzsimons Army Medical Center in Colorado when it was a major medical center. And I was there as well. And I saw the incredible work they were doing through a lot of casualties from Vietnam.

And I am sitting here today. And I, too, am trying to figure out how we got to this point where we decide to gut the system as I knew it and wind up with this other system that we are using.

And what I would like to know when they made the decision to privatize these jobs, was there much input from all of you. Were you asked to give your opinion about all this? Or was it a unilateral decision?

Admiral ARTHUR. Yes, we were. And, yes, it was a unilateral decision. We made many inputs. And they were carefully considered and rejected. Some of our inputs had to do with the cost of the civilian conversions, the cost of the people and the overtime, as Dr. Snyder was saying. Some of it was the culture of the military. And that is a difficult thing to quantify.

But as I said in my opening statement, I was here in the 1970's and saw a very different culture. Every single one of the senior providers in the military now are here because they are volunteers. And they do not work for money alone.

It is not a reimbursement system. They work to give the right care to each of our veterans and their families every day. That keeps the best of our people in.

And I am concerned about people who will come in for a contracted fee and look at the bottom line, the money, work 40 hours, no nights, no weekends and they will sit right next to someone who

makes half as much and the morale impact on that. We have the kind of quality health care we have today because the system has evolved over the last 2 or 3 decades.

And I am afraid that some of these conversions, while we will get some very good people, we will also get people who are not invested in our military families but in the paycheck that comes from their contracted services.

Ms. SHEA-PORTER. I share your concern about that. And it is especially poignant to me today because a couple of days ago I got a call from a relative I am very close to. She lives in North Carolina. And she told me she was in South Carolina because she had been diagnosed with breast cancer. They use TRICARE, and they couldn't find physicians who would provide appropriate care for the funding.

And I want to pay tribute to all who have worked in the military health care system. I remember how dedicated they were, and they are to this day. And I find it deeply disturbing. And I thank you for your candor about that. And I think as a Nation it is ironic that we talk about supporting our troops, and then we sit here and we find out what that translates to if they need medical care.

I did want to talk about the mental health issue for another moment. We have known for a long time that when soldiers go into combat or have any kind of adverse situations there will be some mental illness and post-traumatic stress syndrome. What has happened in the past couple of years as we have been receiving these troops with these brain injuries and post-traumatic stress syndrome that kept us from addressing it at such a heightened level until now?

In other words, if you could talk to me about two years ago. Was this an issue that you were addressing? Were you looking at these troops and their families and saying this is a crisis? And if you did, who did you talk to in terms of, you know, what department, and what was the response?

Admiral ARTHUR. Well, yes, ma'am, we did address that. I think all three services addressed it several years ago. And I think we are actually doing pretty well. For the Navy and the Marine Corps, which we serve in the Navy, we have embedded people in our OSCAR program.

We have mental health providers, technicians, psychiatrists, psychologists embedded into the units that go into combat. They go into combat with them. And instead of being sent for evaluation to some other unit or location, they are treated in theater with personnel that are assigned to their battalions.

So I think that is a very effective way to do it. When they come back, there are debriefings. There are debriefings before they go. The senior leadership is involved. And I think we are seeing a low rate of PTSD compared to what it could be if we weren't paying attention to it.

We also have the reassessment six months after they come back. And it is not because we want to wait six months. It is because that six months is required to get some of the manifestations of post-traumatic stress and the decompression that they need to really manifest some of the post-traumatic stress symptoms.

So we see them. We evaluate all of those assessments. We get them to see mental health providers whenever it is needed. And they can self-refer as well.

So I think we are doing a pretty good job. Are we hitting everyone? I am not sure you can always say that we will hit everyone because it may take a long time for some of these symptoms to manifest.

General ROUDEBUSH. And, ma'am, it is broader than just the PTSD. The PTSD is a critically important piece of this. But as we look at what that means to the family caring for an individual and to the broader community looking across all the behavioral health issues with suicide, for example, being a critical concern always as well as family stress, deployment stress, those sorts of things, and the fact that TBI and PTSD have some overlap.

And as Admiral Arthur pointed out, there are areas where we do not have all the information and the data that we need to fully elucidate that. So I think we are moving in that direction. But I think the on-going research that is required and the attention and the focus on this is a very good thing to help us move that forward and be sure that we do cover this and the whole spectrum of stress, if you will, across the force and the families that we are able to address.

Dr. SNYDER. Mr. Jones.

Mr. JONES. Mr. Chairman, thank you.

And I am going to be very brief. I am sorry I was late getting here because I am very, very interested in this issue and wanted to hear you, the first panel, and look forward to hearing the second panel.

I guess most of the questions since I have been here have been asked that I might would have pursued. But something just came to my mind, in talking about family stress.

And I want to give you an example, Admiral Arthur and only because this touched me so greatly and so dearly. Four or five weeks ago, I was invited to go to Camp Lejeune, which is in my district, and read a book to six-year-old children at the Johnson Elementary School. And they had 10 little children there in front of me.

I am sitting in a rocking chair, probably where I deserve to be anyway, and reading Dr. Seuss, quite an interesting book because I couldn't pronounce half the words. But the teacher told me not to worry about it. The children wouldn't know if I was right or wrong with what I said. [Laughter.]

So anyway at the end, I let the little children make statements or ask me questions. And, of course, everything from, "Have you seen the zoo in Washington?" to "Do you know the President?" to, you know, "Where do you work?"

But one thing that really bothered me, toward the end two or three children mentioned that their father or their mom was in Iraq. And again, these are six-year-old children. But the last child said to me—and I never will forget it—"My daddy is not dead yet." A six-year-old child, "My daddy is not dead yet."

And, Admiral, I guess my question to you: How far down does the Navy and the Marine Corps, Army, Air Force—how far down do you go to try to figure out what services you can offer to the family?

I am not saying that child has a problem. But that was such a deep statement that I heard, "My daddy is not dead yet." You cannot go into every family. You cannot evaluate every child. But where in the world, if this is a problem—not saying this is an emotional problem. But this is a six-year-old child that is thinking that, "My daddy is not dead yet."

How do you reach the family? I mean, does the family in that kind of situation—and not saying there is a problem. I don't know how to evaluate what I am trying to ask you. And I am sure you can't make any sense out of what I am trying to say.

Admiral ARTHUR. Well, Congressman Jones, it is good to see you again.

Mr. JONES. Yes, sir, my pleasure.

Admiral ARTHUR. I think that six-year-old does have a problem. There is nothing more fundamental to a young person's life than the knowledge that the family unit will be there. The insecurity about the death of a parent is fundamental to the development of this young man or woman.

We have all sorts of family services. And they go right down to the children. We involve the teachers in the schools in classes about what is post-traumatic stress, what should they look for in the children, how should they help the children cope, especially on Camp Lejeune, whereas DOD schools—all of or the majority of the children there of active-duty Marines are cared for on the base, especially with those brand-new schools that are beautiful.

Mr. JONES. Yes, sir.

Admiral ARTHUR. And they pay particular attention because all of their mothers and fathers are subject to deployment. We have in the Marine Corps the key volunteers that I think you know very well. They are the spouses of men and women who are deployed. And they are very, very active working with the family unit. So I think they are well-supported.

But that said, you can never get away from the fact that everyone in that school is going to know someone whose mother or father was either very seriously injured or killed in this combat. And you can't get away from that.

Mr. JONES. Sure.

Admiral ARTHUR. So I think the key is to be proactive. That said, we are having a lot of our staff of our military treatment facilities deployed.

I went to Cherry Point last month. The commander of the base said, "You know, we have got longer lines in the pharmacy and longer waits for clinics." And I said, "Yes, sir. Twenty percent of your hospital staff is deployed today."

And they are not on vacation. They are deployed in direct combat service support for their Marines in theater. And saying you can go 40 minutes for an obstetrical appointment to Craven Medical Center is not the kind of service that I think our Marine families deserve.

Mr. JONES. Mr. Chairman, before I close—my time is about up—I could not say enough about the services provided at Camp Lejeune and Cherry Point at the hospital. It is outstanding. I would agree with you that the family support is excellent, I am sure across every base, Army, Navy, Marine Corps, and Air Force.

And I would also say that the DOD schools as long as there is a military in this country I hope that the Congresses of the future when I will not be here will always remember that those schools are an integral part of the quality of life because I have seen so much good at those schools and at Camp Lejeune and the one I visited.

Admiral ARTHUR. Yes, sir.

Mr. JONES. So I appreciate your comments.

Admiral ARTHUR. If I could say one more thing.

Mr. JONES. Yes, sir.

Admiral ARTHUR. My daughters went to those schools at Camp Lejeune. And they could ride their bicycles to school and leave them in a bike rack unlocked in front of that school and know that they would be there in the afternoon when they returned.

Mr. JONES. That is very important.

Admiral ARTHUR. It is a wonderful culture.

Mr. JONES. Thank you, sir.

Admiral ARTHUR. Yes, sir.

Dr. SNYDER. Congressman Jones, I have been talking with the staff. And at some point this year I hope that we will have a hearing of this subcommittee on the specific issue of childcare and DOD schools, both domestically and internationally because it is so important.

Mr. JONES. Thank you, Mr. Chairman.

Dr. SNYDER. We are going to start our—let's see, I think everybody has been around once. We are going to start our second round here.

I had said earlier facetiously that General Roudebush, when he submits his voucher for overtime—it turns out staff corrects me. He has submitted a voucher for overtime. We owe him $2,873,000. [Laughter.]

I wanted to get into specifically this—that is not true. For the record, that is not true, General Roudebush. I made that up.

General Pollock, I want to direct this question to you, General Pollock and Admiral Arthur. But when your predecessor was here March 8th, he specifically stated—it was before the full committee—"I am concerned about 2008 and 2009 we will have an efficiency wedge that, at least as I sit here now, I cannot see efficiencies gained to recover that. I have grave concern if we are going to be able to meet those budgetary cuts in those outyears." That is the end of his quote.

And when I think about efficiencies, I think about, you know, energy efficiencies in the home. It turns out if you have a front-loading washer, that is much more efficient than a top-loading washer. And yet the household doesn't notice anything different.

I can also do energy efficiencies just by dropping the temperature down three degrees. But that is not an efficiency. That is just a cut in service. And I think the concern in this committee is not that you are going to end up with efficiencies. It is just going to be a cut in service, that somebody is going to see something different in their lives.

So my specific question to you, General Pollock, and you, Admiral Arthur, is, as you look ahead for the next calendar year, from this day until one year from now, if nothing has changed from the man-

dates you have received from above, in terms of civilian conversions or these efficiencies, what specific services to our military families and our men and women in uniform do you foresee you will not be able to provide in the same way that you do now?

General POLLOCK. Unfortunately, sir, that is an issue that my staff is already working with. The equivalent for us over the next calendar year is the budget equivalent for one of our large MEDACS. So basically it means we are going to take an entire MEDAC out of the ability to contribute to the health care of the men and women and their families in uniform. There is no way that I can salami slice that. So it will truly be we will need to make a decision about what we are going to stop doing.

Dr. SNYDER. So it is not an efficiency. It is a flat-out cut in service at a time our Nation is at war?

General POLLOCK. Sir, it will be a cut in service.

Dr. SNYDER. Admiral Arthur.

Admiral ARTHUR. I echo that. If you recall the words of Portia, the lawyer in the Merchant of Venice, she said, "You may have your pound of flesh, but draw nary a drop of blood." There is no more flesh to be gained without drawing the blood of the services that our family members and our active-duty will have.

Our cuts are equivalent to one of our large family practice hospitals like Camp Pendleton and Camp Lejeune, Pensacola, Jacksonville, Bremerton. And we will have to have a serious conversation about what services we can provide at 16 percent less funding than the year before.

Dr. SNYDER. As a follow-up to that, Admiral Arthur, you both equated it to the closing of a large unit. But it is not going to be the closing of a large unit. It is going to be sprinkled through the system in a way that this committee, this Congress, you all are going to have trouble following, I would think, in terms of what the cuts in services are. You know, every military family that has a delay in an appointment, instead of one week, it is a month or whatever it is.

Instead of having a service at their normal military treatment facility, they are going to have to drive 25 miles at a civilian facility. That is very difficult to follow, is it not? How are you going to follow this impact?

Admiral ARTHUR. Well, it is. And I would say we are—with the magnitude of these cuts, we are beyond the ability to take salami slices. We are going to have to, in my opinion, close significant service locations.

General ROUDEBUSH. Sir, if I might add with that.

Dr. SNYDER. Sure.

General ROUDEBUSH. There are several ways to get at that. One is the diminution or the loss of services. And actually, that requirement never goes away. So those services will be provided, but it will probably be in the private sector where it could be even more expensive in some regards. But the other way that we try and mitigate that and taking risk is with our sustainment accounts, our care of our facilities, our buying our equipment.

Dr. SNYDER. Through seed corn?

General ROUDEBUSH. Yes, sir. And we push things downstream.

Dr. SNYDER. Yes.

General ROUDEBUSH. And particularly now with Military Construction (MILCON), those dollars being in such short supply, we are taking care of older and older facilities. So it is a bow wave of obsolescence. It is a bow wave of risk because we all work as hard as we can to keep those services up to the last inch before we have to say okay, we are going to have to send that care downtown. So it drives us in a direction that has impact in a variety of ways.

General POLLOCK. Sir?

Dr. SNYDER. Yes.

General POLLOCK. If we cut services and have to send it out to the private-sector care, we also lose our ability to ensure the continuity of care. We lose our ability to evaluate the quality of care that our patients are receiving there. Whereas inside the Army now we are using measures which are national criteria to ensure that we are providing the absolute best that we can.

And our goal is to not meet those measures, but to grossly exceed them so we can clearly demonstrate that our care is superior to that available in the private sector. But we are unable to even measure that right now in the private sector.

Dr. SNYDER. Of course, I will be a little bit of a devil's advocate. The military is always going to have some substantial amount of care done in the private sector.

And if that is a problem, you need to figure out how it is not a problem because we are going to have to follow the quality and the continuity of care that is done in the out-patient civilian sector, even care that sometimes is mandated on top of you that you just as soon not——

General ROUDEBUSH. Well, sir, if I might speak to that. We have good allies in the private sector.

Dr. SNYDER. Right, right. That is right.

General ROUDEBUSH. Our partnership with our TRICARE managed care support contractors is as good now as it has ever been.

Dr. SNYDER. Right.

General ROUDEBUSH. And we need to continue to make that grow and get better.

Dr. SNYDER. And better.

General ROUDEBUSH. But as that care goes into the private sector, there is also the issue of currency. Our providers need a caseload. They need the complexity. They need to take care of patients in order to stay current up on the step to be able to go do the deployed mission as well. So it is important that we keep that care in the direct care system for a variety of reasons.

Dr. SNYDER. We will go to Mr. McHugh. And then we will go to Mr. Kline, who has joined us.

Mr. MCHUGH. I will be happy to pass to Mr. Kline.

Dr. SNYDER. Mr. Kline. And then we will go to Mr. McHugh.

Mr. KLINE. Thank you, Mr. Chairman. I understand we have already discussed the conflict this morning. I am very much disappointed that I couldn't be here for the first hour of this hearing because it is hard to imagine a more pressing issue right now. And because I did miss the first hour, I will try very hard not to trod on old territory.

Admiral, I would like to go, if I could, to you. And I understand you discussed it very briefly. But let's talk about corpsmen. The

Marine Corps is increasing its end strength significantly. And as I understand, as part of this process, the Navy is looking at reducing the number of corpsmen. Is that correct?

Admiral ARTHUR. That is correct. We have the program budget decision that this year is going to reduce 283 corpsmen. They will be gone by October 1st. We are also looking at the Marine Corps' requirement to increase approximately 800 staff, which includes some corpsmen. So we are hoping those will balance. However, we are not including the Marines' families in that calculation. So I think we are still going to be left with——

Mr. KLINE. I am sorry. Explain the balance again. We are cutting?

Admiral ARTHUR. Yes, sir. The program decision memorandum number 4 has required that we cut 901 staff over the next couple of years. The contribution in fiscal year 2008 starting October 1st will be 283 corpsmen. And this was calculated based on the Navy coming down about 30,000 people.

At the same time, the Marine Corps is increasing 28,000 people. And we are trying to work with the Marine Corps to offset this program decision memorandum so that we can properly fill the health service needs of those additional Marines, which turns out to be about 700 or 800. We have yet to have a firm figure on that.

Mr. KLINE. And what would the Marines do to make this offset? I mean, what do you mean you are working with the Marines? They don't have any corpsmen.

Admiral ARTHUR. The program decision memorandum which took 900 staff from us is done. It is in the budget. And those people, the money are gone. So we have to work with the Marine Corps as they increase their staffing by 28,000. The Marine Corps must put in a requirement back to the defense health plan to increase the staff. They are two separate entities, I am being told. One is a cut. It is done. The other is an increase, which we now must properly debt through the system and argue for the corpsmen and doctors, nurses, dentists to support the Marines and, I hope, also their family members who will come with them.

Mr. KLINE. Well, it is Washington. Thank you. I yield back.

Dr. SNYDER. Mr. McHugh.

Mr. MCHUGH. Let us talk go back to the comments I was making about physician losses, 162 that have been lost in the military to civilian conversion but take it from a different perspective. Two of you noted that you are having trouble recruiting in the doctors and into the other health care professions. I mentioned what the Congress has done with respect to trying to make increases for the health profession scholarship program.

We have increased the loan repayment program for officers from $22,000 to $60,000. We have increased the Health Professionals Scholarship Program (HPSP) scholarship grant from $15,000 to $45,000, increased the monthly stipend, which was at $579 a month to no more than $30,000 a year intended, of course, to try to facilitate those recruiting.

Other than addressing the issue from the conversion part, which I think is an important component of that challenge, do you have any suggestions what this Congress can do to help you to be more effective in recruiting health care professionals into your ranks?

Admiral ARTHUR. Sir, I think there are two facets. One is the recruiting, to get young men and women to come into the medical and dental professions and the nursing professions. I think those scholarships and other programs are terrific. I hope in the next few months to be able to announce a program in the Navy to do a medical enlisted commissioning program where we take some bright young corpsmen and put them through medical or dental schools.

I think another important facet is to retain the talent that we already have, to craft the bonuses and shape the organizational rank structure to keep the gray hairs, if you will, the people that have the most experience in combat service support and trauma management and have the highest degree of medical skill.

We are seeing, paradoxically, the highest retention rate that we have had in some time in our general surgeons. And we are seeing that, I believe, because the quality of the service, the kinds of service, and the rewards they get from the service on these casualties is so great that they will stay in just for the satisfaction of the practice.

Mr. MCHUGH. General Pollock.

General POLLOCK. Sir, the retention bonuses and being able to correct them and level some of the disparity between a military salary and a civilian salary so that we can keep the people that have already developed the foundation of military health care and not lose them to the civilian world because they are being very aggressively recruited. And as we look at the multiple deployments and the year deployment for the Army, the year away from their families knowing that they will face that year again, it is very, very difficult to retain them.

Mr. MCHUGH. General Roudebush, your testimony didn't mention you were having recruiting problems. Two years ago General Taylor suggested, in fact, stated that there were some challenges in that regard. What did you do that has been so successful? Great leadership, I know. But beyond that?

General ROUDEBUSH. No, sir. The concerns remain. The HPSP program is a major source for us. And thank you for the increased authorizations within that pay structure. And now we are working—because those are reserve pay dollars that, in fact, support that to work to be sure that there are dollars available to move into that. We have continued to work both on scope and quality of care to retain the individuals once, in fact, we do recruit them. But we still have concerns and difficulties in recruiting fully qualified.

The additional bonuses and the authorities in that regard, I believe, will be helpful as we work through that. But we are no less concerned relative to our ability to do that. And certainly, within the realm of nursing, a very competitive environment to recruit nurses.

And I would also suggest that there are also issues within the reserve realm in terms of being able to recruit reservists of all varieties, whether physicians, nurses, in order to do that as well. And we look forward to working certainly with Congress on incentives that will make that both more attractive and more fulfilling for reserve duty as well because they are an important part of what we do.

Mr. MCHUGH. Thank you. Just while I have got a yellow light, I made a comment earlier that Secretary Winkenwerder suggested that the efficiency wedges in the military to civilian conversion targets were certainly could be revisited. Are you aware of any revisitation happening in that regard, yes or no?

General ROUDEBUSH. In terms of within the Department revisiting the efficiency wedges, I am not aware of any activity. I will tell you with the mil-to-civ conversions certainly all the way up through our secretary, Mr. Wynne, we are concerned what that means in terms of the 2008 activity, particularly because we have to certify by virtue of congressional requirement that there will be no detriment to neither access or quality of care.

So for us to be able to certify at the secretarial level, we do have some concerns and will be addressing that, sir.

Mr. MCHUGH. That is another issue we will get to.

Okay. Yes or no, any formal re-evaluations?

General POLLOCK. Sir, I have been involved in some discussions that they were willing to relook it. But I don't know what specific steps would be required at the DOD level. As a point of clarification on the earlier question, the original mil-to-civ conversions that the Army faced was an Army decision because of the operations tempo (OPTEMPO) they wanted to move more people into the line and away from the fixed or the garrisoned organizations.

So thinking that they would be compatible with conversion to civilian support so that they would have the military strength in the line organizations. But again, some of the decisions we need to relook because what we thought we could hire and what would be available across America have not borne true.

Dr. SNYDER. Ms. Davis.

Mrs. DAVIS OF CALIFORNIA. Thank you.

I think we are all familiar with unintended consequences. And we really need to look at that.

I wanted to just share one of the concerns that I would have from a number of the families that I have met with. At what point do we think that this begins to effect retention? As we know, families feel that the medical benefits that they get are fabulous. And, you know, they rave about them. And they are very important to them.

But when a mom, you know, can't see the pediatrician or doesn't feel that the pediatrician even understands what it is like to go through multiple deployments or really relate to the military family because it is a civilian conversion, that begins to change their on-going decisions.

And so, I think we just need to be aware of that and make sure that we work to do what we can for those families so they feel that they are being taken care of. Because otherwise, that benefit, you know, to the other person who gets a vote in all this doesn't seem very important any more.

I appreciate it. I know you understand that.

I wanted to ask you about the article in the *New York Times Magazine* the other day by Sara Corbett. I don't know if you happened to see that about women in combat and women in theater and the impacts of PTSD on women, particularly as primary care givers, but also some of the instances that were cited in the article, abuse to women in theater and how that is being dealt with and

how the services are providing the kind of care and support that the women need and being certain that they get that while in theater and then they certainly get that when they return home.

Could you speak to that?

General POLLOCK. Ma'am, I have not seen that article. But we have looked at the gender differences to see if there are gender differences for PTSD, for example. And they are comparable. They are in the 15 to 20 percent reported rates. And there has been some discussion because women traditionally have been more willing to talk about their emotions, they are more willing to discuss how they are feeling and where they are at any one particular time.

But that is still relatively new for us to look at. And it will require more attention and more research as well.

Admiral ARTHUR. I also have not read that article. But I can tell you that there is a lot more that we need to know about women in combat, especially direct combat. This is the first conflict where we have really had substantial numbers, I think, especially as they come back with significant injuries.

And this was brought to me by one woman who asked me how am I going to hold my baby with this plastic arm. And I was immediately embarrassed that I had not thought about those special circumstances that we really need to account for. So there is a lot that we don't know and that the current cohort of women in combat are teaching us.

General ROUDEBUSH. Ma'am, I have read the article. And I understand there are some concerns about it. But the issue, I think, is a very pointed and a very valid one.

Certainly, in terms of sexual assault and harassment, we have all taken steps to put advocates and a response system both at home and deployed to be able to attend to that and to be able to address those needs. But there is also, I think, the commander's accountability and responsibility to set the tone, set what is acceptable within a realm. And I think the attention is certainly moving that in the right direction.

Relative to PTSD, there is no gender immunity. And we need to be as concerned regardless of gender. Every individual who is exposed to that needs to have those resources available. So we are certainly attending to that.

Mrs. DAVIS OF CALIFORNIA. Yes. I appreciate that. I think we are all concerned that, you know, for years health studies were done on men and perhaps didn't take in the special dynamics that would affect women. And I think in this same regard, I appreciate your talking about the research because we need to be proactive. We certainly need to be helping our commanders in the field to have a high level of consciousness.

But at the same time, you know, there is a lot that perhaps we don't know. And so, I would hope that as we see some dollars and, you know, perhaps siphoning those off in some way, you know, to be certain that, you know, have we thought about this and make certain that we are really addressing this issue.

Admiral ARTHUR. Yes, ma'am. I can tell you from my initial read of the draft of this mental health task force report that I am reviewing now this is given a significant amount of diligence in that report and looking at not just what are we doing, how can we do

it better, but what should we be doing, what is the model and taking into consideration the entire family. So women's health is highlighted in that report.

General ROUDEBUSH. And given the fact that our combat service support are at risk in these theaters. There is no front line necessarily. Everyone is certainly at risk.

Mrs. DAVIS OF CALIFORNIA. Yes. You know, the other thing that we haven't talked about is that even our health care providers, in many cases, are susceptible to burnout and trauma as a result of treating trauma patients. And we need to be thinking about them.

General ROUDEBUSH. Ma'am, we need to take care of our medics because every time you put a hand on a wounded individual, you are now part of their life. And there is a cost to that. It can be compassion fatigue. It can be burnout.

As we bring our folks back, we have to pay very close attention to their recovery and their reconstitution, their ability to deal with that because in a microcosm, they are giving and giving and giving in a very fulfilling way to be of service. But it still comes at a cost. And we need to be attentive to that.

Dr. SNYDER. General Pollock and Admiral Arthur and General Roudebush, the article that Ms. Davis called to my attention last week is from the *New York Times Magazine* March 18, 2007, "The Women's War" by Sara Corbett.

And, without objection, Mr. McHugh, let's include this as part of our record.

[The information referred to can be found in the Appendix on page 185.]

Dr. SNYDER. And I have no expectation that you all read everything that is in the press out there about men and women at war and their families. But if you would respond for the record to this.

And, General Roudebush, you can have another bite at the apple, too, if you would like, to respond to the record. And hopefully you can work your way through the approval system of OPM in a way that it will be timely in giving to this committee and might be helpful.

Mr. Jones.

Mr. JONES. Mr. Chairman, thank you.

General Pollock, I am very interested—it might be in your printed testimony. You might have discussed this before I got here. It is one of the more difficult specialties to entice graduates of medical schools in the area of orthopedic surgery. Is that a problem in trying to recruit those who specialize in orthopedic surgery?

General POLLOCK. Well, we recruit very few who are board certified in orthopedic surgery. Generally we educate our own. And as the other offices have identified, our training programs are often in the top 10 in the nation. So the men and women that we train as orthopedic surgeons are truly phenomenal.

Mr. JONES. Right.

Admiral Arthur, it seemed like several months ago I had the privilege to visit the hospital at Cherry Point. And in talking with those in the leadership at the hospital and knowing of all these cuts that you are going to have to deal with and we in the Congress are going to have to deal with, there was a concern. And I

don't know if this has taken care of itself or not. And you can answer this.

That as we began to save monies, instead of being open 24 hours a day, we would be open 12 hours a day. There was concern down at Cherry Point that the fact that there would not be a facility open at night from—I don't know what the time was. I can't remember. But let's say 12:00 a.m. to 6:00 a.m. in the morning, particularly with Marines out training, should someone be injured.

Is this happening at more bases than not, that instead of being open 24 hours or having some type of urgent-care-type facility? What is the policy? And I would ask all three this question. And it can be a very quick answer, if you want to.

Admiral ARTHUR. We are looking at what services we can provide based on the projected staffing that we are going to have. At Cherry Point, as I mentioned before, 20 percent of the staff is currently deployed. And we are trying to downsize a bit because, as you know, it has been base realignment and closure'ed (BRAC'ed). We have got Carteret and Craven, which are our main sources of care there. And if an emergency were to occur that requires a surgeon or higher level trauma care, Cherry Point is not the place to bring them, whether it is daylight or nighttime.

Mr. JONES. Sure, I understand.

Admiral ARTHUR. They should go to those other facilities. My concern is obstetrician (OB) care and those other family issues that as we downsize that facility—and the Marine Corps has plans to increase the number of aircraft in squadrons on that base—that we provide those families of deployed Marines a timely access to family level care. And we are working through the issues of the network. I know our TRICARE contractor is being very, very diligent there in helping to expand that network to support the families.

Mr. JONES. General.

General ROUDEBUSH. Sir, over the last 15 years we have closed a significant number of small hospitals because they were both inefficient and, frankly, not busy enough to maintain the kind of currency and competency and there was care available in the community. And in working with our managed care support contracting partners and our community partners we have been able to provide that care in those circumstances.

And relative to the emergency response, we work that in partnership with the communities in which our bases are part of those communities. So it is a collaborative association. And on base in many circumstances, the fire department also has an Emergency Medical Service (EMS) capability. And we leverage that as well where that is available.

General POLLOCK. Across the AMED as well, sir, we have looked at the volume and the competency of the staff that would be there and made the decision in a number of locations to not call them emergency rooms any more because they do not have the capacity that justifies being called an emergency room. But for many folks, because we have grown up talking about well, if you needed care quickly, you went to an emergency room, what we need is access to care when we define we need it. And that is the expectation of the patients.

And that is one of the challenges that we face because they become very frightened when they understand that how they perceive access to emergency care is changing. So it is very important that as we make those decisions we have a very aggressive communication and education plan so that people understand that for what they would need the care is available. We are not eliminating that care.

Mr. JONES. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. I have three more questions which we may be able to move through fairly quickly. And then we will go to Mr. McHugh and then to Ms. Davis.

And starting with General Roudebush and going down the line, do you have a precise number in your mind about the number of medical holds and medical holdovers that you all are currently following in the Air Force now?

General ROUDEBUSH. Yes, sir. In the Air Force, we are following 52 active-duty and 256 reserve medical hold, if you will. However, the definition for medical hold for us is somewhat different than the Army. So there is a small distinction there.

For us our medical hold individuals are those that are at the end of their term of enlistment or service and they have an issue that needs to be attended to before they transit either into the VA system or into civilian life. And we work through that before we, in fact, go ahead and either separate or retire.

Dr. SNYDER. Admiral Arthur.

Admiral ARTHUR. Yes, sir, we have 134 Navy, Marines and one Coast Guard that are involved in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF)-related injuries. We have an additional 203 who are in medical hold for other reasons such as cancer and prolonged illnesses. So most of the OIF casualties are housed at the wounded warrior barracks at either Camp Lejeune or Camp Pendleton.

Dr. SNYDER. General Pollock.

General POLLOCK. Sir, we have approximately 1,000 active-duty medical hold soldiers and about 3,200 medical holdover. And so, it depends on where they are in the country. Some of them will be co-located at an installation or at one of the Community Based Health Care Organizations (CBHCO).

Dr. SNYDER. No, I understand that, General Pollock. I just wanted to get a sense of the number.

And then the question for Admiral Arthur and General Pollock. This specific issue of there has been some activity in Congress about the events of Walter Reed leading to a proposal to change the BRAC decision with regard to Walter Reed. My own view is that that, I think, would be a mistake. But I wanted to hear you all's perspective since it impacts on both your facilities.

General Pollock.

General POLLOCK. Sir, I think that it is very important that we continue with the BRAC. But we must be fully funded in order to do that. Fully funded in order to do that is about $400 million. And that would allow us to truly develop the world-class facilities that are essential at both the Bethesda campus and down at Fort Belvoir.

And it will also be important that we have relief from some of the requirements and legislation that have prevented us from investing in facilities once it is identified as a BRAC location. So we will need the funding to ensure that we sustain Walter Reed at a high level throughout that entire transition period.

Dr. SNYDER. Admiral Arthur, do you have any comment?

Admiral ARTHUR. Yes, Dr. Snyder. I agree with what General Pollock said.

We have an opportunity to create a tremendous national asset with the Walter Reed National Military Medical Center juxtaposed to the National Institutes of Health, the National Cancer Institutes with the USUHS, Uniformed Services University of Health Sciences, on the property as a great medical school and to build the facility that the National Capitol area needs in that location as well as to plus-up the Fort Belvoir facility. And this is our opportunity to create a much better facility than either of the two could be as stand-alones.

Dr. SNYDER. And my final question is the bill that passed out of the full Armed Services Committee last week and will be on the floor this week that will be called the Wounded Warriors Bill. Have any of you had a chance to look at it and have any thoughts or criticisms about it. Would you share that with us today?

We will start with you, General Pollock.

General POLLOCK. One of the concerns that I do have and I have shared with the line Army is it is important that we not discriminate against the different warriors. Not all of them are combat injuries. And the ones who are not combat injuries deserve the same level of care as the others. So I just would like to remind you that it is a warrior medical assistance process because we certainly don't want to only take care of our wounded soldiers.

I think that I would like to provide some of the feedback from the staff in writing as your response. And we can do that for you quickly, sir.

[The information referred to can be found in the Appendix beginning on page 209.]

Dr. SNYDER. Is there anything specific in the legislation, other than the terminology, the title of the bill, a provision that you think specifically discriminates between those who are combat wounded and those who maybe have picked up an illness or something overseas?

General POLLOCK. Well, the concern that we have is so many people now—and now the Congress included—is using the phrase "wounded warrior."

Dr. SNYDER. As is the military. Your point is——

General POLLOCK. And that is why I said I started with the Army leadership.

Dr. SNYDER. Well, your point is a very good one.

General POLLOCK. Just trying to make that point, sir, so that we don't cause yet other second and third effects.

Dr. SNYDER. I get your point.

Admiral Arthur.

Admiral ARTHUR. Only small things that we have looked at so far. One of them is case management. We have a very robust program for case management that isn't only centered on the nurse

case managers, but on social work, on administrative staff who are non-medical who support the families and deal with the pay and records issues.

So some of the issues surrounding the case manager and the requirement to be an active-duty service member who does that we might want to have reviewed because I think we have got a robust system that is contracted civilian. It is active-duty.

And I think the purpose of the bill is to ensure that every service member who needs one has appropriate case management, which should include the medical and administrative needs and the family needs involved in their care.

Dr. SNYDER. General Roudebush.

General ROUDEBUSH. Yes, sir. We, too, use a case manager approach also in our reserves. We have at the command level case managers who are managing reservists in their communities, if you will, getting their care. So we think the case manager approach is a very good one. And we look forward to working with you to identify both the ratio and the location for medical and administrative family support in terms of case managers.

And also the training activities are identified in the language are good, particularly with the disability evaluation system being sure that our folks that are dealing with that are properly trained. And we will look forward to that.

And if I could add one comment on the BRAC.

Dr. SNYDER. Yes.

General ROUDEBUSH. The focus has been on Walter Reed and Bethesda, and very appropriately so. But Malcolm Grow Medical Center at Andrews is a key player in the National Capitol area, both in terms of the implications and the execution of the BRAC as well as meeting the needs for Andrews Air Force Base and the key missions that they support. So I just want to be sure that as we pay appropriate attention that that is not lost as we move through.

Dr. SNYDER. Thank you. Yes. I thank you for that comment, General Roudebush.

Mr. McHugh.

Mr. MCHUGH. Well, actually, Mr. Chairman, you took my intended question on BRAC. And I am glad you did because I think we heard valuable input. And the funding is an absolutely critical component of this, including, by the way, over $470 million if you factor in the cost increases that have been effected by inflation and time, as happens in our economy, of course. So we have got an important role to play there.

Let me just state—and if any of the members want to comment—that we have had a kind of challenging history, if you will, between the services and this Congress with respect to military to civilian conversions, particularly as they relate to required—beginning in 2006—required certifications. And we have had some ups and downs and starts and stops and fits.

And suffice to say that right now we are by law have a freeze on military to civilian conversions prior to an expected submission of report that was due in January. I believe it was January 17th. And we are still waiting on that.

Was it you, Admiral, that spoke about you are working on that certification? Can you fill me on a little bit more about what is happening there?

Admiral ARTHUR. We are working on that. It is very difficult to certify cost, quality, and access prospectively because quality and cost can be a retrospective look at the lagging indicators, if you will.

Mr. MCHUGH. Well, you owe us a retrospective look as well because we required recertification.

Admiral ARTHUR. Yes.

Mr. MCHUGH. Correct.

Admiral ARTHUR. I would say that in clarification these conversions cannot be made until the certification is done. However, the military billets that derive into that process are cut on October 1st. So our military billets are gone by recertification.

Mr. MCHUGH. You mean Personnel Army Manning Document (PMAD)?

Admiral ARTHUR. Pardon me?

Mr. MCHUGH. You mean the PMAD? I would say yes, there is a definitional difference between how the services and how you had been instructed that versus how we do. I agree with that. And I don't think that is a call you made, but it is a call I am very unhappy with.

Admiral ARTHUR. Yes, sir.

Mr. MCHUGH. Because common sense should tell those who made that interpretation for you that Congress intended that to be outright freeze. And if you are losing the billets, you are losing the people. I mean, that is a conversion.

Admiral ARTHUR. No, sir. The billets are gone October 1st.

Mr. MCHUGH. Yes.

Admiral ARTHUR. And even if we were to convert, we don't get the conversion money until third or fourth quarter.

Mr. MCHUGH. I understand. But that wasn't your decision.

Admiral ARTHUR. No.

Mr. MCHUGH. It was somewhere else.

Admiral ARTHUR. Correct.

Mr. MCHUGH. The conversions or the certifications are something we are waiting for. So we are going to get them, right?

Admiral ARTHUR. It is at the secretary of the Navy level at the moment.

Mr. MCHUGH. Okay.

How about the Army? Do you know, General?

General POLLOCK. I know it is with the under secretary, sir.

Mr. MCHUGH. All right. So they are out of your shop?

Is that the same for you as well, General?

General ROUDEBUSH. Yes, sir.

Admiral ARTHUR. Yes, sir.

Dr. SNYDER. Okay. Thank you.

Mr. MCHUGH. Thank you, Mr. Chairman.

Dr. SNYDER. Ms. Davis.

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. Chairman. And I know we have more panels, so I will try and be brief.

I wanted to just address the issues around the Guard and Reserve and the fact that we have so many men and women return-

ing to communities that may be somewhat remote and with difficulty of receiving the kind of follow-up care that they might need. How do you see that that is being addressed? And do these conversions effect that at all?

General ROUDEBUSH. Ma'am, I can speak for the Air Force. For our reservists, our Guard and Reserve, we keep them on status. They are put on Manpower Personnel Account (MPA) days, which keeps their full benefits and entitlements coming while we work through with them in their communities the health care issues that are identified.

So we use case managers at the Major Command (MAJCOM) level that deal with these folks on a daily or weekly basis to make sure that they are getting the care that they need and that their circumstances are properly adjudicated and come to a good conclusion. So for us——

Mrs. DAVIS OF CALIFORNIA. Was there a tendency at the beginning to not have them return to their home communities? And I know their families were——

General ROUDEBUSH. No, for us in the Air Force that is the way we have worked it by policy. And that also puts them back in their support realm where their commanders can attend to them as well so that we have that support structure in place. But that is the Air Force policy to do that and has been.

Admiral ARTHUR. Navy and Marine Corps do very much the same. We send them back to their home units. And we have case managers in the Navy and Marine Corps who follow each and every member.

Mrs. DAVIS OF CALIFORNIA. Do you feel that the support is there, they can get the care that they need?

Admiral ARTHUR. I think it is because we have the case managers who keep track of each patient and know when their appointments are. If they need to be kept on active duty because of continuing medical issues or surgery that is needed, we do that. So we only let them go back to their home stations when they are stable and healing and we are following their progress prior to a medical board.

Mrs. DAVIS OF CALIFORNIA. Okay. I guess part of the concern would be in defining whether they are going to stay in the service or not and what that transition period for the VA is.

Admiral ARTHUR. Yes.

Mrs. DAVIS OF CALIFORNIA. And I appreciate that issue. And just quickly, I think you spoke to the need to anticipate the needs of the service members and so that we are embedding some of the behavioral health providers in units. I know that in San Diego—and I think that we are going to hear from Mr. McIntyre shortly.

But what they are doing with the special forces there is to embed a nurse with the unit because they felt that actually they weren't getting some of the care, that that had been a problem. Do you see that? Or do we have special forces units, for example, that, in fact, have missed out in some ways on some of the care that they should be receiving?

Admiral ARTHUR. The special forces units, the Seals in the Navy have made a decision that their health care providers are going to be from the Seal units. They will train their own health care pro-

viders. So they don't use Navy corpsmen far forward. They use Seals that they have specifically trained to be paramedics.

I applaud Mr. McIntyre's efforts to get that nurse embedded with the units. I think it is very innovative. And I think it speaks to the integration of our TRICARE contractors with our military treatment facilities and the dedication of, especially Mr. McIntyre and his focus on supporting the warfighter and their families. He saw an opportunity and supported it as well to support the comprehensive combat casualty care center that has just been opened at Balboa, which is a collaboration between Balboa, Camp Pendleton Naval Hospital, the Veterans Administration, and TriWest as the TRICARE provider.

Mrs. DAVIS OF CALIFORNIA. So hopefully we will see more of that kind of activity?

Admiral ARTHUR. Absolutely. Put the patients closer to home so that they can be properly supported.

Mrs. DAVIS OF CALIFORNIA. Okay. Thank you very much.

Thank you to all of you.

Thank you, Mr. Chairman.

Mr. MCHUGH. Mr. Chairman.

Dr. SNYDER. Thank you, Ms. Davis.

Mr. McHugh.

Mr. MCHUGH. If I may, just for the good of the order, a little housekeeping here. The staff has identified on the New York Times Web site an addendum, a correction to one of the cases that existed in the article that you have very rightly, and I think appropriately, included in the record. I think just for procedural sake—and I don't think it in any way changes the overall challenge presented by the article.

But this correction as appearing on the Web site ought to also, without objection, be included.

Dr. SNYDER. Without objection, we will include that in the record also.

[The information referred to can be found in the Appendix on page 206.]

Mr. MCHUGH. Thank you.

Dr. SNYDER. So that you all can respond to the article plus the addendum in total.

Anything further, Mr. McHugh.

Mr. MCHUGH. No, thank you.

Dr. SNYDER. Okay.

Ms. Davis, anything further?

Mr. MCHUGH. God bless you.

Dr. SNYDER. We want to thank you all for being here.

General Roudebush, I appreciate you letting me use you as a pawn today in my discussion about the tremendous service that all our men and women in uniform and their families give in terms of well beyond what most of us perceive as the American work week.

And, General Pollock, I neglected to mention that I spent a couple of unexpected nights at Tripper Army Medical Center some years ago and probably received the best advice I have ever received in my life from a cardiologist there. And I appreciate your

service and also you stepping forward at a challenging time in the position that you are in. We appreciate you being here today.

And, Admiral Arthur, our gratitude to you for your 33 years of service to the Navy and to the country. And I look forward to seeing you again, perhaps not testifying before this committee, but we appreciate your efforts and everything you have done for the Navy.

Admiral ARTHUR. Thank you.

Dr. SNYDER. And, Mr. McHugh, why don't we say we will pick up here in precisely five minutes and give everyone a chance, including our next table of witnesses, a chance to bust for the restroom if they need to. But this will be in military five minutes, not congressional five minutes. So we really will be back here.

[Recess.]

Dr. SNYDER. Let's resume our hearing.

And, gentlemen, we appreciate your patience and appreciate your attending the first session. These issues are obviously very important, not just to this subcommittee, but to the American people. And we appreciate you being here.

Our second panel is Mr. David McIntyre, Jr., who is the President and chief executive officer (CEO) of TriWest Health Alliance; Mr. David Baker, the President and CEO of Humana Military Health Care Services; and Mr. Steve Tough, the President of Health Net Federal Services.

And we will begin with Mr. McIntyre and go down in that order.

And as I instructed the first panel, we will have David put the light on, but that is just to give you an idea of the time. If there are some things after the five minutes that you need to tell us, don't let the red light stop you from sharing those with us.

So, Mr. McIntyre, we will begin with you.

STATEMENT OF DAVID J. MCINTYRE, JR., PRESIDENT AND CEO, TRIWEST HEALTHCARE ALLIANCE

Mr. MCINTYRE. Good morning, Mr. Snyder, Ranking Minority Member McHugh, and Congresswoman Davis. Thanks for the invitation to appear before you today.

It is an honor to be here to talk about how our organization, in collaboration with TRICARE regional office West, and our west region military treatment facility partners are doing whatever it takes to make good on the promise of TRICARE for those that reside in the 21-state region, more than 2.8 million beneficiaries.

Together we are taking a concerted proactive approach toward ensuring that these most deserving individuals have access to quality care and dedicated customer service, that which they have earned.

I request that my written statement be accepted for the record. It details much of the work that we have accomplished with regard to communication and education of both beneficiaries and providers, our robust behavioral health initiatives, our comprehensive formalized program to partner effectively with the direct care system, a program we call Joint Strategic and Operational Planning Process (JSOPP), which is affording facilities in our region to do a make, buy business case and much more.

Our overall environment in the west region is one of success. It has come from collaboration and as a result of the partnership that

we together have built and maintained in our on-going effort to leverage the strengths of our colleagues for the benefit of our joint military family customers. It is on these successes that I would like to concentrate my oral remarks today.

Our provider network, which exists to serve as a resource and in some cases, a safety net for the military treatment facilities, has grown, and we continue to enhance its ability to serve our beneficiaries. Our 18 owner organizations also serve in the local west region communities as our network subcontractors. I am pleased to announce that our network is growing 1 to 2 percent a month, and we are now to 117,000 providers across the 21 states. And it is an example of the power of progress inherent in this collaborative focused partnership.

Seeking to make sure that the network reaches into the communities where there is a substantial presence of Guard and Reserve we have called on the 21 governors of our region to join with us in thanking the doctors that are part of our network today and encouraging the others to reach out and support their fellow citizens in the state, much like, Mr. Chairman, the concept that you put in the AMA News a year or so ago.

To date, 15 governors from our states have stepped up and done exactly that. Working together we have been able to grow the network, particularly in the outlying communities, to make sure that the Guard and Reserve have a robust network on which to rely.

In the OB area, an issue of focus for this committee a couple of years ago, we placed substantial effort along with TMA to try and get them to change the rates so that in no state did we have OB rates that were below Medicaid as it related to TRICARE. Seven of those states of the nine were in our region.

I am pleased to say that the folks at TMA did a great job with the involvement of this committee in addressing that issue. And we have now grown that network by 71 percent in our region as a result of the policy change.

And we thank you on behalf of all of the families in our region for your work, especially your leadership personally, Mr. Chairman, in this area.

In spite of all these successes, we are seeing challenges, as mentioned by Congresswoman Davis, with behavioral health. A 5.8 percent cut in reimbursement rates is absolutely unsustainable in terms of making sure that the providers rise to the occasion in our region and come alongside those that have increasing demand in this area. I think, like OB, we have a problem because of the anomaly of Medicare and particularly given the growth of demand that we are seeing in this area.

For the Guard and Reserves, we continue our aggressive outreach. As many units within our region were activated and mobilized overseas and to our borders, we joined forces with Tricare Regional Office (TRI)-West to vigorously pursue numerous opportunities for educating and growing the beneficiary base. We have also done a couple of innovative things with the Guard and Reserve. We put DVDs out to all the families.

We are in the process of releasing the second version that is aimed predominantly at children and their parents. We have embedded the combat stress team concept in the California Guard as

a test. As Congresswoman Davis was talking about, that is being met to much success. And we also have an integrated project in Hawaii that links medical surge and behavioral health together.

As was mentioned previously, we now are focusing on those that are at the sharpest point of the spear. And that is the special operations teams. I have had the ability to visit with the head of the Navy Seals and to talk about the challenges that they face and their families face in making sure that they don't drop through the cracks. These are folks, as we all know, who bear a disproportionate burden because they are often called at night and leave the next day.

Their families don't know where they are going. They don't know when they are coming back. They don't know how long they are going to be gone.

The Seals tell me that they are suffering nearly a 40 percent casualty rate. And they are on average on their ninth deployment. It is very important that all of us continue to look for those gaps in the areas that we together can plug and make the system sharper for all. And I am excited about the work that we are doing together in our region in that area.

Last, in response to the Walter Reed situation, we freed up $1 million a couple of weeks ago, reached out across our region to ask how we might be of assistance to our military partners. One of the things that I am most excited about is something that we are starting with the Navy and the Marine Corps in the West. And that is what I would call an integrated care management prototype.

We are actually taking the concept that we are in the process of working with the Seals and embedding that together with the Navy and the Marine Corps in our region up and down the West Coast. We have a seat at the care management table. That allows us not to drive where a patient goes because that is not our decision. It allows, though, for us to look as a team end to end on what the needs of that patient are and where it is possible that we might be able to place them in the private-sector network if there is not capability and capacity available in the VA system.

And so, we are very excited about that. It is just starting under way this last week or two. And we are looking forward to doing our part.

At TriWest, we believe that the successful delivery of services is a cooperative approach, a joint effort among all the stakeholders in our region: our company, our owners, our TRI-West leaders, our civilian and military medical partners and you. By working together with our beneficiaries' best interests in mind, we can make this program more effective.

I would last like to offer one thought on the budget as I close. And that is we do have challenges. And I think that it is fair to say that none of us, not you, not the services, not ourselves anticipated the kind of demand that we are looking at. While I know it was politically complicated last cycle, I believe that it is time to reopen the question of whether there should be mandatory home mail delivery of pharmaceuticals.

That is not a change in the benefit. It is a change in the delivery of a product for maintenance drugs. It has been done for the VA

for some time. And you can pick up somewhere between $600 million and $1 billion by doing that.

Thank you very much.

[The prepared statement of Mr. McIntyre can be found in the Appendix on page 118.]

Dr. SNYDER. Mr. Baker.

STATEMENT OF DAVID J. BAKER, PRESIDENT AND CEO, HUMANA MILITARY HEALTHCARE SERVICES, INC.

Mr. BAKER. Thank you, Mr. Chairman. Dr. Snyder, Mr. McHugh, Ms. Davis, thank you very much on behalf of the dedicated men and women of Humana Military Healthcare Services for the opportunity to update you today on the state of the TRICARE program from our perspective. I have provided a written statement for your consideration.

Dr. SNYDER. I should have said earlier, Mr. Baker, all the written statements from both the previous panel and this panel will be made a part of the record.

Mr. BAKER. Perfect. Thank you very much, Mr. Chairman.

Dr. SNYDER. Without objection.

Mr. BAKER. For background, our company was awarded its first TRICARE contract in 1995. And we began serving military beneficiaries in 1996. Since 2004, we have been administering our current TRICARE contract for 2.8 million TRICARE eligible beneficiaries in DOD's south region of the United States.

And though it does not seem possible, on Sunday, April 1st, we will begin the fourth option year of our five-year contract. And as we begin the new option year, it is my feeling that the operational status of TRICARE is excellent, thanks in large part to the tangible support of this subcommittee, the oversight of the Department of Defense, and the superior service being rendered by your contractor partners, especially those represented on this panel to my right and left.

I believe active-duty military personnel, retirees and their family members have exceptional access to a rich array of high-quality health care services that are being delivered as cost-effectively as possible. Service levels are outstanding. Processes are stable. And all available evidence indicates high satisfaction among TRICARE members.

Mr. Chairman, my written statement highlights the status of the program across several domains, including cost control, clinical quality, access to health services, and service to the deserving members of the military community, both active and retired. And I have provided examples of processes and programs that we have successfully implemented in the south region under the current contract structure. I am happy to report that after some initial disruption during startup these processes and programs are working very well.

And I chose this array for my statement cost, quality, access, and service, because it reflects the objectives of the TRICARE program as originally set forth by both the Congress and the Department of Defense a decade-and-a-half ago. To be sure, there are challenges for the program, particularly today. But the important point is that

today's TRICARE program has been able to meet the challenges of a changing world environment.

Against that backdrop I am aware that this subcommittee and others on Capitol Hill are carefully examining the delivery of health care to our service members and veterans alike and that the TRICARE program undoubtedly will be subject to careful scrutiny. I applaud those efforts.

But as you go about your critical work, please bear in mind that today's TRICARE program is working very well. We at Humana Military Healthcare Services look forward to working with you and with our Department of Defense partners to continue fulfilling the promise of TRICARE for many years to come.

Again, Mr. Chairman, please allow me to thank the subcommittee for the opportunity to be here today. And I look forward to your questions.

[The prepared statement of Mr. Baker can be found in the Appendix on page 137.]

Dr. SNYDER. Mr. Tough—and I am pronouncing that correct?

Mr. TOUGH. That is correct, sir.

Dr. SNYDER. Mr. Tough.

STATEMENT OF STEVEN D. TOUGH, PRESIDENT, HEALTH NET FEDERAL SERVICES

Mr. TOUGH. Thank you. Good morning, Chairman Snyder, Congressman McHugh, and Congresswoman Davis. And I appreciate, as was stated by my colleagues, to be here this morning to share with you perspectives in experience with the TRICARE program and in particular, the Health Net experience.

Let me begin by giving you some background about the Health Net Federal Services and the dedicated 1,700 employees who are focused and clearly targeted on delivering high-quality benefits and services to the beneficiaries of TRICARE.

Health Net has a long history in working in partnership with the Department of Defense. As Foundation Health Federal Services, we were the first company to develop comprehensive managed care programs for military families. Under the first Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) reform initiative contract, a precursor program to TRICARE, we provided health care services to DOD beneficiaries located in California and Hawaii.

During the first generation of TRICARE contracts, Health Net administered 3 contracts covering 5 regions, 11 states, and 2.5 million TRICARE beneficiaries. Under the current TRICARE contracts, we administer health care services in the TRICARE North region, which includes 2.9 million beneficiaries in 23 states primarily in the Northeast. In addition to our North region contract, our sister company, MHN, provides behavioral health counseling services to military members and families through a number of contracts with the Department of Defense.

These services include military family counseling, rapid response counseling to deploying units, victim advocacy services, and reintegration counseling. We also perform a number of health care-related services for the Department of Veterans Affairs. And

through these various programs, we have helped the VA save over $150 million since 1999.

The primary underpinning of the success of the TRICARE program is our partnership with the military health system. Our 19 years of working with the Department of Defense gives us a clear appreciation for the need to understand and be aligned with our government customer and continuously work to improve, tailor, and integrate our services to be most responsive to the evolving needs of the health system and the beneficiaries we serve.

We do this by working in close collaboration with the Department, the military services, maintaining strong relationships and open and proactive communications with the beneficiary associations and by tapping into the advice and counsel of a group of former military, senior military leaders throughout the TRICARE advisory board. Based on our interaction with these groups as well as our strong performance levels, our perspective of the current state of the TRICARE program is that the program is working exceptionally well. And let me expand on some of the key points.

Health Net and the TRICARE regional office North have fostered a strong collaborative relationship. This relationship ensures open, honest, transparent communications as well as a clear understanding on our part of the goals and expectations of our customer. It also helps ensure that we prioritize our initiatives appropriately, focus on those that help DOD achieve and even exceed the TRICARE contract objectives.

For example, we have been working actively in concert with numerous initiatives to improve on health care costs and quality for the TRICARE beneficiaries. One such initiative is a collaborative effort undertaken recently to increase TRICARE mail order pharmacy usage. I am sure you are aware that DOD achieved significant savings on prescription drugs purchased through the mail order pharmacy program. And that is because the DOD has access to the Federal supply schedule for pharmaceuticals under the mail order program but not to the retail pharmacy outlets.

To help DOD encourage the use of mail order program, Health Net implemented a multi-faceted approach at no cost to the government. This approach had several components: educational efforts targeted to beneficiaries in our disease management, case management, and transitional care programs, an educational program that targeted our high-volume providers with low TRICARE mail order pharmacy penetration and offering e-prescribing tools to a select group of network providers.

These efforts have resulted in a demonstrative increase in the overall pharmacy usage within the north region up 25 percent over the past year. We talked about earlier about the performance excellence. This generation of TRICARE contracts contains a number of performance standards that exceed those used in the commercial health care marketplace. Even though these standards are higher, we are either meeting or exceeding those standards. And I will just give you a highlight of a few.

Beneficiaries calling our toll-free customer service line on average are connected to a customer service representative in four seconds. Health Net now obtains nearly 78 percent of network claims electronically. This is significantly higher than the average com-

mercial mass care experience of 55 to 72 percent. Health Net tries to minimize provider hassle factor paying providers promptly, on average paying within 6 days for claims submitted electronically, 13 days for paper claims and within 2 days for Web-submitted claims. And referrals and authorizations are processed within 2 days.

The efforts to reduce the provider hassles seem to be paying off. Our network is robust. We have nearly 100,000 contractor TRICARE providers servicing the TRICARE North beneficiaries. This number is up by 35,000 or 53 percent since the start of the service delivery in September of 2004.

Regarding the beneficiary satisfaction levels, this program is also performing well in this area. Beneficiary satisfaction with the TRICARE program remains very high, higher than with commercial or other governmental agency programs, according to a recent survey by the Wilson Health Survey Group.

Of all the plans and programs included in the Wilson survey, TRICARE was the top rated health insurer in member satisfaction for the fourth year in a row. The results are consistent with surveys of TRICARE users performed by the TRICARE regional office North, which have also found high beneficiary satisfaction levels.

For the past 5 quarters all beneficiary satisfaction levels have averaged between 87 and 88 percent. Additional proof that the program is working well is the survey results of MTF commanders. For the past 5 quarters, overall MTF commander satisfaction has averaged 86 percent. However, I am pleased to report the most recent performing quarter Health Net received a 94 percent satisfaction rating from the north region MTF commanders.

Earlier I mentioned our 19 years of experience with DOD has taught us the value of understanding our customer and aligning with the objectives of the military health system. Again, we do this by tailoring our services to meet the unique needs of the Military Health System (MHS). Perhaps the best example and the one of most interest to this committee, based on the recent events, is the way we stand ready to help and support the health care needs of our active-duty service members.

While, as you know, the active-duty service members receive most of their care from the direct care system, we do provide a number of important support services. As you know, we support the facilities in the national capital area, which include Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda. And we provide an extensive network of civilian health care providers to augment the services at the MTF.

We also operate a TRICARE service center on-site at each military treatment facility to provide customer service, including enrollment, claims, and referral assistance. The TRICARE service center at Walter Reed averages over 600 beneficiary visits per month.

We provide a full range of medical management support to the wounded warriors and other MHS beneficiaries referred out to care within the civilian network. These include benefit review, customer support and service, transitional care, case management, and discharge planning. Specifically at Walter Reed, Health Net has been

participating in various committees and tiger teams developing solutions for implementation where appropriate.

Our medical management and field operations team are assisting with the training of the wounded warrior transition brigade case managers. And our behavioral health company, MHN, has readied three licensed clinical social workers to provide additional social service support at Walter Reed.

MHN has also identified additional experienced consultants who can be made available on short notice. These social work consultants are experienced in providing non-medical supportive consultation services to active-duty members and their families. If requested, Health Net is prepared to provide additional support to support the Walter Reed Army Medical Center and our Nation's wounded warriors.

Another way we provide support to both active-duty members and their family members is through reintegration counseling. We provided this service in response to the reintegration and redeployment needs at installations where large numbers of returning troops called for greater support for health care access and coordination. This support also extends to the Guard and Reserve members.

MHN for the military family counseling services contract provides short-term, face-to-face problem resolution for military personnel and their families with over 150 counselors on sites at military installations across the United States and overseas. MHN provides rapid response counseling to the National Guard and Reserve members and their family members to help them best cope with the stresses of deployment or reintegration to the civilian life after deployment.

There are two other examples of our tailored approach that best meet the needs of the Department and the TRICARE beneficiaries and include our involvement with the Fort Drum regional health planning organization and our efforts to advance disease management and consumer empowerment. My written remarks go into both of these initiatives in much more detail.

On the disease management and consumer empowerment front we have been talking with the Department of Defense about establishing a program to pilot the use of commercial decision power program as an enhanced disease management, consumer empowerment service that helps members better manage their own health care, navigate the complex health care system, and have a more proactive and productive discussion and interaction with their physicians.

In closing, I would like to thank you for inviting me to testify before this committee today. The TRICARE program is stable and performing exceptionally well. And we are very proud to be a proactive and coordinated partner with the MHS system.

Thank you.

[The prepared statement of Mr. Tough can be found in the Appendix on page 156.]

Dr. SNYDER. Thank you, gentlemen.

And we will put ourselves on the five-minute clock again. I think all three of you were here. I saw Mr. McIntyre and Mr. Baker in the audience.

You were here also, Mr. Tough, during the preceding testimony. Is that correct?

Mr. TOUGH. Correct.

Dr. SNYDER. I wanted to give you all a chance to make any comments that you might want to with regard to anything the surgeon generals said, particularly with regard to their—what we referred to as wedge efficiencies and so on.

Beginning with you, Mr. McIntyre, anything that you heard this morning that you would like to comment on?

Mr. MCINTYRE. I think that you all put your finger on the topic of relevance for the direct care system. The challenge is how do you make the system more efficient in its use of resources. But from the services' perspective, at least our perspective has been they suffer for the ability to hire people on a contracted basis, oftentimes taking as much as 18 months to find people, if they can find them at all. And staying attuned to that issue and pushing through the detail, I think, is going to be very constructive and very useful for the system itself.

Dr. SNYDER. Mr. Baker.

Mr. BAKER. I would echo Mr. McIntyre's comments and the comments of the previous panel members.

As you know, Mr. Chairman, I go back a long way in the military health system. It has always been my belief that it is better to deliver care to military family members, to military members, and indeed to retirees, better to do so when possible in the military system. Our TRICARE contracts are established in a way that incentivizes us to try to make that happen.

I urge the military departments to look carefully at the notion of conversion to civilians and indeed the reduction in military medical personnel. I don't think that serves the system well.

As one of the panel members indicated a moment ago, care is going to be delivered. The question is will it be delivered within the military system or within the purchased care system. I believe this Nation is better served if it is delivered within the purchased care system.

Dr. SNYDER. Mr. Tough.

Mr. TOUGH. Yes, thank you. I would agree with both David and Dave.

You know, it is important to keep in mind that there is a dual mission of the military health system. It is military readiness, military medical readiness, and peacetime health care delivery. And so, it is important that we have that MTF as that centerpiece for care.

And certainly, one of the primary objectives of this contract is to optimize the military treatment facility. And it is difficult to do that with a declining base of active-duty military medical personnel.

Dr. SNYDER. I wanted to ask about the reimbursement online. I think all of you would be in agreement that over the last several years the reimbursement to providers has gotten more efficient. Would you all just briefly describe how you have done that?

How do you handle those small practices that are still struggling a bit with the electronic age? Is it a paper claim? Or do you have a program where you actually install a computer yourself for access?

Again, if you would just make this brief, if we could. Just go down the line, starting with you, Mr. McIntyre.

Mr. MCINTYRE. It is a challenge for small practices. My father actually retired as a surgeon a couple of years ago, not because of loss of dexterity, but because he didn't want to go through the cost of converting and suffered for the fear of what Health Insurance Portability and Accountability Act (HIPAA) was going to bring. And, you know, it really has to be worked practice by practice by practice.

And what we did is we have started with the highest volume practices and are working our way down that list, not because the smaller volume aren't important. But the larger bang for the buck from a taxpayer perspective is to move those things along more readily where there is higher volume. And we are finding success with that.

I was involved a couple of years ago in an effort to wire offices. The challenge is when only three percent of the services that a practice provides are to this population. Why would you retrofit your entire operation by involving software that you are only going to use three percent of the time?

And so, it is a little bit of a challenge. I am not sure we are ever going to get to the last mile, which is the smallest doctor's operation with the smallest volume. But we have seen a dramatic change in the amount of electronic submission since we have started this contract a couple of years ago.

Dr. SNYDER. Mr. Baker.

Mr. BAKER. I would echo Mr. McIntyre's comments. We, too, have had a strategy. In fact, a TRICARE contract has incentivized us to try to move from paper to electronic submission. In our region now for all providers, or all care rendered, rather, we are hitting over 73 percent of the claims are being submitted electronically.

But just as Mr. McIntyre has done, it has often been by the ones. It has started with those providers who had the highest volume of TRICARE claims. They were the ones most interested. And we have tried to make it as easy as we possibly can. We continue to work that every day.

There are simply some providers, though, who are never going to come onboard. Because averages are a bit misleading. In our region, we have over 42 percent of the licensed providers are in our networks. And part of the deal there is that you agree to submit your claims electronically. But they are responsible for 3.7 percent of the population of the region. So that disparity in some areas, some practices have high volumes. Others have very, very low volumes.

We just have to demonstrate to them the benefits of the electronic filing, the statistics that Mr. McIntyre referenced and indeed Mr. Tough referenced about speed and accuracy and payment and so forth and the cash flow advantages seem to resonate. But it is a game of inches.

Dr. SNYDER. Mr. Tough, anything to add?

Mr. TOUGH. Yes, just similar comments. Again, we try to pick them off in order of the highest volume. I think David McIntyre's comment about small percentage of TRICARE beneficiaries in an office practice will not necessarily drive up an individual physi-

cian's interest to specific activities that might work more inclined to electronic communication, electronic transfer of claims.

The Web-based efforts we have undertaken—we have about eight percent of our claims on Web-based transactions. If we can get providers to consider that, that is a fairly simply way to transact claims with us. It also is the fastest turnaround, two days to pay.

Dr. SNYDER. My time is up, Mr. Tough. But so I understand you, when you say Web-based, you mean that the physician's office would not necessarily have to have any new software or anything. He just would go to your Web site with a code and be able to enter it in even if they have a paper-based records system in their own office. Is that a fair way of describing it?

Mr. TOUGH. Yes. There is an express claim process that we have built with our subcontractor at Palmetto Government Benefits Administrators (PGBA). And it allows for that kind of ease in transaction.

Dr. SNYDER. Mr. Jones.

Mr. JONES. Mr. Chairman, thank you. And I couldn't help but think—I have been here 13 years, 7 terms. And I have Camp Lejeune, Cherry Point and Seymour Johnson Air Force Base. And I want to say to you and your companies and corporations that you have made tremendous progress in a very difficult system. And you have talked about it today in certain answers to the chairman with, you know, electronics.

And I realize that no system is perfect. But I would have to say that you have made such progress. And who benefits? The user. And that is our military and our retirees. And you certainly have done a tremendous job.

I want to go to one statement that Mr. Baker said that I think General Pollock, who just left—you know, we all realize that this nation is in serious financial shape. I mean, I don't care which side of the aisle you are on. Anybody that would look at the debt—when I came in 1995, it was $4.9 trillion, $4.6 trillion in debt.

It is well over $8.3 trillion. And if you talk to David Walker, who has spoken to this committee, subcommittee and committee, you know, he will tell you that the true debt is probably somewhere around $50 trillion.

Not only do we have to provide the quality of medical care to our military, but we also have to make sure that they are getting the best value for the dollar. Which, that is your responsibility. And again, I compliment you on that.

Mr. Baker, you made the statement that, you know, at some point in time—at least I interpreted it this way, and I could be mistaken. At some point in time when you have to make the decision of whether the military is going to have to make some very difficult decisions as to the quality of care on base—and we heard General Pollock talking about, you know, pediatrics and Obstetrics and Gynecology (OBGYN)—those services now are pretty much out in the public more so than it used to be.

And then she also mentioned that it is going to be an education process, that from the standpoint of the services that you used to have on base. Let me explain that. Used to have on base we now don't have on base. So therefore, the education to the quality of

life—I am not sure you can answer this question, but I am going to ask it anyway.

What do you see 10 years down the road? And this is your personal opinion. It is not your professional opinion. Or it could be. What do you see 10 years down the road for your industry in providing the service and what the military can provide knowing that we have got some very, very difficult decisions to make, whether we have the war on terrorism or it has all been over? We have got some really difficult times based on the economy of this country and what the government has to spend.

Mr. BAKER. Sir, I am humbled that you would ask my opinion on such a question. And I would be the first to say that my crystal ball is not only cloudy, it is probably scratched up a bit. So it is really hard for me to make that kind of prediction. I think the outcome is going to be predicated on the kinds of decisions that were discussed with the earlier panel. And that is the future of the direct care system.

I mentioned to the chairman that I have been around for quite some time. I had a full Air Force career as a health care administrator and actually grew up in a military family. So I have seen the military health system all my life. And I can tell you that one of the things I have seen during my life is an on-going contraction of the size of the military facilities on installations, the scope of services provided.

General Roudebush made mention of the Air Force and some of the changes that have occurred with the small community hospitals over the years. I saw a statistic not long ago that really drove things home. And forgive me if I don't have the numbers exactly right. But somewhere a little over 100 hospitals among the three services being operated. I remember a day when the Air Force operated 120 facilities.

So if we follow the same glide path, it strikes me that we are going to continue to contract. The people who can change that are resident in the Congress and they are resident in the Pentagon. And I urge them to look very, very carefully at what we are trading off.

Mr. JONES. The other two gentlemen?

Mr. MCINTYRE. If I might, Congressman Jones. I think as Mr. Baker said, you put your finger on an important issue. And I, too, have somewhat of a warped crystal ball. I started my career on Capitol Hill doing health policy on the Senate side for a decade before I came to do operations. And I grew up in a health care family, my father having served in the Army at Fort Bliss for a while while I was a child.

I look at this from the standpoint of what is it that we can afford and how is it that we properly make the right make, buy decisions. In my own company, I buy spikes or surges in a contracted way. I staff to the average. And I came to that conclusion—and I have now been running this company that I built for a decade. And I came to that conclusion when I started looking at the spikes and the changes in my budget from cycle to cycle. And I started to come to the conclusion that I need to figure out what are those averages and how do I make that work.

And the first responsibility, as we all know, that the military health system has is to be ready to support the warfighter as they go into combat. The second responsibility is to make sure that they have got caseload that will give them the capacity to keep those skills sharp and to serve basic needs of the family. And then the third is to either build or purchase the rest of that care.

And I think that one of the challenges we have together in this environment is what is the right make, buy analysis. How do we do that right? And how when we look at this over the complexity of the Federal debt—and that was a topic when I was working for Senator Gorton in Washington state in the mid-1980's when we lost the Senate on the Republican side over the debt issues and our reaction to the debt issues or the members' reaction.

I think the challenge is to look at the system on the totality of the budget, not just firewall component parts and get all the pieces at the table to include the VA, to talk about the care from end to end. How do we leverage where the DOD spent money, for example, to pay the three of our organizations to build massive provider networks to support the DOD's direct care system when they have to surge?

Why would the VA be buying with a different checkbook? Why wouldn't we size it together? Why wouldn't we buy one way? Why would we not only spend one check of the taxpayers' rather than two? And I think the examples of that go on and on.

And I think my hope is that the heat of Walter Reed and the fire and the focus has all of us backing up together and asking the kinds of hard questions that you all this morning have been asking of all of us, those of us that contract, those of us that support in that area, the VA, the DOD, and Congress coming together to talk about what is the right way for us to do this for the next century, not for the one we have been through.

Mr. TOUGH. If I can take a moment and add, agree with my colleagues. Again, I have 19 years of experience with this same contract. And I reflected back as Dave Baker and David McIntyre were talking and said I can recall when the CHAMPUS reform initiative contract was started in California and Hawaii. Letterman Naval Hospital, Oakland, McClellan—those facilities aren't there anymore.

So I think the key is really what is the basic floor of what is needed for military readiness and to prepare the warfighters for the military medical system for warfighting and combat. And I think that is a question that needs to be solidified because, again, we see a retraction of the system.

I would also agree with Dave McIntyre's comment about joint spending. God save me for using this term, but there is a need for, you know, a common checkbook. We even see it a little bit in today's contractors. There is the military health system activity, and then there is the civilian health care spending.

And I think if we look more jointly as to that as being one common checkbook and how we would best manage those assets in make, buy decisions, then we can decide exactly what we want to purchase in the military health system and exactly what we want to purchase in the external system and then configure those purchases in different kinds of ways. Dave has taken it a step further

in embracing the VA, which is yet but another dimension of government spending.

Mr. JONES. Thank you very much.

Thank you, Mr. Chairman, for that time.

Dr. SNYDER. I have to share this anecdote with you. But it was some years ago prior to—I don't know, seven years ago or something. And I, in my early fifties, came down with appendicitis when I was here and was referred to Bethesda Naval Hospital.

And it was about 2:00 p.m. in the afternoon. And I am laying on a stretcher looking at a bunch of people looking down on me. And the surgeon who was going to do the surgery said, "We have a slight delay on an operating room availability." He said, "Let's spend that time talking about military medicine." Now, that is lobbying. [Laughter.]

And I appreciate the discussion that is going on. I think it is an important one. I think back to a friend of mine who maybe still is, but was in the Army Reserve and had a solo private practice as a family doctor and was mobilized during the first Gulf War and was struggling, scrambling trying to find someone to cover his practice and I don't think he did.

And I think his life—I mean, he loved the military and loved the participation. But it was a big, big hit on his family and his business, which was a solo medical practice because we can talk about it is great to have these reserve medical people and we can surge them when we need them, forgetting what is left behind. So that was——

Mr. MCINTYRE. A lot of providers lost their practices during that period.

Dr. SNYDER. Right.

Mr. MCINTYRE. I was on the Senate staff at the time. And it is one of the reasons why the deployment cycles for doctors have changed in the reserves.

Dr. SNYDER. Yes.

Mr. MCINTYRE. Was to reflect that burden.

Dr. SNYDER. I wanted to ask specifically, again, a brief question for the three of you.

I think, Mr. McIntyre, you talked the most about the improvement that has been made specifically in obstetricians, which I appreciate. As you are looking ahead now rather than back, what do you see as the needs that you are facing with regard to either numbers of providers or geographic areas with regard to providers or specialty needs with regard to providers? Is there any gaps that you see out there or issues that are facing you in the provider issue? Shall we start with Mr. Tough just to——

Mr. MCINTYRE. Sure, go right ahead, yes.

Mr. TOUGH. Actually, certainly, in low-supply areas we are always going to have some difficulty in gaining access to providers because providers in low-supply areas have choices that they may wish to make. But in terms of gaps, we haven't seen as many gaps as early on in the program. And I think a lot of that has to do with the fact that a lot of the other improvements that have occurred in the relationships. The streamlining of the relationships has helped.

We always have a concern regarding compensation. So that is going to be—it is an on-going issue. And quite frankly, we live with some concern that Medicare can change a reimbursement on us, and then we are off running trying to figure out how to resolve relationships with providers.

I see the one that is coming downstream, the one that concerns us the most has been talked about here earlier is in the mental health arena. We have about 800 mental health providers, different kinds of categories from physicians to psychologists to licensed clinical social workers. But I think to strike to the point, the current circumstances of the war on terrorism has created some added stress.

We are in an environment we haven't seen in an awfully long period of time. And I don't think some of the mental health issues or the family issues are going to surface for a while, whether those are child issues or spousal issues or other kinds of mental stresses and strains that exist. And I think that is the one area that we have the most concern.

We have some pocket areas, as you know. We talked a little bit about the Fort Drum area. We have got a special effort that has being undertaken with the Fort Drum regional health planning organization. And we are very dedicated and focused on that community in particular. We have done some gap analysis work with the community.

It is one of the few communities, quite candidly, that I have seen a totally engaged and embraced effort by the medical community, the military system, and ourselves to try to find the best way of meeting the needs of that military system up there as well as the community at large. But we are, in fact, working on mental health case workers to bring into that community specifically to respond to the, we know, the on-going up and down pressures of deployment, redeployment.

Dr. SNYDER. Mr. Baker.

Well, let me ask a follow-up. You say you are bringing in mental health. Who do they then work for?

Mr. TOUGH. They will actually be working—they are actually contracting providers. We bring them in under contract and set them up in clinical practice in the community to respond to the need.

Dr. SNYDER. So it is essentially a full-time military family caseload?

Mr. TOUGH. Yes.

Dr. SNYDER. Yes.

Mr. Baker.

Mr. BAKER. Yes, sir. I would echo Dave's comments. I think over the years that we have done better in terms of networks and in terms of those non-network providers who are participating. There are pocket shortages in our region just as there are in the others. But overall I think our coverage is pretty good.

The mental health issue that we have talked about today concerns me a great deal because I am not sure that we yet know what the demand is going to be. We know it is increasing. We know that we are not particularly rich in terms of mental health

providers as a Nation. And so, I worry about that, I would say, a great deal.

The other piece, though, that I would also pass along is relevant to the earlier discussion and the question that Congressman Jones raised a moment ago about the on-going downsizing. That can have a significant impact on the availability of care in a community. If you think about it, the medical community in a civilian setting flexes to the demand. And it flexes to the demand based on the amount of care that is required for the civilian members of the community, but also the amount of care that has been coming out from the base.

Significant reductions in the capacity and capability of the military facilities can often put a stress on the availability of medical care in a civilian community, whether it is a TRICARE beneficiary or not a TRICARE beneficiary. And I worry about the impact of what we are seeing long-term here, particularly where we have our bases located today.

Dr. SNYDER. Mr. McIntyre.

Mr. MCINTYRE. I would like to associate myself, Mr. Chairman, with my colleagues' comments because I think they are right on. We are all working at this as hard as we can. There was a year a couple of cycles ago when we were all talking about dramatic concern around reimbursement rates. I stated at the time that I didn't think it was just rates. I thought it was about how we pay. It was about making the system more effective for providers.

And at the end of the day, it is about——

Dr. SNYDER. We used to talk about it was low, slow and complicated.

Mr. MCINTYRE. That is exactly right.

Dr. SNYDER. And I think you all are taking care of slow and complicated, but we have still got low to deal with.

Mr. MCINTYRE. Yes, sir. That is right. And, you know, the challenge is it is the Federal budget. And I remember when I came to Capitol Hill in the middle of the 1980's, my father was an ophthalmologist. They were the first ones to go under the knife on Medicare provider cuts. And, man, I didn't want to go home. In fact, he wouldn't pay for my tickets home when I was working as a young staffer because he wanted to disown me.

I think we have made it complicated. Yet what we are doing is we are demonstrating that it can work. And when you ease the complication and you pay people quickly, it is money that they are not having to subsidize out of their own pocket for already tight rates. And I think all three of us and our staffs are told regularly you are the fastest payer in the marketplace. That is a great thing. They deserve that. And they deserve every piece of what we can do.

We, too, have embedded mental health folks at our own dime into certain areas because that is important. There is one item that has not been covered that I think is one of the very complicated things that members of the military family are facing. Particularly, it has been spearheaded by the Marine Corps in terms of the focus. You all have addressed this in the way of asking for some reports. But that is the issue of autism.

And I had the privilege of spending a day at Camp Pendleton a few weeks ago with General Conway's wife where we listened to beneficiaries and their families talk about the challenges in autism. And the thing I was struck by—and this is where our greatest challenge, I think, as an enterprise with your assistance, is going to be.

There is only one certified provider to care for autistic kids in all of New Mexico. And it stretches from Florida with 3,800 providers to California with 1,700 to Hawaii with 22 to New Mexico with one. How do we address that?

And how is it that we take care of the challenge that is being faced by these families when they rotate every couple of years based on their time in the military and the role that they have and they drop to the bottom of the state's eligibility priority list and they can never earn their way all the way back up that list before they rotate again?

And I think there are some opportunities there to do some very focused and specific work and something that I would hope would be on your priority list as you are working through this legislative cycle.

Dr. SNYDER. I think that report—Jeanette or David, you can correct me—I think the autism report is scheduled to come back to us in April, is my recollection. I think that is right. And we will see what that shows. It is an interest of mine. And there are so many dynamics to it, as, you know, we are aware more and more how frequent the diagnosis is, about one in 94 boys now.

The intensive therapy seems to help substantially, but it is not without cost. And then you think of our military families who are dealing with a child, a special needs kid or kids—this can be more than one child in a family. And then one of them is literally pulled out of the household for a year or 16 or 18 months in a mobilization, which can happen both with the reserve component or active component. And what the change in the family dynamic is. So it is an important topic to this committee.

Mr. Wilson for five minutes.

Mr. WILSON. Thank you, Mr. Chairman.

Actually, I apologize. I was at another committee meeting. And as the ranking member, I wanted to stay through the conclusion. But I want to thank you for your service and providing services to our veterans and current military.

And particularly, Mr. Baker, I am very pleased that PGBA–LLC is in the district that I represent along with Blue Cross-Blue Shield.

And they are, Mr. Chairman, extraordinary public minded companies that if anybody needs a sponsor for the 5K run, somehow they get called upon and participate. And so, they promote health in different ways.

And again, I am just happy to be here. Thank you for your service. And truly a way—I know you are doing a good job. And I think this may apply to all of us is the number of complaints we get, which are so few. And indeed, my late predecessor, the late Congressman Floyd Spence, was such a promoter and person supporting the development of TRICARE to really serve our military. And thank you for bringing that to fulfillment.

I yield the balance of my time.

Dr. SNYDER. Mr. Jones.

Mr. JONES. Mr. Chairman, thank you. And as you were talking about mental health, I was looking at the paralyzed veterans. They had supported the supplemental bill that was up last week. And in their letter to Members of Congress, it was all about the funding issue. And I am reading here very quickly of that total of the $1.7 billion total. Of that total, $100 million would go for contract mental health care for men and women returning from the war.

And, Mr. Baker, you and the other two gentlemen, I am sure, would—I took from your comments—and maybe it is the other two as well—that we know with the PTSD, the brain injuries that this is something that is going to be hard to project. You can, through your experts, determine that, yes, there are going to be a larger number of men and women that are going to have these mental health needs. But we don't know exactly how many and how long.

You made the comment—and I wish you would all three pick up on this—that as this need grows and expands over the next two or three years—because if a man or woman—I will never forget a kid. All of us go visit the hospitals. But I will never forget a kid from New Mexico named Eric. Eric was in a wheelchair. His mother was there from New Mexico. His little sister, about seven or eight, was there with him. And the doctor—it was another Member of Congress. And I think it was Gene Taylor. I stand to be corrected.

But anyway, when we left the room, Eric could not speak. And his mom kept saying, well, you know, these nice congressmen came to visit you. And all he could do was move his finger that was on his chest. And I will never forget the doctor when we walked out said that Eric is going to need care. He was 26 years old. Eric will probably need care for the next 45 or 50 years. And I realize that is not quite the same as mental care, but it is a brain injury. So it is related.

Where do you see—this is the question. Your comments, well, we have got a problem because we need the medical experts, whether they be psychiatrists or psychologists or doctors. Do you see that pool is in a situation where we need to as a government, both state and Federal Government, we need to encourage more young people to look at that as a profession? Because where are we going to get the providers if we don't educate and get out in the field?

Mr. BAKER. Well, again, I appreciate the opportunity to offer an opinion on that.

Mr. JONES. Sure. Right, certainly.

Mr. BAKER. But it is not very informed. And I need to be the first to indicate that. But the truth of the matter is that I think we probably do need to try to encourage people to go into those sorts of professions. I believe the demand is going to increase. I think that is one of the outgrowths of this conflict. And I am not sure that we have the capacity to deal with that increased demand, whether it is within the military health system or outside.

Mr. TOUGH. I would have to agree with Dave's comments. I don't think we really have a full sense of what the magnitude of the patient load is likely to become.

I know that as a result of the efforts that are being undertaken to manage the active-duty service members who may suffer from traumatic brain injury we are in the process of doing a national

survey and search for every hospital that has the capacity to do treatment for TBI and try to develop an inventory of those services and a relationship with those contract facilities or those facilities individually as well as providers who are well-schooled and trained in TBI cases so that we can use them as advisers on cases that may be of a difficult nature.

The beauty of a national program such as TRICARE is that we have three contractors we can coordinate and communicate with regarding care across the country. And we recognize that there is also an infrastructure of VA that also has similar types of support mechanisms. There are four traumatic brain injury centers in the VA.

So it is trying to look at the pool of the universe of what we can access. But being quite candid, I don't think we yet know what the requirements are going to be for whatever is extended into the future.

Mr. MCINTYRE. The challenge in this area is obvious. The challenge is to figure out how much demand are you going to have. And then do you build it or do you buy it or do you use a combination thereof? In this environment in this city, the decision was made to build it. That probably is the right decision.

In San Diego, as was referenced previously, the military and us made the decision that while we wanted people to come closer to home, the volume that was going to end up there probably did not justify the full construction of everything to be resident on the Balboa campus.

And so, we searched the market in San Diego, which is very medically robust, and brought two institutions to the market, to the table that have specific expertise in brain injury, now, not blast brain injury like what we are seeing in Iraq and Afghanistan, particularly in Iraq, but brain injury nonetheless that they could work from.

I am struck—and I spend time like you all at these facilities from time to time every couple of months just to keep me grounded in why it is important to stay focused and what the needs are. I had the chance about six weeks ago to spend time with the highest ranking patient at Walter Reed. He is a reservist one-star general from Florida. And he was the military attaché to the U.S. ambassador to Afghanistan.

And he was second in line behind a Humvee that blew over. And he hit his head against the crossbar. This is a very, very smart guy. I know his law partner in Florida personally. He is a medal of honor recipient. And he was walking me through his journey of the last 18 months in dealing with this.

And here is a judge, and, you know, very articulate, but struggling. And so, it is going to show up in a lot of different ways. And I think the analogy of sports injuries is a good one. And you all are putting focus in this area, which is to be applauded. All of us as a society are going to learn about this going forward.

And the challenge is to be impatient about it, but also very focused and to be marshalling the resources that are available and matching those with things that need to be constructed but to be very careful to not build capacity where it may not be warranted long-term or we are going to create an on-going expense that can't

be sustained to the degree that we are able to get out of this kind of conflict in the near future.

Thank you.

Mr. JONES. Thank you, Mr. Chairman.

Dr. SNYDER. And we will continue to learn about this for 60 or 70 years as this generation of veterans ages and deals with these impacts.

I think we are winding down here, gentlemen. But I had a few more questions I wanted to ask.

When you all first picked up the newspaper when *The Washington Post* began running their stories on Walter Reed and then saw the events that occurred over the next several weeks up until now, what did you all and do you all see today as your responsibility in dealing with this whole complicated issue of—I mean, obviously you don't have responsibility for mold at Walter Reed—but that whole issue of the medical holdover care?

What did you all see as your responsibility or do you see as your responsibility?

Mr. MCINTYRE. I believe that we have the responsibility to do two things. One is as the partners of those that wear the uniform and who lead organizations like Walter Reed—and they are all over our regions of all different service types. And there are challenges in many of them. How do we come to the table to bring our assets and expertise to assisting them where there are gaps that we can plug together? That is first.

Second, I believe strongly that the real challenge that came from Walter Reed—and it was not the mold and the cockroaches and all of that. It is the bureaucracy. And it is having patients and their families fall into the trap of the bureaucracy. And how is it that we streamline the focus to make sure that we are having the system serve the patient, not the system be a slave—or the patient be a slave to the system?

And clearly, the focus that you all are putting in this area to look at the medical boarding process and the like is very useful. The plussing up, the care coordination is useful. I believe that we have a responsibility to share in the work on care coordination. It is why we are working on the pilot with the prototype with the Navy and the Marine Corps right now in the West.

And it does come down to a resourcing question but also a make, buy portion of that resourcing question. But it is solvable. And it is going to take the kind of heat, in my opinion, having served on the Senate side as a staffer for a while. It is going to take this kind of heat to melt the bureaucracy in our programs in a direction that is more responsive to the patients and their families.

Dr. SNYDER. Mr. Baker.

Mr. BAKER. Sir, I think we all do have a responsibility here. And in terms of the steps that we took after the Walter Reed story started to break, one of the first things we did was to reach out to the commanders of the military facilities in our region, again, to try to determine was there something that we could do to assist. We felt like that was a key component.

The other thing, frankly, that we looked at was facility by facility where did we have the opportunity to flex. That is, where did we have networks that perhaps were too large as justified by the de-

mand, but also that those other facilities where perhaps our network was not as robust as it might have been and what could we do to renew our efforts on the theory that if the commanders were going to have pressure to process the troops through faster, that could displace some care for non-active-duty folks down into the network. So we felt like we had to do that.

The third thing we looked at was, again, to make an offer under the terms of our contract. Are there services that you need that we could bring into your particular military facility? Under a program in this contract that we collectively, I think, all refer to as optimization—is there something we could do there? Is there a nurse or a technician or something that you need that we could help you acquire? So I think across those domains those were the kinds of activities that we engaged in.

Dr. SNYDER. Mr. Tough, anything to add?

Mr. TOUGH. Yes, I think this is uniformly the same approach we all took, was that we are partners with the military health systems, counterparts. And when the need arose, we immediately tried to jump in and assist them and how we could best support them.

Clearly, the majority of the care is in the direct care system. But when that care is in need of being outsourced to the civilian sector, we need to make sure it is a seamless transition and to make sure that we have solid case management support between that case that has been transferred from within a military treatment facility to the civilian sector.

Dr. SNYDER. If I might ask you all—and, in fact, we will go down the line. Because it was General Pollock, I think, that she and I had a brief exchange about she was—I don't know if the word was critical, but concerned about that she couldn't follow quality control so much with services that were contracted in the private sector.

Do you remember that comment?

Mr. TOUGH. Correct.

Dr. SNYDER. I think this is what you are getting at here. Would you comment on what she said, please, about that?

Mr. TOUGH. Well, exactly. What she was trying to get at is that when we do get into that transfer of care into the civilian sector, we are going to have to have a mechanism to get that information back into a centralized point of control.

And I think that is now being more actively worked as a result of the Walter Reed experience, I think, more clearly today than probably ever before because a centralized point of control is now evolving within the Walter Reed and certainly other military treatment facilities. So it is that information flow back and forth.

We recognize, too, that sometimes in the nature of the care we are asked to get engaged in some of that might be very short-term in nature. It could be as simple as an out-patient visit or a short-term burst. But it could be longer term in nature. It could be a case managed activity that is in a civilian facility for a longer period of time. So it is important that we have that ability to communicate those case records back into the system.

The difficulty we are challenged with and faced with right now is that is not electronic. It is going to be paper. So one of the things we are going to have to work and overcome—but again, we are also involved in other kinds of activities similar to what Dave Baker

just mentioned. We have been asked to do some case manager training as they begin to ramp up their case managers within the system.

We have also stepped forward and indicated we would be willing to help recruit those case managers. We would even deploy some of our staff. We have several of our personnel that work for us that actually came out of the Walter Reed facility. And we told them we would be happy to just deploy them back into the system because they are well-familiar with the Walter Reed's needs, put them back on the ground, and they could use them in any ways they wished.

I think the challenge, quite frankly, that remains is when you get into the civilian sector—and this may be true for the active-duty side as well—is the beneficiary is going to move down a continuum of coverage. They are going to move from TRICARE. They might move to VA. And they might even move to Medicare.

And so, we have to make sure that that process is as seamless as possible because there are going to be differences in the way that care is managed. There might be pass points that need to be thoroughly flushed out. And there might be differences in scope of coverage. So we have to make sure that that becomes a fairly clear and clean process.

Our takeaway of all of this is that we really have to understand that when there is an active-duty service member that ends up in our hands or at any point that they need somebody's hand to hold. That is the primary issue. And we actually should treat this as both a concierge service, that we really have to care—take the ultimate in care management to that active-duty service member.

Mr. MCINTYRE. That is the very reason why in our region we have done what we have done with the Marines and the Navy, is to get all three legs of the stool under the chair. And that is the VA, the DOD, and downtown. And it is this seamless handoff issue that is critical.

It is important to look at the needs of the patient through that entire cycle and do it together. And it is important to make sure that if we are going to place someone downtown like a reservist that was at 29 Palms whose family was in Colorado who could be placed in Colorado for a while to convalesce and then potentially come back into the reserves that the only way to manage that well is to make sure that all three of those domains are focused on that individual as they morph in and out of the different systems getting what they need. And this notion of surge capacity is very, very important.

This is where we are going to struggle, in my opinion, because it is not——

Dr. SNYDER. With the surge capacity?

Mr. MCINTYRE. Well, potentially the surge capacity because it is not natural for people to say well, maybe I should buy it versus build it. That is the first thing. That happens in our own organizations. It happens everyplace.

The second thing, I think, where we are going to struggle systemically is this notion of really making sure that all the parties are at the table at the same time because there is this natural inclination that I own this, I want to make sure that it is delivered the right way. The challenge is, if you go back to medical hold of

a couple of years ago growing out of Georgia, you can't hire case managers or move them off a ward and have them take care of TBI and know what to do the next day.

They flat out can't get there. It is a very, very specialized niche. And that is where it is important to draw from the assets that are available as we continue to share information and train each other in how to optimally manage these patients.

Dr. SNYDER. Which is why, as we are closing down here, Mr. McIntyre, I disagree a little bit. I don't use the term. I don't say that I think the problem at Walter Reed is a bureaucracy problem. That implies that somehow the laws are perfect and the people that are there—it just kind of gets lost in the maze.

I think if we don't have adequate numbers of people with adequate training with well-understood expectations of what the laws are, I don't think it is fair to call that a bureaucracy problem. I mean, it is a maze. But I think that may not recognize the real cause of the problem. We as an institution may be the cause of the problem if we have disability laws that are really hard to navigate through.

I have one final question. I think it is probably just a yes or no to you, Mr. Tough. In your written statement, you say that 95 percent of the calls to your hotline are answered within 30 seconds. Is that a real person that answers them?

Mr. TOUGH. Yes.

Dr. SNYDER. Thank you very much.

Mr. Wilson, do you have further questions?

Mr. WILSON. No, Mr. Chairman.

Dr. SNYDER. Mr. Jones, do you have any further questions?

Mr. JONES. Mr. Chairman, I just want to thank this panel and the first panel. This has been very, very helpful and educational to me.

Mr. Chairman, I want to thank you as well.

This is an issue that you have all articulated extremely well. It is with us. It is in front of us.

And, Mr. McIntyre, I will use your term. Hopefully we will encourage the common checkbook, one check, I hope.

Dr. SNYDER. Mr. McIntyre, Mr. Baker and Mr. Tough, we appreciate you being here.

The committee is adjourned.

[Whereupon, at 12:21 p.m., the subcommittee was adjourned.]

A P P E N D I X

MARCH 27, 2007

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 27, 2007

Opening Remarks - Rep. John M. McHugh

Military Personnel Subcommittee Hearing

The State of the Military Health Care System

March 27, 2007

Mr. McHugh's Opening Statement:

Thank you Dr. Snyder. Before I begin I'd like to thank you for holding this very important hearing on the state of the military health system and the extraordinary care it provides to our service members and their families. It is undeniable that the care provided to our troops, their families and to our retired beneficiaries is vital to the success of our military now and in the future.

"I'd also like to thank our witnesses, General Pollock, Admiral Arthur, General Roudebush, David Baker, David McIntyre and Steven Tough. Together these dedicated individuals work tirelessly to deliver the finest health care in very complex and challenging environments.

"I would particularly like to welcome General Pollock. I believe this is your first time testifying before this subcommittee and, although you assumed the responsibilities of the Surgeon General during a chaotic time for the Army, we wish you all the best as you lead the Army Medical Command through the challenges that it now faces. I would be remiss if I did not also mention that you are the first nurse to assume the duties of the Surgeon General and, for that reason especially, I offer you my sincere congratulations.

"Admiral Arthur, I understand that you intend to retire this summer, so this will likely be your last appearance before the subcommittee. You have my deep appreciation for your leadership and dedication in striving to deliver the highest quality healthcare to our sailors and Marines during your 33 years of service to the nation. Thank you, Admiral.

"There is no doubt that these are most difficult times for the military health system. One of the most severe challenges rests in the fact that, for the second year in a row, the budget for the Defense Health Program has been significantly reduced with the hope of Congressional support for changes to the benefit in the form of increased fees for TRICARE. Further, the budget assumes reductions to funding for military treatment facilities for the third year in a row with the expectation that these facilities must become more efficient. The fiscal year 2008 budget reduction is $2.1 billion. I am interested to hear from the witnesses about where these reductions might be realized and how they might affect the ability to provide care to our beneficiaries.

"The budget also includes an increase of $157 million dollars in civilian pay to fund an additional 2,712 positions planned for conversion from military to civilian positions in fiscal year 2008. In light of the 5,507 military positions that have already been converted since 2005, I can't help but wonder what effect this will have on the ability of the military health system to carry out its mission. Given our witnesses' expertise in recruiting and retaining medical professionals, I am interested in their prospective on the ability of the Services to attract high quality individuals into these positions.

"In light of the issues raised at Walter Reed Army Medical Center regarding the care of injured and wounded troops as they recover and transition either back to duty or to civilian life, I would like to also hear from the panels how they are working as partners to ensure these issues are resolved.

"I thank you for being here with us today and I look forward to your testimony."

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RECORD VERSION

STATEMENT BY

MAJOR GENERAL GALE S. POLLOCK
ACTING THE SURGEON GENERAL OF THE UNITED STATES ARMY
&
CHIEF, ARMY NURSE CORPS

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

MEDICAL POSTURE HEARING

27 MARCH 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Statement By
Major General Gale S. Pollock
Acting The Surgeon General of The United States Army

Mr. Chairman, Congressman McHugh, and distinguished members of the subcommittee, thank you for the opportunity to discuss the current posture of the Army Medical Department (AMEDD). America is well aware of our medical capabilities and the challenges we face as your Army remains engaged in combat operations in Afghanistan and Iraq. During these operations, we have recorded the highest casualty survivability rate in modern history. More than 90 percent of those wounded survive and many return to the Army fully fit for continued service. Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding Soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, and reassuring them that the health of their families is also secure.

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

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

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

The superb performance of our healthcare professionals during the Global War on Terrorism cannot be understated but it is not our only area of focus. AMEDD personnel supported nation building engagements not only in Iraq and Afghanistan but in 15 countries during 25 medical readiness training exercises during Fiscal Year 2006. Our medical logistics system has moved more than 17,000 short tons of medical supplies into Iraq and Afghanistan. More than 70 percent of the workload in our deployed combat support hospitals is emergency care provided to Iraqi forces and Iraqi citizens injured in fighting. Today, we maintain one combat support hospital split between two detainee facilities in Iraq – providing the same care available to American Soldiers in Iraq and in compliance with all internationally-recognized laws and standards for care of detained persons.

The toll has been high in terms of cost and human sacrifice. Army Medics have earned 220 awards for valor and more than 400 purple hearts. One hundred and two AMEDD personnel have given their lives in Iraq and Afghanistan. These heroes represent many aspects of Army Medicine including Combat and Special Forces

medics, Army Medical Service Corps, Army Medical Corps, and Army Veterinary Corps. These men and women are truly the best our Nation has to offer and will make any sacrifice in defense of their Nation and, most importantly, for the care of their patients.

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

However, we are concerned about the long-term morale of our serving Army medical force as well as our ability to recruit our future force. Fiscal Year 2006 presented Army Medicine with challenges in recruiting healthcare providers. For the second consecutive year, the Army fell short of its goals for awarding Health Professions Scholarships in both the Medical Corps (83% of available scholarships awarded) and Dental Corps (70% of scholarships awarded). These scholarships are by far the major source of accessions for physicians and dentists. This presents a long-term manning challenge beginning in Fiscal Year 2009. As part of the 2007 National Defense Authorization Act, the Congress provided important authorities to allow the Secretary of Defense to increase the monthly stipend paid to scholarship recipients. These increases will make this program more attractive to prospective students and ease the financial burden they face as students. Thank you for taking this important step to improve this critically important program. We are working hard to ensure every

available scholarship is awarded this year. In conjunction with United States Army Recruiting Command (USAREC) we have initiated several new outreach programs to improve awareness of these programs and to increase interest in a career in Army Medicine.

The Reserve Officer Training Corps (ROTC) is a primary source for our Nurse Corps Force. In recent years, ROTC has had challenges in meeting the required number of Nurse Corps accessions and as a consequence, USAREC has been asked to recruit a larger number of direct accession nurses to fill the gap. This has been difficult in an extremely competitive market. In Fiscal Year 2006, USAREC achieved 84% of its Nurse Corps mission (goal of 430 with 362 achieved). To assist USAREC we have instituted an Accession Bonus for 3-year obligation and have increased the bonus amount for those who obligate for four years. Additionally, we raised the dollar amount that we offer individuals who enter our Army Nurse Candidate Program to $5000 per year for max of two years with a $1000 per month stipend. In 2004, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs.

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

Director of the Army National Guard, we continue to explore ways to improve Reserve Component accessions and retention for this important group.

The high operations tempo has also placed strain on our equipment. The Fiscal Year 2007 Emergency Supplemental Appropriation request and the Fiscal Year 2008 Budget Request adequately funds the replacement and reset medical equipment in Iraq and Afghanistan as well as equipment organic to units deploying to and redeploying from the Middle East. One area that requires our focused attention is the need for an armored ground ambulance. Because our current ground (wheeled) ambulances are not armored they are not employed outside the Forward Operating Bases (FOB) on a regular basis. This reduces a maneuver commander's ability to employ ground ambulances in support of combat operations. When the ground ambulances have operated outside the FOB perimeter, it led to the death of some medical personnel. The Army's modernization plan addresses this issue and your continued support of the Joint Light Tactical Vehicle (JLTV), which includes an armored ground ambulance, will help alleviate this problem. The Army has tested several methods of providing armored ambulances to the force until production of the JLTV commences. Product Manager for Light Tactical Vehicles (PM LTV) has indicated that armoring a four-litter M997 ambulance, to include the patient care area, would cause a significant overload condition resulting in an unsafe, top-heavy vehicle. Studies to armor the current ambulance shelter and placing it on the M1152A1 also indicate a significantly overloaded vehicle. Currently, PM LTV has awarded a work directive to AM General Corporation to complete a feasibility study for a two-litter armored ambulance based upon the M1151/52/65 vehicle chassis.

PM LTV is also working with AMEDD to address immediate armored ambulance needs through development of an improved Casualty Evacuation (CASEVAC) kit for the M1114 and eventually the M1151A1 vehicles. The US Army Medical Research and Materiel Command (MRMC) has developed a temporarily installed one-litter CASEVAC kit in which the casualty is suspended on litter mounted crossways over the rear seats that can be fitted on either the M1114 or M1151A1. Once the CASEVAC mission is complete, the kit is stowed and the vehicle is ready for normal operations.

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

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

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

Hypothermia was leading to poor casualty outcomes and, as a result, the Army added new equipment for patient warming and fluid warming to medical equipment sets

including the Combat Medic's aid bag, ground and air ambulances, the battalion aid station, the Forward Surgical Team, and the Combat Support Hospital.

The Joint Theater Trauma Registry is proving invaluable; rapidly collecting the lessons learned and guiding decisions about training, equipment and medical supplies based on near real-time data. An organized, systematic method to collect information and use it to drive improvements is a key component of future military medical operations. As knowledge of the actual experience of US medical units in Iraq and Afghanistan has grown, Army Medicine has developed a Theater Combat Casualty Care Initial Capabilities Document under the Joint Capabilities Integration and Development System that captures the required capabilities and capability gaps in combat casualty care to guide research and development efforts and effect changes in doctrine, organizations, training, materiel, leadership, personnel and facilities.

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

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

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

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

Despite our operations tempo, we have maintained quality of care for Soldiers, their families, and our retirees. Private sector care enrollment and workload are

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

Going to war affects all Soldiers. The number of Soldiers with Post Traumatic Stress Disorder (PTSD) and other stress-related symptoms has gradually risen. The AMEDD has been supporting our Soldiers at war for 5 years, during 9/11 at the Pentagon, in Afghanistan, in Iraq and around the globe. But America does not know about the extensive array of mental health services that has long been available for Soldiers and their families. Since 9/11, the Army has augmented behavioral health services and post-traumatic stress disorder counseling throughout the world, but especially at Walter Reed Army Medical Center and at the major Army installations where we mobilize, train, deploy, and demobilize Army forces. Demand for these services will not decrease in 2007 and we are committed to providing the long-term resources necessary to effectively care for Soldiers and families dealing with a wide variety of stress-related disorders.

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

The AMEDD is also performing behavioral health surveillance and research in an unprecedented manner. There have been four Mental Health Advisory Teams (MHATs)

performing real time surveillance in the theater of operations, three in Iraq and one in Afghanistan. COL Charles Hoge has led a team from the Walter Reed Army Institute of Research in a wide variety of behavioral health research activities. His research shows that generally the most seriously affected by PTSD are those most exposed to frequent direct combat.

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

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

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

and personal relationships, normalizing combat-related mental health symptoms, and teaching Soldiers to look out for each other's mental health.

The acronym "BATTLEMIND" identifies 10 combat skills that, if adapted, will facilitate the transition home. An example is the concept of how Soldiers who have high tactical and situational awareness in the operational environment may experience hypervigilence when they get home. The post-deployment BATTLEMIND training has been incorporated into the Army Deployment Cycle Support Program, and is being utilized at Department of Veterans' Affairs Vet Centers and other settings. We have also been developing pre-deployment resiliency training for leaders and Soldiers preparing to deploy to combat using the same BATTLEMIND training principals, as well as training for spouses of Soldiers involved in combat deployments.

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

In December 2006, The Surgeon General chartered an Army Task Force on TBI to review our policies and resources dedicated to TBI from scientific research, acute diagnosis and treatment, to long-term rehabilitation. This Task Force, led by Brigadier General Don Bradshaw, includes subject matter experts from across Army Medicine. We also invited the Navy, the Air Force, and the Department of Veterans Affairs to have

representatives participate in the Task Force. I expect General Bradshaw to provide me a report and recommendations by late spring 2007.

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

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

Fiscal Year 2007 and Fiscal Year 2008 will be challenging years for the Defense Health Program (DHP) and Army Medicine. Our estimates for cost growth through 2013 are not complete, but we are still witnessing sizable growth in the number of TRICARE-reliant beneficiaries in our system, and the pressures on the defense budget continue to grow while military healthcare costs continue to substantially increase. The FY 2008 President's budget request includes a legislative proposal that aligns TRICARE

premiums and co-payments for working-age retirees (under age 65) with general health insurance plans. The Department may modify or supplement this request after it considers recommendations from the DoD Task Force on the Future of Military Healthcare that has been recently established with distinguished membership from within the Department, other federal agencies and the civilian sector. A key area the Task Force will study is "beneficiary and government cost-sharing structure." We believe this and the other recommendations they make will markedly benefit the MHS in the future.

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

We continue to aggressively work to improve the transition from inpatient care to outpatient care for our Wounded Warriors at Walter Reed Army Medical Center and across Army Medicine. Under the leadership of General Cody, the Army's Vice Chief of Staff, we have taken the lessons learned at Walter Reed and implemented an Army-wide action plan. This plan includes operation of a Wounded Soldier and Family Hotline, an "800-number" call center and operation center located at the US Army Human Resources Command. If there are issues, they'll get elevated to the Army leadership quickly and not be allowed to percolate at a low level without being addressed. We are also implementing a One Stop Soldier and Family Assistance Center at Walter Reed. This center brings together case managers; family coordinators; personnel and finance experts; and representatives from key support and advocacy organizations such as the Army Wounded Warrior Program, Red Cross, Army Community Services, Army Emergency Relief, and the Department of Veterans Affairs. We are also creating a formal Patient Advocate Program (an ombudsman program

established initially at Walter Reed) to be established at other major installations across the force.

We are also revamping the administrative process of evaluating and adjudicating our Soldiers' disabilities. Our goal is to streamline the process to eliminate confusion among Soldiers and families. As we revamp this system we must be careful that we do not compromise the quality of medical care received or the Soldier's right to a full and thorough medical evaluation.

The Army will ensure that Soldiers will no longer leave the resources and attention of its medical system behind when they walk out the hospital doors. The Army will ensure that Wounded Warriors and their families are treated the way they so richly deserve and the way the Nation rightfully expects. We are grateful to the Congress for the concern and attention paid to Soldiers - and will continue to keep the Congress informed as we improve these identified challenges.

In closing, let me emphasize that the service and sacrifice of our Soldiers – and their families – cannot be measured with dollars and cents. The truth is that we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss. Thanks to your support, we have been very successful in developing and sustaining a healthcare delivery system that honors the commitment our Soldiers, retirees, and their families make to our Nation.

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

Major General Gale S. Pollock

Commander USAMEDCOM/Acting The Surgeon General
Chief, Army Nurse Corps

MG Gale S. Pollock became the Commander US Army Medical Command/Acting The Surgeon General on March 20, 2007.

MG Pollock is also Chief, Army Nurse Corps.

MG Pollock received a Bachelor of Science in Nursing from the University of Maryland. She attended the U.S. Army Nurse Anesthesia Program and is a Certified Registered Nurse Anesthetist (CRNA). She received her Master of Business Administration from Boston University; a Master's in Healthcare Administration from Baylor University, a Master's in National Security and Strategy from the National Defense University, and an honorary Doctorate of Public Service from the University of Maryland. She is also a Fellow in The American College of Healthcare Executives (FACHE).

MG Pollock was Commanding General, Tripler Army Medical Center, Pacific Regional Medical Command, U.S. Army Pacific Surgeon; and Lead Agent, TRICARE Pacific, Honolulu, Hawaii. MG Pollock's military education includes the Department of Defense. CAPSTONE Program; the Senior Service College at the Industrial College of the Armed Forces; the U.S. Air Force War College; the Interagency Institute for Federal Health Care Executives; the Military Health System CAPSTONE program; the Principles of Advanced Nurse Administrators; and the NATO Staff Officer Course.

MG Pollock's past military assignments include Special Assistant to the Surgeon General for Information Management and Health Policy; Commander, Martin Army Community Hospital, Fort Benning, Ga.; Commander, U.S. Army Medical Activity, Fort Drum, N.Y.; Staff Officer, Strategic Initiatives Command Group for the Army Surgeon General; Department of Defense Healthcare Advisor to the Congressional Commission on Service Members and Veterans Transition Assistance; Health Fitness Advisor at the National Defense University; Senior Policy Analyst in Health Affairs, DoD; and Chief, Anesthesia Nursing Service at Walter Reed Army Medical Center, Washington, D.C.

MG Pollock's awards and decorations include the Distinguished Service Medal, Legion of Merit (with 2 oak leaf clusters), the Defense Meritorious Service Medal, the Meritorious Service Medal (with 4 oak leaf clusters), the Joint Service Commendation Medal, the Army Commendation Medal, and the Army Achievement Medal. She earned the coveted Expert Field Medical Badge, and is proud to wear the Parachutist Badge. She received the Army Staff Identification Badge for her work at the Pentagon and earned the German Armed Forces Military Efficiency Badge "Leistungsabzeichen" in gold.

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Statement of

Vice Admiral Donald C. Arthur

Surgeon General of the Navy

Before the

Subcommittee on Military Personnel

of the

House Armed Services Committee

Subject:
Defense Health Program

27 March 2007

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Introduction

Chairman Snyder, Ranking Member McHugh, distinguished members of the subcommittee, I welcome the opportunity to share with you how Navy Medicine is taking care of our nation's Sailors, Marines, and their families across the globe and at home.

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

Our first step in caring for the warfighter is to make sure they are physically and mentally prepared to consider whatever mission they are asked to complete. We are dedicated to maintaining a healthy and fit force that is ready to deploy and to deploying medical personnel ready to provide the best health care to our warfighter on the battlefield. And when that is not enough, we are committed to restoring the health of those injured on the battlefield, whenever possible, through the full continuum of care until they have healed from their wounds.

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

Defense Health Program and Navy Medicine Budget for Fiscal Year 2008

In recent years, Navy Medicine faced many fiscal challenges and anticipates that some will continue throughout fiscal year 2008. Fiscal year 2008 provides funding challenges in that the efficiency wedge increases and certain assumptions regarding savings opportunities may not be borne out in execution. These reductions represent leadership and management challenges,

which we must meet. We are vigorously integrating these fiscal challenges, and our military to civilian conversion requirements, into an ongoing business process review that is designed to make Navy Medicine an efficient, effective health care provider.

As you know, the Department of Defense faces tremendous difficulty with balancing the growing costs and long-term sustainability of the Military Health System. We will need to consider all options available to ensure a superior benefit remains available for the long term. I look forward to hearing the recommendations from the recently-established Department of Defense Task Force on the Future of Military Health Care – a group made up of distinguished members from within the Department, other federal agencies, and the civilian sector.

Combat Casualty Care

We have made significant advances in combat casualty care and have redefined trauma management for military operational medicine. Navy Medicine is continually assessing its medical capabilities to make improvements resulting in real time adjustments to ensure the right health care capabilities are deployed as far forward as possible. These improvements are based on our experience and lessons learned, and on the requirements mandated by the warfighter. As a result of these improvements, 97-98 percent of service members who are wounded and reach medical care within 60 minutes after being wounded, survive their injuries, return to the U.S. and their families. These survival rates do not just happen and are a result of foresight, research and development efforts, and improved training, planning and logistics. We must continue to invest the necessary resources to sustain these efforts to care for outstanding veterans on and off the battlefield.

One of the most important contributors to saving lives on the battlefield, historically and currently, is Navy corpsmen—Navy Medicine's first responders on the battlefield. The platoon

corpsmen are supported by a team of field surgeons, nurses, medical technicians and other support personnel in theater. This group is supported by medical evacuation teams and overseas MTFs working together with MTFs in the US – this is the Navy Medicine continuum of care.

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

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

Changes have been made in the training of the physicians, nurses and corpsmen who first encounter injured service members, as well as to the way certain types of injuries are treated. In addition, new combat casualty care capabilities such as one-handed tourniquets and robust vehicle first-aid kits for use during convoys are being deployed. Navy Fleet Hospital

transformation is currently redesigning Expeditionary Medical Facilities (EMFs) to become lighter, modular, more mobile, and interoperable with other Services' facilities in theater.

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

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

Providing preventive and treatment services as early as possible is the best way to avoid or mitigate the long-term effects of war. Navy Medicine is monitoring the health of deployed service members with the use of pre- and post-deployment health assessments. These assessment tools are designed to identify potential issues of concern, both physical and mental. The program also provides service members information on how to access medical services for any physical or mental health issues that may occur after returning from deployment.

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

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

For combat casualty care to be effective, Navy Medicine has incorporated service members' families into the care model. We first launched this concept at the National Naval Medical Center several years ago and are now making it part of the way we treat our combat casualties at every Navy MTF. We learned early on that families can play a critical role in the recovery of wounded service members. Because the injury may also have an impact on the families, we have ensured they too are provided with the tools and support they need to help their member transition through the stages of recovery.

As part of the Navy-Marine Corps team, we recognize the value and efforts of Marine Corps liaisons at our MTFs. They have played a very important role providing non-medical support for the service members and their families as they navigate through the process of transitioning back or out of the service. We are steadfast in our commitment to continue to improve our processes and our support of our wounded service members and their families.

Recently at Naval Medical Center San Diego, we established a new concept of care -- the Comprehensive Combat Casualty Care Center (C5). C5 is based on the models for amputee care developed at Walter Reed and Brooke Army Medical Centers, and is expanded to include other types of injuries such as TBI and Post-Traumatic Stress Disorder. C5 monitors and coordinates the medical care of the service member in and outside of the MTFs, including outpatient visits, home care, care at outside facilities, other MTFs. In addition, C5 provides support to the families in every way possible and focus on ensuring that the service members and their families have a smooth transition to civilian life or continued military service. C5 is already a vibrant/active program which will become broader in scope and more robust as it adds people and capabilities. When completed, NMCSD will be the Department of Defense's comprehensive combat casualty care "center of excellence" for the west coast.

Humanitarian and Joint Missions

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

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

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

USNS MERCY (T-AH 19), our hospital ship home-ported in San Diego, completed a humanitarian assistance mission to Southeast Asia last year. MERCY provided direct aid to more than 87,000 people in Indonesia, Bangladesh and the Philippines. MERCY's deployment was a model of cooperation and deliberate planning with non-governmental organizations and partnering nations. The team included a dozen NGOs; US Army, US Air Force, and Public Health Service medical personnel, naval construction forces and medical professionals from Canada, India, Malaysia, Australia and Singapore.

MERCY's deployment was an exciting and important opportunity to support the U.S. National Security policy—both at sea and ashore—in a region where we have important interests. This international collaboration underscores the Navy's commitment and tradition of providing medical and humanitarian assistance where and when needed and added a new dimension to forward presence.

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

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

Also in 2006, Joint Forces Command (JFCOM) tasked the Navy with providing medical staffing in support of the Army's Landstuhl Regional Medical Center (LRMC) Germany. Upon arriving in November, this group of more than 300 Navy medical reservists and 30 active duty personnel became part of the LRMC team and are providing superior medical, surgical and preventive health care to wounded warfighters returning home. This mission demonstrates how our active duty and reserve components seamlessly integrate the talents and strengths of our

reservists to accomplish the mission. This call to meet Landstuhl personnel needs also demonstrates the increased operational requirements and tempo to which Navy Medicine has been responding since the beginning of OEF/OIF.

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

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

Joint initiatives are underway across the full spectrum of military medical operations around the world. Navy Medicine is committed to increasing the ways we jointly operate with the Army and Air Force. The goal is for all U.S. medical personnel on the battlefield-regardless of service affiliation to have the same training, use the same information systems and operate the same equipment because we are all there for the same reason – to protect our fighting forces and provide them the best healthcare possible when they are injured.. It should not matter whether the casualty is a Soldier, Sailor, Airman, Marine, or Coast Guardsman, or what color uniform the medical provider wears. **Medical Personnel and Quality of Care**

On an average day in 2006, Navy Medicine had over 3,800 medical personnel from the active and reserve components deployed around the world supporting Operations, Exercises or Training. While continuing to support our missions we are challenged to ensure that sufficient numbers of providers in critical specialties are available to fill both the wartime mission and our mission to provide beneficiaries health care at our MTFs.

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

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

Navy Medicine also promotes healthy lifestyles through a variety of programs. These programs include: alcohol and drug abuse prevention, hypertension identification and control,

tobacco use prevention and cessation, and nutrition and weight management. Partnering with community services and line leadership enhances the programs' effectiveness and avoids duplication. We have established evidence-based medicine initiatives and currently measure diabetes, asthma and women's breast health. Soon, we will add dental health and obesity.

Recruitment and Retention Efforts of Medical Department Personnel

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

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

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

As of December 2006, the Medical Corps remained below end-strength targets and continues to experience acute shortages in critical wartime subspecialties. Recruiting challenges continue to exist within the HPSP, the primary student pipeline for medical corps officers. The

HPSP met only 56 percent of goal in fiscal year 2005 and 66 percent in fiscal year 2006 for medical students. These shortfalls will be realized in fiscal year 2009 and 2010 with 230 fewer accessions than required. Retention issues continue to be of concern for this community and the effect of increased medical special pay rates offered for fiscal year 2007 will not be known until the end of the fiscal year.

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

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

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

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

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

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

Research and Development Efforts

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

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

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

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

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

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

Navy Medicine and the Department of Veterans Affairs

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

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

Navy Medicine is also exploring new relationships with the VA such as the Balboa Career Transition Center. NMCSD recently entered into an agreement with the U.S. Department of Labor, the VA and the California Employment Development Department to provide quality VA benefit information and claims intake assistance, vocational rehabilitative services, career guidance, and employment assistance to wounded and injured service members and their

families. This unique program will successfully coordinate all of the services available to these individuals.

Conclusion

Chairman Snyder, Representative McHugh, distinguished members of the committee, thank you again for the opportunity to testify before you today about the state of Navy Medicine and our plans for the upcoming year.

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

Vice Admiral Donald C. Arthur
Medical Corps, U.S. Navy
Surgeon General
Chief, Bureau of Medicine and Surgery

Vice Admiral Donald C. Arthur is the 35th Surgeon General of the Navy and Chief of the Navy's Bureau of Medicine and Surgery.

Vice Adm. Arthur, a native of Northampton, Mass., entered naval service in 1974 and attained his Doctor of Medicine degree from the College of Medicine and Dentistry of New Jersey. After a surgical internship, he completed Navy training in Flight Surgery and Undersea Medicine. His additional operational qualifications include Surface Warfare Medical Department Officer, Saturation Diving Medical Officer, Hyperbaric (Recompression) Facility Operator, Radiation Health Officer, Navy-Marine Corps Parachutist & Jumpmaster, and he is qualified in submarines.

Vice Adm. Arthur's early naval service includes research in mixed gas saturation diving and cold weather medicine. He served in the Philippines as both a Flight Surgeon and Diving Medical Officer followed by duty as Senior Medical Officer in *USS Kitty Hawk* (CV-63). He completed his residency in emergency medicine and served as Head of Emergency Medicine at Naval Hospital San Diego. At the Naval Aerospace Medical Institute, he was Head of the Special Products Division. Following deployment to Southwest Asia with the Marine Corps Second Medical Battalion during *Operations Desert Shield/Storm*, he served as Director of Medical Programs for the U.S. Marine Corps at Marine Corps Headquarters, Washington, D.C. He then served as Deputy Commander (Chief Operating Officer) of Naval Medical Center, San Diego and, subsequently, as Commanding Officer (Chief Executive Officer) of Naval Hospital Camp Lejeune, N.C. In 1998, Vice Adm. Arthur returned to Washington, D.C. to serve as Assistant Chief for Health Care Operations, Navy Bureau of Medicine and Surgery. He held the positions of Deputy Surgeon General, Vice Chief (Chief Operating Officer) of the Navy's Bureau of Medicine and Surgery, and Chief of the Navy Medical Corps before assuming command of the National Naval Medical Center, Bethesda, Md., in 2002.

Vice Adm. Arthur attained board certification in Emergency Medicine and Preventive Medicine (Aerospace). He is a Fellow and Past President of the Aerospace Medical Association and was President of the Association of Military Surgeons of the U.S. in 2005. He is a member of the Alpha Omega Alpha Honor Medical Society. He was also the 2002 recipient of the American College of Healthcare Executives' Federal Excellence in Healthcare Leadership Award and 2002 Association of Military Surgeons of the U.S. Outstanding Federal Healthcare Executive Award.

Vice Adm. Arthur has been awarded the Navy Distinguished Service Medal, four Legions of Merit, three Meritorious Service Medals, three Navy Commendation Medals, and a Navy and Marine Corps Achievement Medal in addition to unit, service, and campaign awards.

Updated 11 April 2005

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE MILITARY PERSONNEL SUBCOMMITTEE

COMMITTEE ON ARMED SERVICES

U.S. HOUSE OF REPRESENTATIVES

SUBJECT: Medical Readiness

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

March 27, 2007

NOT FOR PUBLICATION UNTIL RELEASED
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U.S. HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 42,400 people assigned to 74 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar

Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS
1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster

Air Force Longevity Service Award with silver oak leaf cluster
Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American College of Preventive Medicine
American College of Physician Executives
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of August 2006)

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

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

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

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

Taking Care of Our Expeditionary Force and Joint Warfighter

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

Aeromedical Evacuation

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

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

Our modern AE teams – which include active duty, Guard and Reserve forces – coupled with our innovative Critical Care Air Transport Teams (CCATT), operate flying intensive care units in the back of virtually any airlift platform. This success resulted from our shift to designated, versus dedicated, aircraft and training universally qualified AE crew members able to execute their AE mission on any airlift aircraft. This

transformation of AE has been repeatedly proven in the global war on terrorism, as evidenced by the safe and rapid transfer of more than 40,000 Operation ENDURING FREEDOM and Operation IRAQI FREEDOM patients from overseas theaters of operation to stateside hospitals!

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

Barbara Wynne, spouse of our very own Secretary of the Air Force, recently

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

Commitment to Jointness

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

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

To that end, we believe it is critically important to work closely with our sister Service medics in leveraging our joint capabilities. Working to improve our common "enabling" platforms—such as logistics, information management, information technology, and medical research and development—will serve to make all medics better prepared to support the Joint warfighter. Side by side with our Service counterparts, we recently concluded a 72-day

humanitarian and civic assistance deployment with the Navy on board the USNS Mercy. Yes, we are all about jointness and supporting the joint warfighter.

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

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

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

Taking Care of Our Air Force Family

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

Warfighter Fitness and Deployment Health

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

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

Prior to deployment and upon redeployment home, we evaluate our Airmen's health—physical, mental, and emotional— through the use of a Pre- and Post-Deployment Health Assessment (PDHA). We then reevaluate at three to six months post deployment using the Post Deployment Health Reassessment (PDHRA) as the next link in the continuum of care. To date, 70 percent of required PDHRAs are completed. Thirty-eight percent of

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

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

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

Partnerships

Our commitment to the health of our Airmen and their families also includes partnerships with leading civilian institutions. For instance, the AFMS and University of Pittsburgh Medical Center have teamed in collaborative efforts to prevent and/or delay type II diabetes, including associated complications, through education, early treatment modalities and community outreach. Other critically important efforts include the development of collaborative relationships with various Department of Veterans Affairs facilities and a robust TRICARE network. Throughout this continuum, we work closely with our sister Services and civilian counterparts to provide preventive health care,

interoperable surveillance, research and development, outreach, and treatment. Caring for our Air Force team and family also means taking care of our medics. We ensure that they are healthy and prepared for the mission they will face. With that in mind, our next priority involves taking care of our Air Force medics.

Taking Care of Each Other

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

Professional Development

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

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

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

that enables a balance between duty and family.

Balance

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

Air Expeditionary Force and Constant Deployer Model

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

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

Air Force Smart Operations for the 21st Century, AFSO21

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

efficiency and reduce waste.

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

Challenges Ahead

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

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

Summary

The talent and dedication of military medics ensures that an incredible 97 percent of the casualties we see in our deployed and joint theater hospitals will survive today. We safely aeromedically evacuated nearly 40,000 patients from theaters of operations since the beginning of Operations IRAQI FREEDOM and ENDURING FREEDOM, provided compassionate care to 1.5 million people on humanitarian missions over the past 6 years, and continued to care for 3 million patients annually all over the world.

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

Written Testimony of

David J. McIntyre, Jr.
President and CEO
TriWest Healthcare Alliance

Before the

House Armed Services Committee
Military Personnel Subcommittee

March 27, 2007

Introductory Comments

Chairman Snyder, Ranking Minority Member McHugh and distinguished members of the House Armed Services Committee Military Personnel Subcommittee, I am David J. McIntyre, Jr., President and CEO of TriWest Healthcare Alliance. It is an honor to appear before you today to discuss how we as an organization, in collaboration with the TRICARE Regional Office-West (TRO-West) and our West Region military treatment facility (MTF) partners, are doing "Whatever It Takes" to make good on the promise of TRICARE for our 21-state region's more than 2.8 million beneficiaries. Together, we are taking a concentrated, proactive approach toward ensuring that these most deserving individuals have access to the quality health care and dedicated customer service they have earned, and it is my pleasure to have this opportunity to share more about our work with you.

Since launching operations in 1996 with our first TRICARE contract, TriWest Healthcare Alliance and our locally based owner organizations (which now include 16 non-profit Blue Cross Blue Shield plans and two University Hospital Systems) have maintained a single objective: to honor the service and sacrifice of military families by doing our level best to deliver outstanding service and access to best-value, high-quality health care. Now, more than 10 years later, our mission remains the same—and we have never been more committed to it.

In this, our third year under our West Region contract, we have much to report on our progress in a variety of functional areas. And, though we have certainly weathered challenges during this period (some of which we've eliminated, some of which we continue to work toward resolving), our overall environment in the West Region is one of success—*collaborative* success as a result of the partnerships we've built and maintained in our ongoing effort to leverage the strengths of our colleagues for the benefit of our joint military family customers. It is on these successes that I would like to concentrate today.

Ladies and gentlemen, we are most privileged to be partners in this business of TRICARE—for there is no more deserving population than the one we, together, serve. While my discussion today focuses on the efforts and achievements of TriWest, the ultimate focus is on how these efforts and achievements affect our beneficiary customers. They are the reason we toil, the reason we take such care in every decision we make. They deserve our unwavering service, and we are honored to deliver it.

Responsive and Robust: West Region Provider Network Stands and Delivers

Our provider network has grown and we continue to enhance its ability to serve our beneficiaries. For TriWest, the key to successful delivery of services is partnerships, for we believe there is no more effective way to optimize the TRICARE program than to find collaborative teammates as committed to military families as we are. We are tremendously fortunate that our owner organizations, who also serve in local West Region communities as our network subcontractors, are precisely this caliber of partner.

These established health care entities, in conjunction with our internal Provider Services staff, are wholly dedicated to building and maintaining a robust and responsive provider network throughout our 21 states. In fact, our current West Region provider network boasts nearly 117,000 providers—an example of the power and progress inherent in this collaborative, focused partnership. However, despite the expansiveness of our network, TriWest and our owners—flanked and led by our TRO-West colleagues—are not content. Indeed, network expansion and provider retention activities are never off our radar. Our customers do not rest in their support of this nation, and, certainly in terms of network building and maintenance, we do not rest in our support of them.

We are engaged in an exciting effort, having called on the governors of our region to support our provider network initiatives. In collaboration with TRICARE Management Activity (TMA), we have been able to leverage the local presence and prestige of governors in our region by partnering with the Western Governors Association to encourage provider participation in the TRICARE program. To date, 15 states from our West Region have sent letters to their respective states' medical associations congratulating providers who already accept TRICARE patients, and encouraging more to do likewise. This joint effort has proven both effective in sustaining and building our provider network and in solidifying relationships with our regional government leaders.

Evidence of our continued work in the provider networking and retention arena is our relentless pursuit of obstetric professionals to serve our regional customers. Currently, our network has 5,483 contracted OB providers—which represents a 71-percent increase since January 2005. The TMA's May 2006 increase in OB reimbursement rates in seven of our West Region states, where TRICARE payment was identified as less than Medicaid reimbursement, has proven critical in both our recruitment and retention efforts. Affected states included Alaska, Arizona, Montana, Nevada, Oregon, Washington and Wyoming, with reimbursement rate increases ranging from 7.4 percent in Arizona to 27.9 percent in Wyoming. TMA's response to this reimbursement issue has been integral to provider and beneficiary satisfaction in these states, and we applaud these leaders for their timely and appropriate action. Mr. Chairman, I want to personally thank you for your focus in this critical area and making sure that we were all standing up to the task.

In addition to OB network achievements, we have also concentrated our recruitment efforts on enhancing the availability of primary care providers in the often rural areas where our region's Guard and Reserve families reside. This effort began in August 2006, as part of our organization-wide focus on meeting the unique needs of our Reserve Component beneficiaries. To date, we have added an additional 1,296 providers to our network in these challenging but vital regional areas.

Building our network is just the first step in delivering access to quality care, however. It is also imperative that we ensure our TRICARE beneficiaries have access to this extensive network by maintaining the accuracy of our provider demographic data. While the commercial industry standard is 80-percent accuracy of provider data, TriWest consistently maintains its provider data accuracy at 92 percent. We take great pride in

knowing that, when our customers need care, they can find it. Accurate, up-to-date provider information—and ready access to it—is the key.

While developing a broad network is certainly vital to successful care delivery, ensuring that those providers are satisfied and properly educated is equally essential. TriWest's solid performance delivery and our provider education and outreach efforts are concentrated on ensuring just that—and considering that we have maintained an overall turnover rate of less than 5 percent for the past few years and have been maintaining a network growth rate of between 1 and 2 percent—it is clear these efforts are having the desired effect.

Given the size of our network, and the intricacies of the TRICARE program, our outreach is vast and varied. Our efforts, which include regional provider education seminars, personal office visits, e-mail newsletters, participation in local provider societies and partnerships with state governors to increase support of provider TRICARE participation, have proven remarkably successful. Among other results, this outreach has improved providers' understanding of how to navigate the TRICARE program (thereby enhancing their delivery of service and services to our beneficiaries); reduced provider issues/questions; offset provider concerns regarding low reimbursement rates and perceptions of administrative hassles (by letting them know we are doing our part to make the program functionally and fiscally more attractive); and kept them informed, proactively, of changes in the TRICARE program and TriWest processes.

In 2006 alone, we hosted more than 400 seminars throughout our 21 states (attended by 11,672 provider-office representatives); conducted nearly 16,500 office visits; and, distributed bimonthly e-newsletters to 54,197 provider e-mail addresses. We are extraordinarily proud of our provider outreach activities and believe they are essential to maintaining a satisfied health care network for the military families entrusted to our care.

Though our provider outreach has been tremendously effective, we continue to face the inherent challenges associated with managing a complex, and historically low-paying, health care program. Case in point is the issue surrounding 2007 CHAMPUS maximum allowable charge (CMAC) changes. Although Congress' action to stop the overall decrease in Medicare reimbursement was well received, there remain significant decreases in several key areas that are causing current disruption within our provider network.

In particular, the overall impact of the 2007 CMAC changes to behavioral health reimbursement is a 5.8 percent decrease in payments. Understandably, this decrease has not been well received by our network's behavioral health providers, particularly psychiatrists and child psychiatrists, who are already overburdened and in short supply. This decrease, coming at a time when behavioral health services are in great demand due to the impact of the war, is likely to jeopardize the system's ability to meet that demand. Likewise, the TRICARE program's ongoing struggle to flex its reimbursement structure to the growing availability and demand for immunizations has resulted in many providers not receiving reimbursement for the cost of such medications. In a program so aware of

the benefit of preventive health care (as evidenced by TRICARE's generous preventive health care coverage), it is imperative this discrepancy be addressed so that those who protect this nation are themselves protected.

An Expanded Service Force Deserves Expanded Service

As our nation continues to call on the support and service of National Guard and Reserve members, responding to the unique and varied needs of this "new" TRICARE population has been an ongoing effort for the greater Military Health System (MHS) team. We have dedicated significant time and resources to expanding our provider network in the rural areas of the West Region with high densities of Reserve Component families. This has resulted in adding nearly 1,300 additional providers to our network in these areas.

Most importantly, we have expanded our relationships with various West Region National Guard and Reserve organizations to better reach these families and provide consistent, responsive service when and where they need it. For example, for Army Guard and Reserve soldiers in medical holdover status, we continue to play an instrumental role in providing TRICARE information (and in working TRICARE-related issues) to the Community Based Health Care Organization staffs that manage their care.

Additionally, we continue to strengthen communications with the National Guard Bureau's Family Programs, Personnel and Chief Surgeons' offices through regular updates, briefings, and teleconferences for Transition Assistance Advisors. In ongoing efforts to supplement communication with Reserve Component chain of command, we have attended Retired Officers of America "Meet the Chief" annual meetings; met with commanding officers of West Region Army Reserve Regional Readiness Commands; and initiated the implementation of regular communication with our region's Reserve Component flag officers.

TriWest also has become increasingly active in our education and outreach efforts to the Reserve Component and their families residing in the West Region. As many units within our region were activated and mobilized overseas and to our borders (as part of Operation Jump Start), TriWest joined forces with the TRO-West to vigorously pursue numerous opportunities for educating this growing beneficiary base about the TRICARE programs available to them, and the West Region-specific efforts being undertaken on their behalf.

These efforts, initiated last year and continuing today, include launching a pilot project to test the effectiveness of a "mobile TRICARE Service Center" for beneficiaries in remote regional areas; implementing a Reserve Component-specific portal on our Web site (www.triwest.com); undertaking comprehensive marketing and education outreach about the TRICARE Reserve Select program; and, embedding behavioral health providers in California National Guard units to provide education and immediate service/referrals for service for returning or deployed Reserve Component members with combat stress issues (discussed in greater detail later in this testimony).

In addition, we increased our Beneficiary Services and Education Representatives by 29 percent in 2006 in order to adequately educate and disperse information to this growing beneficiary group. In just the last six months, we also increased our number of Reserve Component educational briefings/events by more than 30 percent, which has resulted in reaching an additional 12 percent of these customers.

Because we recognize that these beneficiaries (and, indeed, all active duty Service members) face significant challenges with reintegration upon return from deployments, we have also increased our support efforts in this regard by entering into memorandums of understanding (MOU) with several West Region reintegration teams. We have committed through these MOUs to being an active supporter of reintegration efforts in Arizona, Washington and Wyoming. And, though informally, we have also committed our assistance to the Oregon National Guard Reintegration Team, with whom we have partnered since its inception as participants in each of its informational summits. We continue to look for more opportunities to partner in this fashion in other areas of the West Region, knowing that these returning Service members need and deserve all of the assistance we can make available to them.

Our National Guard and Reserve outreach also involves participation in Inter-Service Family Assistance Committees in the West Region states of Idaho, Wyoming, Minnesota, North Dakota and Nebraska. Additionally, TriWest's participation with Guard and Reserve-affiliated associations as sponsor and conference exhibitor provides an effective method of outreach and networking, as well as a way to get feedback on how our service is being received by Reserve Component families. We maintain an ongoing relationship with ROA, NGAUS, EANGUS and AGAUS, and have participated in each of their annual national conferences for the past three years. In fact, in 2006 alone, we participated in 14 state National Guard Association annual conferences, and anticipate that this year we will actively participate in conferences in each of our 21 states.

In ongoing support of this population, and government initiatives involving them, we have also become staunch supporters of the U.S. Border Patrol and its Operation Jump Start efforts. Last year, TriWest representatives realized the only way to reach these remote Service members was to go to them, establish contacts in each of their remote base locations, and educate them about the availability of TRICARE and TriWest assistance. As part of this outreach, TriWest representatives toured 29 Operation Jump Start stations and sites along 1,350 miles of border between San Diego and Marfa, Texas, during which time they met with 200 soldiers/airmen on duty and established points of contact at each locale. This proactive initiative has engendered great respect from the government and affected beneficiaries; but, more than that, it has created an active and effective dialogue about TRICARE with these Service members who might otherwise have gone under the radar.

Where There's a Gap, There's a Way: Supporting the Naval Special Warfare Command

I often have the opportunity to travel with RADM Nancy Lescavage, Regional Director of the TRO-West, to locations of great interest in the West Region. We recently had the

honor of visiting RADM Joseph Maguire at the Naval Special Warfare Command, headquartered on the Coronado Naval Amphibious Base in San Diego. Through dialogue with RADM Maguire, RADM Lescavage and I learned about the very high tempo of operations under which the Navy SEALs currently operate.

The several thousand members of that command are largely based in San Diego and in Norfolk, Virginia, with teams deployed at many locations worldwide. Due to the nature of their operations, they often deploy on very short notice to undisclosed locations. As you can imagine, this puts a large strain on the command members and their families. Those who are ill, injured or wounded in combat rely on the Special Warfare Command for assistance and support regarding health care information, coordination and rehabilitation assistance and support. Many of the requests for that information and support are directed to the staff of the Naval Special Warfare Command in Coronado from command members and their families throughout the country. RADM Maguire explained that his command staff is not linked directly with the local Naval Medical Center MTF in San Diego or TriWest, thus resulting in a perceived gap in the support for Special Warfare Command members and their families.

After hearing of this issue, I committed to RADM Maguire that TriWest would develop a position within his command that would serve as a TRICARE liaison and health care coordinator. This position has since been established and will be staffed by a registered nurse. The nurse will begin working in the office of the Naval Special Warfare Command in May, once TriWest medical management and customer service systems have been installed and the office preparations are completed. The goal with creating this position is so that a TRICARE contact will exist with the staff and members of the command and their families. This will involve providing health benefits information, assistance and counseling to members of the command and their families wherever they are located. Additionally, the nurse will be dedicated to facilitating referrals and other health care support on behalf of members of the command.

This is an example of how collaboration and dialogue with those who are facing the real issues on the ground can serve to address the gaps and needs of our Service members and their families that are often overlooked.

Treating the Body, Mending the Spirit: TriWest's Approach to Behavioral Health Care

As we all appreciate, Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) are the focus of both Congressional and Department of Defense (DoD) efforts to help those who are returning from deployments to Iraq and Afghanistan. Truly, there is no more pressing medical concern in the Service member community than the need for focused, accessible and de-stigmatized behavioral health care. To that end, TriWest has launched "Help from Home," a comprehensive set of behavioral health initiatives to aggressively and effectively meet the unique and ever-growing behavioral health needs of our deserving customers. We believe that a concentration on our troops' physical health can only do so much if their social, emotional and behavioral health needs are left unmet. That's why we have placed such importance on revolutionizing the delivery of this vital

element in the health care paradigm—and we are pleased to be setting a benchmark for future system-wide initiatives in this very regard.

Because it is our belief that an integrated medical-surgical/behavioral health care model is the only way to optimally treat our Service members, TriWest implemented a pilot project in three Hawaii MTFs to test this theory. In October 2006, we co-located three specially trained, supervised behavioral health care providers into these participating MTFs so that, when a behavioral health issue presented itself during a medical examination, the beneficiary could be immediately referred (within the facility) to an appropriate specialist. Our goal was to provide beneficiaries with swift access to behavioral health care without the need for scheduling an off-base appointment or weathering the stigma often associated with this type of care. In January, our organization leaders, Board members and owners met in Hawaii for a series of planning meetings, during which time we had the opportunity to hear from participating MTF and behavioral health providers how this pilot is faring—and the news is good. The integrated model is effectively reaching beneficiaries with behavioral health needs, and in doing so working to lower the rates of alcoholism, spousal abuse, depression and other related concerns.

As referred to previously, we have also launched a pilot program in which we've embedded behavioral health professionals in California National Guard units to provide deployment-related behavioral health support to this special population. Because these beneficiaries and their families are at risk of having limited resources for such issues as PTSD, TriWest recruited select behavioral health providers with expertise in PTSD, grief and marriage-and-family therapy to join National Guard units at drill weekends; work with Commanders to coordinate behavioral health education opportunities; and provide immediate emotional support, consultation and referral services. As a result, more than 2,400 soldiers have received individual services, 43.4 percent of which have been initiated by the soldiers themselves. Pilot program providers have made more than 300 referrals for ongoing treatment as a result of their participation. This program has been so effective since its launch that a total of 38 California National Guard units have requested and received embedded behavioral health providers through this pilot.

Just as we enhanced our Web site to respond to the unique information needs of our Reserve Component members, we have also launched a dedicated portal focused on behavioral health care via www.triwest.com. We believe this initiative is particularly important, given the number of rural and remote areas within the West Region where behavioral health care providers are scarce. In these areas, primary care managers and pediatricians have the increased burden of providing behavioral health support in conjunction with medical services. It is our hope that, by providing extensive support and information via our behavioral health Web portal, we can supplement these services and better serve our customer base. Phase I of this portal project launched in January 2006 with information and resources on deployment-related behavioral health, emotional well-being, and addiction recovery. Phase II, launched in September 2006, added nine child/adolescent-specific topics; and, just this year, we have added an interactive map to help beneficiaries find local, national and military resources in their communities.

As part of our provider outreach efforts, we have implemented continuing education seminars on post-deployment behavioral health issues. With program support from the University of North Texas, TriWest has organized and hosted a series of seminars for both primary care and behavioral health providers focused on combat stress, PTSD, and other related post-deployment behavioral health concerns. Last year, we conducted over 800 seminars throughout our region, as well as an all-day summit in Alaska in conjunction with the Alaska Veterans Affairs department.

Because, as with any medical condition, behavioral health concerns do not confine themselves to a "nine-to-five" timeframe, our initiatives have also included the launch of a 24/7 Behavioral Health Contact Center to serve as a first-line intervention in directing appropriate referrals to callers in crisis, providing sound clinical guidance and suicide prevention. Staffed by service representatives and licensed mental health clinicians, the Contact Center (available by calling 1-866-284-3743 or 1-888-TRIWEST) receives an average of 750 calls each month.

Another initiative spearheaded by TriWest in response to customer needs, rather than contractual requirements, was the development of our "Getting Home... All the Way Home" readjustment/reintegration DVD designed to assist Service members and their families following military deployment. The DVD is distributed to Reserve Component members during their demobilizations, as well as available via www.triwest.com. This DVD has proven immensely effective in disseminating important information about behavioral health issues, resources and associated TRICARE coverage. Since the beginning of production, we have provided 105,000 DVDs to Service members, their families and military and family support organizations across the West Region. Currently, a successor DVD is in production for military families that discusses deployment and reunion experiences, with a special focus on maintaining family life. To make access to this information more convenient, Web-enabled downloads of the successor DVD will be available at www.triwest.com.

To address the specific behavioral health needs of our youngest constituents—the children of active and deployed Service members—TriWest has also partnered with the National Military Family Association (NMFA) to sponsor 26 "Operation Purple" camps in the West Region for more than 1,000 children. In addition to our sponsorship, TriWest's Behavioral Health department provided NMFA with program development support and coordinated behavioral health providers as consultants for camp staff.

At TriWest, when we see a need going unmet—or under-met—it is in our nature to step up services to alleviate the deficit. We believe that is exactly what our behavioral health initiatives and pilots are doing. Above and beyond our contract requirements, we have dedicated approximately 6,500 hours of staff time, involving five departments, and committed $2.5 million to developing and implementing these "Help from Home" projects and pilots. At this time in history, when our Service members and their families are facing unprecedented challenges associated with lengthy deployments and devastating emotional and physical warfare, we feel it's the least we can do.

Maximizing Services, Minimizing Costs: The Promise of TriWest's JSOPP Program

We have one program of which we are particularly proud that has realized a projected purchased-care cost reduction of over $15 million to date.

TriWest is an organization that prides itself on developing proactive, inventive and effective solutions to health care delivery challenges that present themselves in this business of TRICARE. Because our organizational philosophy is that collaboration is the cornerstone of successful solutions, we focus our initiatives on leveraging the strengths of our counterparts within the West Region to optimize service for our joint customers: America's military families. Among the most successful of these initiatives has been our Joint Strategic and Operational Planning Process, otherwise known as JSOPP.

JSOPP's goal is to optimize MTF care delivery by addressing demand and capacity and, with the MTF's input, formulating a plan to fix identified gaps in services and/or identify better ways to deliver services at the best value to the government. Direct and purchased care data is mined and then presented to MTF Commanders in the form of information for decision-making. Targeted, actionable and measurable optimization projects are then presented for potential implementation.

To date, TriWest's JSOPP team (made up of former MTF Commanders, deputy commanders, physicians, and medical service corps officers) has provided optimization consultations for 96 percent of the West Region's 45 targeted MTFs, and has visited with all Multi-Service Market offices, Intermediate Commands, and the Surgeons General offices. Of the MTFs assisted, 78 percent have requested 138 targeted data analyses for decision support. The team has also forecast the effects of troop repositioning and Base Realignment and Closure on MTF capacity and network capability and costs for nine Army MTFs and the Office of the Surgeon General. Similarly, at the request of Navy Medicine West, the cost and network impact of the deployment of the USNS Mercy was analyzed using JSOPP and submitted to BUMED.

Among the most notable of 16 projects through which JSOPP found ways to save costs and maximize care delivery were the expansion of the NICU at Naval Medical Center, San Diego; re-establishment of the CT surgery program and retention of interventional cardiology at William Beaumont Army Medical Center at Ft. Bliss; and nine Joint Incentive Fund projects with the Veterans Administration (VA) for sleep labs, MRIs and behavioral health services. The VA is expected to reduce its purchased care costs by $3 million through these projects.

Though these achievements are exceptional, there are a few road blocks in the way of JSOPP performing optimally—which we hope can be alleviated in time to allow this program to realize its full potential and, in doing so, save the government even more unnecessary expenditures while ensuring adequate access to care. These roadblocks include TriWest not having access to important clinical and business data integral to proper planning, execution and evaluation; the absence of a Resource Sharing program at MTFs; general MTF staffing gaps and contracting challenges; MTF concern that

adequate resources will not be available in the long term; and TMA purchased care cost management not accounting for purchased care costs at the local MTF level.

We are extraordinarily proud of the work of our JSOPP team, and have received government and military kudos for this proactive planning initiative.

Making a Good Program Better: Addressing System-wide Challenges

While we at TriWest have labored for many years to continually improve upon the delivery of health care to our Service members and their families, there have traditionally been challenges associated with enterprise-wide health plan management. Our focus has been, and continues to be, collaboration with our MTF and TRO-West partners to creatively and collectively affect change in key areas. I would like to share with you some of the challenges we've encountered while working within the system of the TRICARE program so that you can fully understand the issues that are currently facing our men and women protecting this great nation.

The first area where we've come across concerns has been in the psychiatric services offered to our active and deployed Service members. While we've made great progress through implementing our "Help from Home" projects and pilots which I previously discussed, there are systemic issues that continue to counteract these efforts.

In the 1990s, a rate adjustment policy was implemented in an effort to bring TRICARE rates in line with Medicare rates. When the Medicare rates were cut by nearly 8 percent earlier this year, TRICARE rates were also impacted on average with a 5.8 percent decrease in the behavioral health reimbursement rates in the West Region. Today's rate cuts come at a time when there is a marked increase in the behavioral health needs of soldiers returning from war. Lower reimbursement rates pose a major challenge to TriWest's ability to provide access to quality, best-value mental health services for our TRICARE beneficiaries because it makes it difficult to contract with quality mental health practitioners. The recent reduction has made it particularly challenging to recruit specific types of providers, namely child psychiatrists, psychiatrists and psychologists, into our network. While there are not currently any gaps or service shortcomings resulting directly from this rate decrease, the impact on our ability to provide access to the best care possible for our beneficiaries has certainly been felt.

I would like to take a moment to elaborate on how the linkage of TRICARE reimbursement rates to the Medicare rates impacts not only our behavioral health program, but the system as a whole. As you know, the recent cut in Medicare rates resulted in a subsequent decrease in the TRICARE reimbursement rate. On average, Medicare pays between one-fourth to one-third less than commercial rates—and TRICARE rates are even lower than Medicare rates. While many providers consider it their civic duty to support military beneficiaries and their dependents despite the low reimbursement rate, it only goes so far before providers decide not to renew contracts or contract at all with a TRICARE contract. Not only are the contractors asking providers to accept lower rates by participating in TRICARE, but they're asking providers to take on

the additional administrative duties that are unique to the TRICARE program. Ladies and gentlemen, I ask you to consider these points when deciding on future changes to the reimbursement rates.

To date, there has been little discussion on revising TRICARE's behavioral health benefits. There are likely several reasons for this including TriWest's proactive efforts to address the needs of our beneficiaries, and the fact that the TRICARE benefit is broadly more generous than many commercially managed mental health plans. Currently, Commander DiMartino at the TMA has formed a workgroup to address and review the current benefit and provide recommended changes for improvement. As an organization, we continue to actively support his workgroup and other initiatives designed to improve the behavioral health benefit for all TRICARE beneficiaries, but we need the additional help of Congress.

There are several opportunities to enrich the TRICARE behavioral health benefits and our recommendations for improvement include incorporating a variety of intensive outpatient services into the program which would be designed to support patients in their home environment rather than in an institutional setting. Specific services could include recognizing outpatient clinics as appropriate for treatment for chemical dependency and detoxification, allowing nutritional counseling for patients with eating disorder diagnosis, and allowing behavioral health counselors the ability to see patients without a doctor's referral. Your help in supporting these ideas would allow all TRICARE contractors, including TriWest, to be as flexible as possible to respond to the continually evolving needs of our beneficiaries, and ensure that force readiness and retention are not pressing issues now, nor in the years to come.

The second area which impacts our ability to fully support our beneficiaries is the changes in command at our MTFs and within the MHS leadership every few years. While change is inevitable, it can have negative results in our ability to follow-through and complete projects and address ongoing budget initiatives. Constant command change also results in the inability to truly optimize MTF resources; a goal which TriWest works hard to achieve. Those in the TRICARE system have done a fine job in focusing on the short-term planning required to meet the immediate needs. However, this has created a culture which does not allow much time to think critically about the future and address long-term goals and clinical outcomes. Ideally, the best long-term solutions should be determined and attained through the collaborative input of the MTFs, TRO-West and contractors like TriWest to ensure that all parties are unified in their approach to providing access to best-value health care.

Another issue TriWest has come across has been when a beneficiary's primary care manager (PCM) is changed frequently if he or she is faced with a deployment or a provider is reassigned. Obviously, this causes frustration, customer dissatisfaction, and additional costs. TriWest conducts monthly beneficiary satisfaction surveys, randomly sampling call records from our contact center. As part of the survey analysis, we found that PCM changes are a large disatisfier for our customers. It can slow down the enrollment process and takes an estimated 5.4 full time equivalents (FTE) at TriWest to

perform the tasks associated with a PCM change at the MTF level. In former managed care contracts, beneficiaries were enrolled directly to an MTF—not a specific doctor within the MTF. We are now considering if we can find a middle ground with our government partners to still assign to a specific provider, but enroll our beneficiaries to a group or clinic and therefore not require all the enrollment changes when a provider deploys. We also want to give our customers the option to change their PCM online through a self-service option. We continue to seek opportunities such as these to expand upon the already innovative solutions that we are discovering to continually increase our service to those who have sacrificed so much already.

I would now like to take a moment to specifically discuss certain system issues that have been impacting the Guard and Reserve community in our region. Despite the fact that deployments have been decreasing over the last 12 months, these deployments still have lasting and complex effects. Many of our beneficiaries are spread out and not in close proximity to the MTFs where they can receive immediate care. Their deployments are also impacted when providers outside the MTFs are not available or accept TRICARE. I am pleased to share with you that TriWest has undertaken a network expansion project to contract in these areas where there are gaps and expand the network for our Guard and Reserve. We've recently distributed 1,278 contract packets to cover an estimated 5,207 providers; and our hope is that we receive at least 50 percent of the contracts back. We will strive to complete this contracting effort and work as long as it takes to ensure that TRICARE providers are accessible to all eligible Guard and Reserve beneficiaries under our care.

In order to effectively impact many of the challenges I've summarized for you, it is our duty to operate with a cooperative approach in managing our contract with one of our greatest partners—the TRO-West. I view our collaboration a prospect to impact some of the negative perceptions which have often permeated this TRICARE contract—that the TRICARE Regional Offices are only responsible for oversight and not the business aspect of health care. While this is not the case, there is an opportunity to clearly define the role of the TRICARE Regional Offices, as well as their functions, limits and expectations within and beyond contract management responsibilities. This would be particularly beneficial for our MTFs, as it would provide clarification and also insight into how MTFs and the TRO-West could partner further. It is our vision that joint efforts with the MSMOs and other intra-regional efforts would improve relations and serve to support the over-arching goals of the MHS. Additionally, we need to consider breaking the boundaries of the TRICARE regions and share clinical or operational best practices which could potentially result in increased collaboration and potential improvements system-wide.

Utilizing Government-Wide Resources: Our Growing Partnership with the VA

Finally, ladies and gentlemen, I would like to discuss our partnership with the Department of Veterans Affairs (VA)—another important entity with which we strive to collaborate. Historically, there has been a lack of care coordination and case management within the Services and in dealing with the VA. There are multiple systems of care and

no single DoD office to coordinate transition among the multiple programs that may be working in parallel tracks. Traditionally, there have been issues with coordinating medical care and benefits during the transition from active duty to veteran status.

One solution that has been implemented at some West Region locations is the use of a VA representative who is assigned to the DoD Soldier Readiness Processing site. If there is an indication that the soldier may want care after he or she returns home, the soldier will already be entered into the system by the VA representative. There are also VA/DoD liaisons who collaborate with the MTF staff to coordinate transfers to VA. Social workers are also present in VA facilities to work with patients and families before leaving the MTF and assist with case management. An interdisciplinary team collaborates for treatment planning at the VA. The social workers assist in obtaining records from the MTF as care continues at the VA. One single DoD office for coordinated transition would also provide policy guidance and a more cohesive system to provide care for our customers.

A partial solution for sharing of data between the VA and DoD is the use of a bi-directional health information exchange. Over the past couple years, the VA and DoD have collaborated on a software package to allow the VA and DoD to track certain types of clinical data, and is a real-time sharing of information on patients who are currently receiving care in both DoD and VA facilities. I am delighted that innovation solutions such as this are being considered. As of October 2006, the DoD transmitted data to the VA on 3.6 million patients, which is an impressive improvement to address the care coordination issues that have historically faced this sector of the retired military population.

Concluding Remarks

At TriWest, we believe the key to successful delivery of services is a cooperative approach—a joint effort among all stakeholders in the TRICARE paradigm: our organization, our owners, our TRO-West leaders, our civilian and military medical partners and you. By working together, with our beneficiaries' best interests in mind, we can make this program work effectively now, and we can make it make it function even more soundly in the years to come.

Indeed, the foundation of TriWest's business model is partnership... and we believe this is precisely what the TRICARE program—in the West Region and around the world—needs to remain robust and responsive for our nation's active and retired Service members and their dedicated families.

Before I conclude, allow me to pause for just one moment to mention MG Elder Granger, Deputy Director and Program Executive Officer of the TMA, Office of the Assistant Secretary of Defense (Health Affairs). I was fortunate to have a chance two years ago in Iraq to meet with then BG Granger, and I was incredibly impressed with both his knowledge, his systematic approach, and caring manner for his troops as he briefed me and the rest of the visiting party on what was happening with health care and his

soldiers. He was impressive then; he is impressive now. The system and the beneficiaries could not be better served. He is a soldier, a physician, and a leader whose untiring days are focused on the care of his troops and their families, and I wanted to take a moment to publicly thank him for his leadership within the MHS.

Finally, in conclusion, I appreciate the opportunity to speak before you today, and to share with you the progress we are making in the West Region to improve and enhance services and service delivery to our deserving beneficiaries. At TriWest, our motto is "Whatever It Takes." And, we are truly dedicated to upholding that motto in everything we do. The way we see it, these men, women and families have given their lives in service to this nation. It is our honor, our privilege and our responsibility to do "Whatever It Takes" to give back.

Again, thank you for this opportunity. I hope that I have provided you and your colleagues with an adequate sense of how things are progressing in the West Region. I look forward to continued collaboration with this Committee, and with the entire MHS team, to optimize the TRICARE program for our beneficiaries. They deserve nothing less.

I would now be happy to address any questions or concerns.

David J. McIntyre, Jr.
President and CEO
Triwest Healthcare Alliance

David J. McIntyre, Jr., is president and CEO of TriWest Healthcare Alliance. Mr. McIntyre was the chief architect of the strategic vision behind TriWest Healthcare Alliance and has led the company since its inception. The privately-held company, which is based in Phoenix, Arizona, is owned by 15 Blue Cross Blue Shield plans and 2 university hospital systems. Its primary line of business is serving the health care needs of nearly 3 million members of our nation's military family through a Department of Defense Managed Care Support (MCS) contract covering the 21-state TRICARE West Region.

Mr. McIntyre has more than 20 years of experience, success and accomplishments in national health care policy development, business development and leadership. He served for nearly nine years in the offices of the U.S. Senate, where he was responsible for health policy issues, for Senator Slade Gorton (R-WA), Senator John McCain (R-AZ), the Senate Indian Affairs Committee and contributing to the work of the Senate Armed Services Committee. As a vice president of Blue Cross and Blue Shield of Arizona, Arizona's largest health care organization, Mr. McIntyre assisted with the management of the corporation's strategic planning process and had direct responsibility for legislative matters, media relations and managed several strategic projects including the development of TriWest and its initial MCS proposal in the mid-1990's.

Mr. McIntyre has a bachelor's degree in political science from Seattle Pacific University, a master's degree in administrative sciences (with an emphasis in management and health policy/administration) from Johns Hopkins University and he participated in the Executive Education Program for Senior Government Managers at Harvard University. In 2000, he was named one of 12 "Up and Comers" in health care by Modern Healthcare magazine, in 2004 was named as one of "12 to Watch" by Arizona Business magazine, and in 2004 was selected as CEO of the Year by the Arizona Chamber of Commerce and the Arizona Business Journal. In addition to leading TriWest, he is honored to serve on the Board of the Congressional Medal of Honor Society Foundation, the USO World Board of Governors, the Board of the Fisher House Foundation, the Board of Trustees of his alma mater (Seattle Pacific University), the Board of Arizona State University's Center for Customer Service Leadership, and is a member of the Greater Phoenix Leadership (a CEO roundtable comprised of Arizona's top business and community leaders).

DISCLOSURE FORM FOR WITNESSES
CONCERNING FEDERAL CONTRACT AND GRANT INFORMATION

INSTRUCTION TO WITNESSES: Rule 11, clause 2(g)(4), of the Rules of the U.S. House of Representatives for the 110th Congress requires nongovernmental witnesses appearing before House committees to include in their written statements a curriculum vitae and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants) received during the current and two previous fiscal years either by the witness or by an entity represented by the witness. This form is intended to assist witnesses appearing before the House Armed Services Committee in complying with the House rule.

Witness name: David J. McIntyre, Jr

Capacity in which appearing: (check one)

___Individual

X Representative

If appearing in a representative capacity, name of the company, association or other entity being represented: TriWest Healthcare Alliance Corp.

FISCAL YEAR 2007

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0009	TMA	2,088,440,000	TRICARE West Region
W81K04-05-D-7003	CHCC-MEDCOM HC	6,025,600	Patient Appointing Service

FISCAL YEAR 2006

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0009	TMA	1,947,610,000	TRICARE West Region
W81K04-05-D-7003	CHCC-MEDCOM HC	6,060,000	Patient Appointing Service

FISCAL YEAR 2005

Federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0009	TMA	1,837,870,000	TRICARE West Region
W81K04-05-D-7003	CHCC-MEDCOM HC	1,785,280	Patient Appointing Services
V673(90F) P0012	VETERANS ADMIN	6,232,500	APPOINTING BRIDGE
MDA906-96-C-0004	TMA	0	TRICARE Central Reg- Close Out

Federal Contract Information: If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) with the federal government, please provide the following information:

Number of contracts (including subcontracts) with the federal government:

Current fiscal year (2007): 2;
Fiscal year 2006: 2;
Fiscal year 2005: 4.

Federal agencies with which federal contracts are held:

Current fiscal year (2007): 2;
Fiscal year 2006: 2;
Fiscal year 2005: 3.

List of subjects of federal contract(s) (for example, ship construction, aircraft parts manufacturing, software design, force structure consultant, architecture & engineering services, etc.):

Current fiscal year (2007): TRICARE, Patient Appointing;
Fiscal year 2006: TRICARE, Patient Appointing;
Fiscal year 2005: TRICARE, Patient Appointing.

Aggregate dollar value of federal contracts held:

Current fiscal year (2007): *2,094,465,600.;
Fiscal year 2006: 1,953,670,000;
Fiscal year 2005: 1,845,887,780.

Federal Grant Information: If you or the entity you represent before the Committee on Armed Services has grants (including subgrants) with the federal government, please provide the following information:

Number of grants (including subgrants) with the federal government:

Current fiscal year (2007): 0;
Fiscal year 2006: 0;
Fiscal year 2005: 0.

Federal agencies with which federal grants are held:

Current fiscal year (2007): 0;
Fiscal year 2006: 0;
Fiscal year 2005: 0.

List of subjects of federal grants(s) (for example, materials research, sociological study, software design, etc.):

Current fiscal year (2007): NONE;
Fiscal year 2006: NONE;
Fiscal year 2005: NONE.

Aggregate dollar value of federal grants held:

Current fiscal year (2007): 0;
Fiscal year 2006: 0;
Fiscal year 2005: 0.

HUMANA MILITARY

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WRITTEN TESTIMONY OF

DAVID J. BAKER
PRESIDENT AND CEO
HUMANA MILITARY HEALTHCARE SERVICES, INC.

BEFORE THE

HOUSE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

MARCH 27, 2007

INTRODUCTORY COMMENTS

Mr. Chairman and Members of the Subcommittee, on behalf of the dedicated professionals of Humana Military Healthcare Services, Inc. (HMHS), thank you for the opportunity to update the Subcommittee on our efforts to provide access to high quality, affordable health services to the military community under the TRICARE program. Our company values the special trust the Government has bestowed on us as a TRICARE partner.

As President and CEO of Humana Military Healthcare Services, and as a TRICARE beneficiary myself, I want to personally thank the Subcommittee for its continued support of the Military Health System (MHS). Delivering exceptional healthcare benefits under TRICARE is a complex undertaking for everyone. Together with our Department of Defense (DoD) partners, we at HMHS believe we are effectively and efficiently administering the TRICARE benefit that you oversee.

COMPANY BACKGROUND

Humana Military Healthcare Services (HMHS) is a wholly-owned subsidiary of Humana Inc., one of the nation's largest health benefit companies. Our subsidiary was formed in 1993 to deliver military health solutions. We were awarded our first TRICARE contract in 1995, and we began serving military beneficiaries in 1996.

Today, under contract with DoD, our company provides support for approximately 2.8 million TRICARE-eligible beneficiaries in DoD's South Region of the United States. The South Region includes the states of Georgia, Florida, South Carolina, Alabama, Louisiana, Mississippi, Arkansas, and Oklahoma, as well as most of Tennessee and the majority of Texas. Our company is made up of more than 1,500 employees, many of whom are beneficiaries of the MHS. We provide services in 70 TRICARE Service Centers (TSC) located throughout the South Region.

Further, as part of our South Region contract, we are responsible for processing all claims for TRICARE services rendered outside the United States. We also administer the Continued Health Care Benefits Program (CHCBP). Supporting us in these endeavors, is an exceptional team of partners, including: PGBA, LLC of Columbia, South Carolina (for domestic claim processing); Wisconsin Physicians Service Insurance Corporation (WPS) of Madison, Wisconsin (for foreign claim processing); ValueOptions, Inc. of Norfolk, Virginia (for behavioral health services); and BlueCross BlueShield of South Carolina (for operations in the State of South Carolina). As a team, we have more than eleven years of TRICARE experience.

Under separate contracts, Humana Military Healthcare Services also furnishes limited TRICARE support for active duty members and their families in the Commonwealth of Puerto Rico. In addition, we provide patient appointing services for several military treatment facilities (MTF) including: Keesler Air Force Base, Mississippi; Fort Bragg, North Carolina; Wright-Patterson Air Force Base, Ohio; Fort Carson, Colorado; the United States Air Force Academy, Colorado; Peterson Air Force Base, Colorado; and Barksdale Air Force Base, Louisiana.

As we begin our fourth year of the five-year South Region contract, we believe we are contributing to the overall success of the TRICARE program. Today, I would like to focus on four areas in which we are adding value to the Defense Health Program (DHP): (1) cost control; (2) clinical quality; (3) access to care; and (4) beneficiary service. My perspectives on these important subjects follow below.

COST CONTROL

As TRICARE partners, we understand the need to control costs and to ensure maximum value for taxpayers. With healthcare costs continuously rising across the country, it is appropriate for DoD and Congress to seek opportunities to provide TRICARE services in the most cost-effective manner possible. Within that context, I thought it might be helpful to provide the Subcommittee some examples of measures we have collaboratively taken with DoD to control TRICARE spending.

a. Provider Network Expansion. Since contracted healthcare providers normally agree to accept discounted reimbursement for their services, building a robust provider network is an essential cost control strategy. I am pleased to report that our South Region TRICARE provider network is both comprehensive and growing. To illustrate, on November 1, 2004 (when we began full operation in the South Region), our network of contracted hospitals, physicians and other health professionals was made up of just over 43,000 providers. Today, our network consists of 61,172 providers – a 42 percent increase in just over two years – and last month, over 79 percent of *all* claims submitted were paid to network providers. We calculate that the savings to the Government from our discounted arrangements exceeds $175 million annually.

b. MTF Optimization. Fully utilizing MTFs and MTF personnel is another way in which we help our DoD partners to control healthcare spending. Collectively, we call our efforts "MTF Optimization" and we are proud of our progress in this regard. One "Optimization" approach involves the placement of civilian providers and support personnel into military facilities. I am happy to report that, in the past year, we saw an increase of 75 percent in such arrangements, netting healthcare cost savings of more than $7 million annually. Another "Optimization" tool – called "External Resource Sharing" – allows military providers to deliver care to TRICARE beneficiaries in civilian network facilities. Last year, our External Resource Sharing efforts yielded an additional $3.9 million in savings.

c. Case Management. Individually managing the healthcare services rendered to the most complex patients helps to ensure cost-effective, high quality outcomes. Case management savings are achieved in several ways, including the individual negotiation of reimbursement rates for costly services such as: high-dollar durable medical equipment; inpatient rehabilitation; long-term acute care; pediatric bone marrow transplantation; hourly nursing; and care rendered by highly specialized non-network

providers. Last year, we realized more than $5 million savings from case management interventions.

d. Disease Management. Management of patients with specific diseases represents another way in which costs can be controlled while simultaneously enhancing the quality of healthcare services. Under our South Region TRICARE contract, patients with chronic heart disease have long been eligible to participate in our disease management program. As of early February 2007, a total of 2,700 patients were enrolled in our chronic heart disease program. The impact on cost and utilization has been significant. For example, last year we demonstrated an overall 9.4 percent decrease in annual inpatient days/per 1,000 participants; among those most at risk, inpatient days decreased 45 percent. At the same time, emergency room visits decreased 8.4 percent for beneficiaries who actively participated in the program. Such results reduced costs by millions of dollars.

   Last year, the Government added asthma as a second approved disease management program. Today, approximately 5,600 patients are enrolled in our asthma disease management program. It is too early to accurately calculate the financial effects of this program, but we are confident they will be substantial.

e. Program Integrity. Identification of potential fraud is an important element of our cost control effort. To that end, our company has been extremely active in reporting potential cases of fraud and abuse to the Government. Last year, we reported 64 instances of questionable services claimed in both the domestic and overseas environments to the TRICARE Management Activity (TMA). As part of our ongoing auditing efforts, we also seek to identify duplicate claims for the same services. Through the continuous dedicated efforts of our Program Integrity team, we achieved more than $5 million in savings through duplicate claim reviews and recoupments.

   Finally, we employ commercially-available claim editing software to identify inappropriate claim submission practices. Last year, we estimate these tools yielded savings of more than $44 million.

f. Electronic Claims. Congress has long expressed a desire to increase the volume of TRICARE claims processed electronically. I am delighted to report that our company has achieved remarkable growth in the number of Electronic Media Claims (EMC). In January 2005, 49 percent of the claims submitted by our network and non-network providers were filed electronically. By January 2007, the percentage had grown to 73 percent – a 24-point increase over a two-year period. Based on our claim volume in the South Region, this increase in EMC represents a reduction of the Government's claim processing costs equal to approximately $9 million per year.

g. Promoting the TRICARE Mail Order Program (TMOP). Though pharmacy service is no longer a part of our contractual responsibility, we at HMHS recognize that pharmacy is the most rapidly increasing component of expense within the MHS. We also understand that it is much more cost-effective to provide pharmacy service through the

mail order system than in the retail setting. Therefore, when TMA asked us to actively promote beneficiary use of TMOP, we gladly agreed to do so at no cost. I'm pleased to report that our multi-channel communication efforts have been very effective. To illustrate, TMOP usage in the South Region grew by more than 25 percent in the past twelve months, to approximately 125,000 unique users. As of January 2007, the South Region continued to lead the nation in TMOP usage with more than 40 percent of the unique users in the nation.

Looking ahead, we will continue to strive for additional opportunities to generate cost savings in the delivery of high quality services. Our contract provides an effective incentive for us to do so, and as partners with the Government, we feel an obligation to ensure that the TRICARE program is using taxpayer dollars wisely.

CLINICAL QUALITY

Over the years, Humana Military Healthcare Services has been committed to providing the highest possible quality of health services to the TRICARE beneficiaries we serve. Especially at this time of war, we believe this commitment is critical to the success of our nation. Today, I would like to share several indicators, and actions we have taken to ensure the delivery of high quality clinical services to those we serve.

a. Program Accreditation. Since becoming a TRICARE contractor, we have routinely sought outside validation that our policies, procedures, and services meet or exceed best industry practices. Today, I am pleased to report that we have received impartial outside evaluations of several of our programs from URAC (formerly the Utilization Review Accreditation Commission), one of the nation's leading organizations dedicated to healthcare quality assurance. We currently carry URAC accreditation for our programs in: (1) Utilization Management; (2) Network Management (including Provider Credentialing); (3) Case Management and Disease Management; and (4) HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy. URAC accreditation demonstrates that we at HMHS are delivering appropriate standards of care, that patients are receiving their due process through our appeal procedures, and that healthcare information is being handled in a confidential and appropriate manner. It also ensures that patient safety is a priority in all of our operations.

b. Clinical Quality Reporting. Objective evaluation of outcomes is also a key element for ensuring the delivery of high quality health and wellness services. To that end, our company recently studied 2005 healthcare outcomes for South Region TRICARE beneficiaries. We published the results of our study in a document titled, *"Mapping the Patient Experience – Humana Military's Clinical Quality Report Card."* Measurement methodologies, benchmarks and goals were acquired from respected sources including the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and Healthy People 2010.

Our *Report Card* addresses 25 separate indicators across 7 domains of healthcare quality in the purchased care environment: (1) Preventive Services and Wellness – use of screenings to identify diseases that benefit from early detection; (2) Mental Health; (3) Living with Illness – provision of best practice, evidence-based care to persons with chronic diseases; (4) Patient Safety and Selected Procedure Utilization; (5) Provider Network – the numbers, distribution, and quality of providers available to beneficiaries; (6) Cost of Care – controlling health plan costs within budget; and (7) Customer Service – meeting service standards and satisfying beneficiaries.

Overall, HMHS compared favorably with accepted national standards for indicators measured in the *Report Card.* Specific results appear below.

Domain	Number of Metrics	Better Than Expected	Results As Expected	Worse Than Expected
Preventive Services and Wellness	4	-	4	-
Mental Health	2	-	2	-
Living with Illness	7	1	5	1
Patient Safety & Procedure Utilization	8	6	1	1
Provider Network	1	1	-	-
Cost of Care	1	1	-	-
Customer Service	2	1	1	-
TOTAL	**25**	**10**	**13**	**2**

Figure 1 – 2005 HMHS Health Care Quality Report Card Results in Purchased Care Sector

As noted, two measures fell below expectations based on national benchmarks: (1) our screening of diabetic patients for kidney disease did not meet national standards; and (2) our rate of hysterectomies in the South was higher than the nationwide norm. In response to these shortcomings, we mailed reminders for kidney screening to selected physicians and patients, and we are implementing a clinical study to explore possible interventions to influence our rate of hysterectomies.

Notwithstanding these two outliers, we are pleased with the results to date, and we will continue to measure and intervene where indicated.

c. Disease Management. As noted above, disease management programs can have a significant impact on controlling costs. Such programs also enhance the delivery of high quality clinical services. Our first program, focusing on patients with a history of heart disease – the nation's leading cause of death – began nearly two years ago, and currently serves nearly 2,700 beneficiaries. At the direction of the TRICARE Management Activity, we implemented a disease management program for asthmatics about seven months ago. In a very short timeframe, we were able to target and enroll over 5,600 people into the asthma program. Both programs teach patients

how to live healthy lifestyles, and they provide participants medical guidance from registered nurses. Our nurses provide realistic goals for each patient with appropriate follow-up, and they facilitate physician appointments when necessary.

Our data demonstrate that active participation in these programs assists beneficiaries and providers with the management of patient diseases. For example, among participants in our heart disease program, we have documented an 11 percent increase in the use of ACE inhibitors and beta blockers. Moreover, 75 percent of smokers in the program who set goals to reduce or quit smoking have succeeded.

We have also seen a high degree of acceptance and satisfaction among program participants. Beneficiary feedback indicates 96 percent of a recent sample expressed satisfaction with the information provided to them. Seventy-nine percent of those enrolled in the programs indicate their health status has improved. Seventy-eight percent felt their quality of life had improved since enrolling in a disease management program and 89 percent indicated they would be willing to participate in other disease management programs if offered.

With the obvious success of these programs, HMHS would like to expand our disease management offerings to include other clinical conditions. We are anticipating new programs coming on-line this year as a result of the legislative language in the 2007 National Defense Authorization Act, requiring DoD to offer additional disease management programs for diabetes, cancer, chronic obstructive pulmonary disease, and depression/anxiety disorders. We stand ready to implement these much needed programs when directed to do so by DoD.

d. Case Management. Humana Military Healthcare Services also provides case management services on a variety of clinical needs for participants of special programs. The focus of case management is to empower beneficiaries and families to actively participate in their own care. Fully supporting the case management process, HMHS has established and maintains a regional system of case management that ensures the coordinated delivery of quality and cost-effective services, with primary emphasis on patients with medically complex conditions and a high potential for extraordinary costs. Helping beneficiaries and families gain a greater understanding of their conditions enables them to make informed decisions and engages them in the planning and delivery of their care. At the same time, our case managers provide personalized attention to beneficiaries' particular needs and assist them in dealing with the complexities of the healthcare delivery system.

   HMHS provides education, assistance, and coordination of care to selected TRICARE beneficiaries and their health care professionals. For example, upon entering the case management program, we mail a packet to the beneficiary that contains a welcome letter introducing the beneficiary to the case manager, resource information, and a document explaining the beneficiary's rights and responsibilities. This activity

improves access to resources and cost-effective utilization of appropriate military and community health and health-related resources and services.

e. Post Traumatic Stress Disorder (PTSD). Like Americans everywhere, all of us at HMHS have become aware of the special impacts of the Global War on Terror on returning service members. Our valued partner, ValueOptions, has focused on the need for assisting those who may be suffering from PTSD – either diagnosed or undiagnosed. ValueOptions is acutely aware of the increased incidence of PTSD symptoms of returning service members and has taken the following steps to address this issue.

1) In 2005, we sent a detailed educational summary to all behavioral health providers discussing the prevalence of PTSD, tips on diagnosing the condition, and treatment recommendations.

2) In February 2007, we sent a revised summary to providers supplying additional information on PTSD such as the percentage of behavioral health issues in service members returning from Iraq and Afghanistan; the paradigm of looking at post traumatic stress; and a new treatment being pioneered in San Diego regarding virtual reality exposure in the treatment of PTSD.

3) We are working collaboratively with our partner, Value Options, to provide educational materials to primary care physicians focused on screening for PTSD in the primary care setting.

4) The HMHS website has been enhanced to include educational materials, tools and tests on PTSD and other behavioral health risk factors and issues that can be accessed from one's home.

5) In the spring of 2006, we jointly distributed a brochure to over 32,000 activated National Guardsmen and Reservists explaining risk factors for PTSD, depression, substance abuse, etc. However, we have not seen any significant change in behavior based on this outreach.

In addition to the above focus, ValueOptions encourages providers, through Primary Care Manager (PCM) education and provider mailings to educate family members of returning veterans on signs and symptoms to watch for as soldiers transition back to their pre-combat life.

f. Transparency. Finally, I would be remiss if I didn't discuss our work to support the Presidential Executive Order on Transparency. In August 2006, the President issued Executive Order 13410, which directs federal health programs, like TRICARE, to promote transparency regarding healthcare quality and price, and make relevant

information available to beneficiaries, enrollees, and providers. We are currently developing two strategies to help the MHS fulfill this directive. First, users of our on-line provider locator will see information on how providers compare regarding the cost for certain episodes of care, clinical quality issues, and compliance with TRICARE administrative requirements. And second, to help beneficiaries evaluate inpatient care, we plan to make quality information about hospitals available through our website.

In sum, we believe we are having a positive impact on the quality of clinical services being provided to TRICARE beneficiaries throughout the South Region. We look forward to additional advances in the future.

ACCESS TO CARE

Unlike other TRICARE Regions, we offer TRICARE Prime to any beneficiary who resides in the South. This means that we have committed to building a network of contracted TRICARE providers to meet the access needs of TRICARE Prime enrollees who live in both urban and rural areas. In so doing, we have enhanced access for all beneficiaries, including those who have chosen to use the TRICARE Extra and TRICARE Standard benefits.

To illustrate, today there are approximately 77 million people who reside in the South Region. Of those, approximately 2.8 million (or 3.7% of the total population) are eligible for TRICARE. On a state-by-state basis, the breakdown is as follows:

STATE	TOTAL POPULATION (2004 US CENSUS)	TRICARE ELIGIBLES	TRICARE PERCENT OF TOTAL
ALABAMA	4,530,182	151,124	3.3%
ARKANSAS	2,752,629	92,246	3.3%
FLORIDA	17,397,161	760,270	4.3%
GEORGIA	8,829,383	396,400	4.4%
LOUISIANA	4,515,770	129,974	2.8%
MISSISSIPPI	2,902,966	123,711	4.2%
OKLAHOMA	3,523,553	140,170	3.9%
SOUTH CAROLINA	4,198,068	226,039	5.3%
TENNESSEE	5,900,962	118,483	2.0%
TEXAS	22,490,022	686,454	3.0%
GRAND TOTAL	**77,040,696**	**2,824,871**	**3.7%**

Figure 2 – South Region Population

At the same time, there are slightly more than 151,000 licensed practicing providers in the South Region. Of those, about 61,000 (or approximately 42% of the total) are part of our TRICARE network of contracted providers. Again, a state-by-state breakdown may provide some insight:

STATE	LICENSED PRACTICING PROVIDERS	HMHS NETWORK (MD, DO, PSYCH)	PERCENT OF TOTAL
ALABAMA	9,746	3,480	36%
ARKANSAS	5,405	2,962	55%
FLORIDA	38,216	13,991	37%
GEORGIA	16,483	7,642	46%
LOUISIANA	10,963	3,797	35%
MISSISSIPPI	5,074	2,234	44%
OKLAHOMA	6,888	3,792	55%
SOUTH CAROLINA	8,974	2,415	27%
TENNESSEE	13,960	6,238	45%
TEXAS	35,681	14,621	41%
GRAND TOTAL	**151,390**	**61,172**	42%

Figure 3 – South Region Provider Data

When we overlay the two elements, the following perspective emerges:

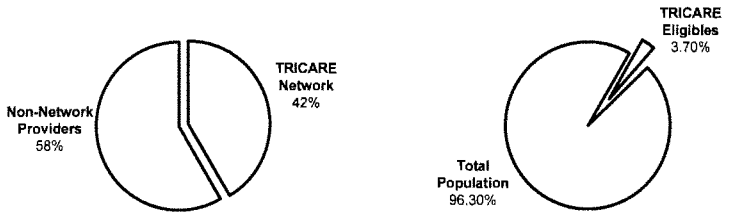

Figure 4 – South Region Network in Perspective

In sum, we believe our provider network offers good access for all beneficiary categories – TRICARE Prime, TRICARE Extra, and TRICARE Standard alike.

However, we also recognize that some beneficiaries will exercise their right to go outside of our network. In such cases, we try to ensure that they have access to non-network providers who *participate* in TRICARE – that is they will agree to see TRICARE patients and file their claims, but without agreeing to discount their reimbursements below the maximums allowed by the TRICARE program. We do not know all the reasons why some providers refuse to see TRICARE beneficiaries, and we do not know how many actually do so. However, what we do know is that approximately 139,000 providers (or about 92% of all licensed practicing providers

in the 10-state South Region) have seen a TRICARE beneficiary and submitted a claim on their behalf during the past year.

To be sure, there are some areas within the South Region that are medically underserved, and as a result, access to medical services is very limited. These areas are very challenging for us, and they sometimes lead to a perception of a lack of access for our beneficiaries. Currently, there are no TRICARE Prime enrollees, and only 24 TRICARE Prime Remote beneficiaries out of 1.4 million TRICARE Prime enrollees who are currently not assigned to a contracted network PCM.

Additionally, the recent Government Accountability Office (GAO) Report issued in December 2006 on *Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE Managed Care Option* states on the Highlights page, ". . . that access is generally sufficient for non-enrolled beneficiaries." It also says, "Throughout the three regions, about 16 percent of non-enrolled TRICARE beneficiaries reside outside of the Prime Service Area (PSA). Because the South Region has extensive PSAs, no TRICARE beneficiaries live in locations without a civilian provider network." [1]

We are well aware of the need for behavioral health access – particularly in light of the increased demand for such services brought about by the Global War on Terror – and the Subcommittee's concern for this matter. The data are positive, though certainly there is room for improvement.

According to the Center for the Study of Traumatic Stress, nearly 31% of National Guardsmen and Reservists returning from active duty overseas deployment are doing so with warning signs for several behavioral health disorders, including PTSD and depression. [2] This continues to be a rising concern for our men and women of the armed forces, and a focal point for us.

In December 2006, our partner, ValueOptions, provided testimony to the DoD Task Force on Mental Health. During this session, the ValueOptions representative noted that the use of behavioral health services in the South Region has continued to increase since 2002. Fortunately, network access has remained high. From November 2005 to November 2006, reimbursement for 90 percent of behavioral health inpatient admissions and 87 percent of behavioral health outpatient services (including unmanaged visits) was made to network providers, while 96 percent of all referrals were made to either MTFs or the network. Not only has network utilization been high, but beneficiaries have had *convenient* access to at least three hospitals within 40.3 miles and three providers within 8.7 miles. Again, we recognize that there are some remote locations within the South Region that contain few TRICARE-certified providers, and that can result in a beneficiary having to further, or experience a delay in scheduling an appointment. Nonetheless, these areas are minimal and when identified are aggressively pursued for network development by our partners at ValueOptions.

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[1] Staff Writer, "Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option." GAO Report, December 2006 Summary ppg 1.

[2] Staff Writer, "Mental Illnesses Appear Common Among Veterans Returning From Iraq and Afghanistan." Archives Internal Medicine, Spring 2007; 167:476-482.

In sum, these indicators reflect excellent access to quality healthcare services for beneficiaries in the South Region. Notwithstanding the successes to date, however, we continue to expand our network coverage to meet the special needs of the TRICARE population we serve.

BENEFICIARY SERVICE

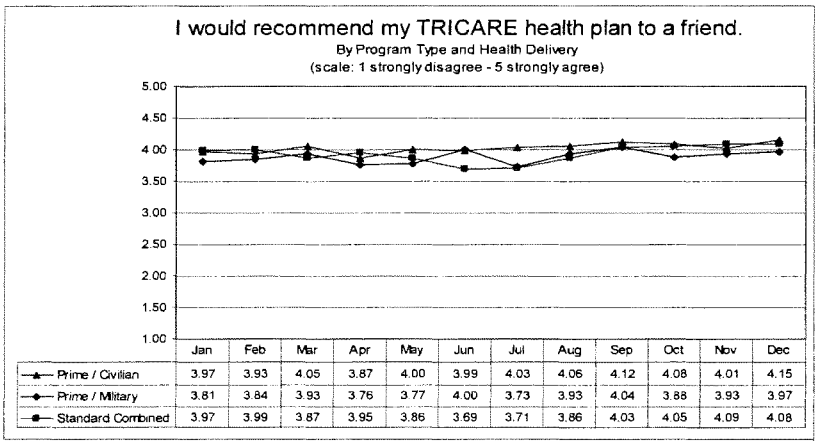
Throughout our history, Humana Military Healthcare Services and our subcontracting partners have been customer-centric organizations. Stated simply, we strive to provide excellent service to all TRICARE beneficiaries. Depicted in the chart below is a small sample of the service metrics that we continuously and carefully monitor.

Service Metric	Standard	Mar 06	Jun 06	Sep 06	Dec 06
Phone Answered in 30 Sec.	**95.00%**	99.00%	98.97%	96.24%	98.94%
Initial Call Resolution	**80.00%**	97.42%	97.35%	97.36%	97.08%
TRICARE Service Center – less than 10 minute wait time	**100.00%**	99.93%	99.93%	99.90%	99.97%
Routine Correspondence reply in 15 days	**85.00%**	99.74%	99.81%	99.86%	99.72%
Enrollments Processing completed in 5 days	**80.00%**	100.00%	100.00%	100.00%	100.00%
Medical Prior Authorizations processed in 2 days	**90.00%**	98.63%	98.41%	100.00%	97.95%
Referrals Processed in 2 days	**85.00%**	99.37%	99.10%	99.37%	99.44%
Percent of referrals to MTFs or the HMHS network	**96.50%**	97.69%	98.02%	97.07%	97.49%
Claims processed in 30 days	**97.50%**	99.95%	99.98%	99.96%	99.97%

Figure 5 – Selected South Region 2006 Customer Service Levels

We are proud of our ability to provide these high levels of performance, and we continue to look for opportunities to improve the experience of TRICARE beneficiaries.

We believe our high levels of operational performance have translated into positive attitudes from the TRICARE beneficiaries we serve. Our website seeks to obtain voluntary feedback by posing several questions. Feedback on one question *("I would recommend my TRICARE health plan to a friend")* seems particularly illuminating. On a scale of 1 ("Strongly Disagree") to 5 ("Strongly Agree"), overall results have been consistently high as reflected in the following graph:



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Prime / Civilian	3.97	3.93	4.05	3.87	4.00	3.99	4.03	4.06	4.12	4.08	4.01	4.15
Prime / Military	3.81	3.84	3.93	3.76	3.77	4.00	3.73	3.93	4.04	3.88	3.93	3.97
Standard Combined	3.97	3.99	3.87	3.95	3.86	3.69	3.71	3.86	4.03	4.05	4.09	4.08

Figure 6 – 2006 South Region Beneficiary Feedback

In summary, we believe we are providing high levels of service across the entire spectrum of beneficiary interaction – as required by the Government under the terms of our South Region TRICARE contract – and as we are committed to do in support of this most deserving population. In turn, these performance levels have yielded positive feedback from those we serve. Notwithstanding our successes, we are committed as a company to continuously improving the level of services – just as the Congress has repeatedly encouraged us to do in the past.

CONCLUSION

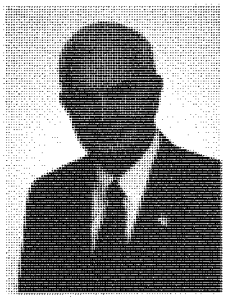
As I believe the foregoing statement illustrates, today, we are delivering on the original objectives of the TRICARE program when it was established more than 15 years ago. We have implemented a multitude of industry best practices to help control costs, and enhanced the clinical quality of services delivered to military beneficiaries throughout the South Region. At the same time, we have expanded access to care for all TRICARE beneficiaries, and we believe our operational service levels are unequaled anywhere in the United States.

Achieving these results has required a total team effort on the part of all TRICARE stakeholders. Earlier, I noted the HMHS team, including our partners at PGBA LLC, BlueCross BlueShield of South Carolina, Value Options, Inc., and Wisconsin Physicians Service Insurance Corporation. I am convinced that there is no finer group of industry professionals collaboratively working to ensure service excellence on all levels.

At the same time, I would like to personally commend the Department of Defense for the leadership provided to us on a daily basis. In particular, I respectfully call the Subcommittee's attention to the staff of the TRICARE Management Activity under the skilled leadership of Major General Elder Granger, MC, USA, as well as the dedicated members of the TRICARE Regional Office-South, professionally led by Mr. Michael Gill, SES. Collectively, these exceptional public servants have challenged those of us in industry to provide "world class" healthcare support service to members of the military community. Under their stewardship, I believe we are doing so.

In conclusion, please allow me to also thank you, Mr. Chairman, and the Subcommittee for the guidance and leadership you have provided, as well as for the opportunity to submit my testimony for the record. The health and wellness of our military personnel – and their families – is essential to the success of our nation. We look forward to working with the Subcommittee and with the entire Congress to achieve even greater success in the future.

I stand ready to answer any questions you may have.



DAVID J. BAKER
President and Chief Executive Officer,
Humana Military Healthcare Services (HMHS)

Mr. Baker serves as President and Chief Executive Officer of Humana Military Healthcare Services, Inc. of Louisville, Kentucky.

Following a distinguished active duty career of 27 years in the United States Air Force Medical Service Corps, Mr. Baker joined Humana Military Healthcare Services as the Region 3 Executive Director in 1996. In this capacity, he was responsible for all HMHS field operations in Georgia, Florida, and South Carolina. In 1999, he became the Chief Operating Officer, and in January 2000, he assumed his current position.

Mr. Baker holds a Masters Degree in Business Administration (with a concentration in Health and Hospital Administration) from the University of Florida and a Bachelors of Science Degree in Business Administration from the University of Maryland. He is also a graduate of the Executive Program in Health Care Management of The Ohio State University. While on active duty, Mr. Baker completed the Interagency Institute for Federal Health Care Executives, Air War College, Air Command and Staff College, and Squadron Officer School.

Raised in an Air Force family, Mr. Baker is the only TRICARE CEO who is a life-long beneficiary of the military health system.

Humana Military Healthcare Services -- Disclosure Statement
Testimony before the Committee on Armed Services, U.S. House of Representatives
By:
David J. Baker, President & CEO
Spring 2007

		FY05	
Contract Number	**Contracting Office**	**10/04 - 9/05**	**Subject**
MDA906-03-C-0010	Department of Defense TRICARE Management Activity	$2,318,078,736	TRICARE Next Generation of Contract, South Region
H94002-04-D-0003	Department of DefenseTRICARE Management Activity	2,437,546	TRICARE Puerto Rico
W81K04-04-P-0026	Department of the Army, Army Medical Command Healtcare Acquisition Activity	3,467,536	Patient Appointment Services - Bridge Contract for Tidewater Area
V673(90F)P0010	Department of Veterans Affairs, Chief, Acquistition & Material Management, James A. Haley Veterans Hospital, Tampa FL	611,793	Patient Appointment Services - Bridge Contract for Keesler Air Force Base
W81K04-04-P-0028	Deparatment of the Army, Army Medical Command Healtcare Acquisition Activity	1,441,703	Patient Appointment Services - Bridge Contract for Wright Patterson Air Force Base
W81K04-05-D-7002	Department of the Army, Army Medical Command Healtcare Acquisition Activity	381,822	Multiple Award Task Order (MATO) Indefinite Delivery Indefinite Quantity Contract for Patient Appointment Services (PAS). Basic contract & Task Orders (T.O. for Ft. Bragg & WPAFB)
T.O. RC01	Department of the Air Force, 81st Contracting Squadron, Keesler, AFB	233,556	Multiple Award Task Order (MATO) Keesler, AFB
FA7000-05-F-0049	Department of the Air Force, 10 MSG/LGC - Multi - Service Market Office, Colorado Springs	864,273	Multiple Award Task Order (MATO) Colorado Springs Multi- service Market Office
T.O. 6G01	Department of the Air Force, 2D Medical Group, Barksdale AFB, LA	28,109	Multiple Award Task Order (MATO) Barksdale, AFB
V674P-3482	Department of Veterans Affairs, Central Texas Veterans Health Care System	43,930	General Surgeon Services for Veterans Adminstration Outpatient Clinic, Austin TX
		$2,327,589,004	

Humana Military Healthcare Services -- Disclosure Statement
Testimony before the Committee on Armed Services, U.S. House of Representatives
By:
David J. Baker, President & CEO
Spring 2007

		FY06	
Contract Number	**Contracting Office**	**10/05 - 9/06**	**Subject**
MDA906-03-C-0010	Department of Defense TRICARE Management Activity	$2,504,041,174	TRICARE Next Generation of Contract, South Region
H94002-04-D-0003	Department of DefenseTRICARE Management Activity	2,421,677	TRICARE Puerto Rico
W81K04-05-D-7002	Department of the Army, Army Medical Command Healtcare Acquisition Activity	1,232,934	Multiple Award Task Order (MATO) Indefinite Delivery Indefinite Quantity Contract for Patient Appointment Services (PAS). Basic contract & Task Orders (T.O. for Ft. Bragg & WPAFB)
T.O. RC01	Department of the Air Force, 81st Contracting Squadron, Keesler, AFB	1,167,512	Multiple Award Task Order (MATO) Keesler, AFB
FA7000-05-F-0049	Department of the Air Force, 10 MSG/LGC - Multi - Service Market Office, Colorado Springs	2,925,900	Multiple Award Task Order (MATO) Colorado Springs Multi- service Market Office
T.O. 6G01	Department of the Air Force, 2D Medical Group, Barksdale AFB, LA	288,739	Multiple Award Task Order (MATO) Barksdale, AFB
W9124D-05-C-0045	Department of the Army, MEDDAC, Property Management, Ft. Knox, KY	177,658	Dermatologist Physician Services for Ireland Army Community Hospital, Ft. Knox, KY
W9124D-06-C-0001	Department of Army, MEDDAC, Property Management, Ft. Knox, KY	306,527	Ireland Army Community Hospital, Ft. Knox, KY-- Diagnostic Radiologist Services
		$2,512,562,120	

Humana Military Healthcare Services -- Disclosure Statement
Testimony before the Committee on Armed Services, U.S. House of Representatives
By:
David J. Baker, President & CEO
Spring 2007

		FY07	
Contract Number	**Contracting Office**	**10/06 - 2/07**	**Subject**
MDA906-03-C-0010	Department of Defense TRICARE Management Activity	$1,133,577,033	TRICARE Next Generation of Contract, South Region
H94002-04-D-0003	Department of DefenseTRICARE Management Activity	1,119,497	TRICARE Puerto Rico
W81K04-05-D-7002	Department of the Army, Army Medical Command Healtcare Acquisition Activity	537,025	Multiple Award Task Order (MATO) Indefinite Delivery Indefinite Quantity Contract for Patient Appointment Services (PAS). Basic contract & Task Orders (T.O. for Ft. Bragg & WPAFB)
T.O. RC01	Department of the Air Force, 81st Contracting Squadron, Keesler, AFB	422,243	Multiple Award Task Order (MATO) Keesler, AFB
FA7000-05-F-0049	Department of the Air Force, 10 MSG/LGC - Multi - Service Market Office, Colorado Springs	1,265,235	Multiple Award Task Order (MATO) Colorado Springs Multi- service Market Office
T.O. 6G01	Department of the Air Force, 2D Medical Group, Barksdale AFB, LA	136,475	Multiple Award Task Order (MATO) Barksdale, AFB
W9124D-05-C-0045	Department of the Army, MEDDAC, Property Management, Ft. Knox, KY	24,185	Dermatologist Physician Services for Ireland Army Community Hospital, Ft. Knox, KY
W9124D-06-C-0001	Department of Army, MEDDAC, Property Management, Ft. Knox, KY	83,118	Ireland Army Community Hospital, Ft. Knox, KY-- Diagnostic Radiologist Services
V797P-7071A	Dept of Veterans Affairs Office of Acquisition & Material Mgmt.	99,006	Professional & Allied Healthcare Staffing
		$1,137,263,818	

HUMANA MILITARY HEALTHCARE SERVICES – DISLOSURE STATEMENT
TESTIMONY BEFORE THE COMMITTEE ON ARMED SERVICES, U.S. HOUSE OF REPRESENTATIVES

BY
DAVID J. BAKER, PRESIDENT & CEO
SPRING, 2007

Federal Contract Information

Number of Contracts (including subcontracts) with the federal government:
Current fiscal year (2007): 9
Fiscal year 2006: 8
Fiscal Year 2005: 10

Federal Agencies with which federal contracts are held:
Current fiscal year (2007): Department of Defense, Department of the Army, Department of the Air Force, Department of Veterans Affairs
Fiscal year 2006: Department of Defense, Department of the Army, Department of the Air Force
Fiscal year 2005: Department of Defense, Department of the Army, Department of the Air Force, Department of Veterans Affairs

List of subjects of federal contract(s) (for example, ship construction.....):
Current fiscal year (2007): Managed Healthcare, Patient Appointment Services, Staffing of Healthcare Professionals
Fiscal year 2006: Managed Healthcare, Patient Appointment Services, Staffing of Healthcare Professionals
Fiscal year 2005: Managed Healthcare, Patient Appointment Services, Staffing of Healthcare Professionals

Aggregate dollar value of federal contracts held:
Current fiscal year (2007): $1,137,263,818
Fiscal year 2006: $2,512,562,120
Fiscal year 2005: $2,327,589,004

Federal Grant Information

HMHS does not receive any federal government grants.

Statement By

Steven D. Tough

President

Health Net Federal Services

Before The House Committee On Armed Services

Subcommittee On Military Personnel

United States House of Representatives

March 27, 2007

Steven D. Tough

President, Health Net Federal Services

Steven D. Tough is president of Health Net Federal Services (HNFS), the government operations division of Health Net, Inc. HNFS is one of the largest TRICARE Managed Care Support Contractors, providing managed care services to active duty family members, military retirees and their dependents. Health Net is among the nation's largest publicly traded managed health care companies.

Mr. Tough oversees the day-to-day administration and management direction for HNFS, which includes preparation for reprocurement opportunities of our TRICARE contract, as well as strategizing our growth in future businesses that include veterans affairs and other government funded health care services.

Formerly the president and chief operating officer of Foundation Health Corporation (FHC), a predecessor company of Health Net, Mr. Tough brings first-hand experience of complex government programs (CHAMPUS, TRICARE, Medicare, Medicaid, and Veterans Affairs). In addition, he brings knowledge of Health Net's organization and people, familiarity with key players on Capitol Hill and federal agencies, and more than 30 years of health care management and operational know-how.

Mr. Tough has a long-standing career in the health care industry. He spent 20 years at FHC, nine of those years as a president and chief operating officer in the Government and Specialty Services groups. Since leaving FHC in 1998, Mr. Tough started his own firm providing health care consulting services to a variety of companies, and served as president of the California Association of Health Plans and MAXIMUS, Inc., a health care services organization.

Mr. Tough earned his Bachelor of Arts in Health and Safety Studies from California State University, Sacramento; a Master's of Public Health from the University of Michigan; and is a graduate of the National HMO Fellowship Program, sponsored by the U.S. Department of Health, Education and Welfare (now U.S. Department of Health and Human Services), Office of Health Maintenance Organizations.

Health Net's mission is to help people be healthy, secure and comfortable. The company's HMO, insured PPO, POS and government contracts subsidiaries provide health benefits to more than 7 million individuals in 27 states and the District of Columbia through group, individual, Medicare, Medicaid and TRICARE programs. Health Net's subsidiaries also offer managed health care products related to behavioral health and prescription drugs, and offer managed health care product coordination for multi-region employers and administrative services for medical groups and self-funded benefits programs.

Introduction

Mr. Chairman and Distinguished Members of the Subcommittee, thank you for the opportunity to address the state of the TRICARE program – specifically the North Region. It is an honor to be invited to share our team's perspectives and experience with you today.

My objective today is three-fold: First, to reacquaint this committee with Health Net Federal Services (Health Net) and its long-standing commitment to serving the Department of Defense and its beneficiaries. Secondly, to provide you with an overview of the current state of our partnership with the Military Health System, the successes that are being achieved, and our use of tailored and integrated services to enhance quality in the most cost-effective manner. And thirdly, to share with you our thoughts on ways to further strengthen and advance the TRICARE program, helping to make this well performing program even more effective at meeting the health care needs of service members, their families, retirees and their families.

Health Net Federal Services is a division of Health Net, Inc.; one of the nation's largest publicly traded managed health care companies. Health Net's mission is to help people be healthy, secure and comfortable. The company's HMO, POS, insured PPO and government contracts subsidiaries provide health benefits to approximately 6.6 million individuals in 27 states and the District of Columbia through group, individual, Medicare, Medicaid, TRICARE and Veterans Affairs programs. Health Net's behavioral health services subsidiary, MHN, provides behavioral health, substance abuse and employee assistance programs to approximately 7.3 million individuals in various states, including the company's own health plan members and military service members and their families. The company's subsidiaries also offer managed health care products related to prescription drugs, including administering Medicare Part D benefits for more than 470,000 members nationwide, as well as managed health care product coordination for multi-region employers and administrative services for medical groups and self-funded benefits programs.

Health Net has a long history of working in partnership with government agencies, including the Department of Defense, and was one of the first companies in the United States to develop comprehensive managed care programs for military families. Health Net has served the Department of Defense since the beginning of the Military Health System, originally operating under the name Foundation Health Federal Services.

In 1988, we were awarded the first CHAMPUS Reform Initiative contract located in California and Hawaii. Following the CHAMPUS Reform Initiative, Health Net was awarded three contracts under the original TRICARE structure of 12 regions and seven contracts. These three contracts included five regions and 11 states across the country. Through this contract, Health Net provided managed health care services to over 2.5 million TRICARE beneficiaries for 9 years. In 2003, Health Net was awarded a 5-year contract to administer health care services for 2.9 million beneficiaries in the TRICARE North Region, which encompasses 23 northeast, southeast and mid-western states, including the District of Columbia.

In addition to our North Region contract, Health Net, Inc. also provides behavioral health counseling services to the Department of Defense through our behavioral health company MHN. These services include military family counseling, rapid response counseling to deploying units, victim advocacy services and reintegration counseling.

Health Net also is proud of its partnerships with the Department of Veterans Affairs. Currently, we provide audit and recovery services; staff, manage and operate 13 community based outpatient clinics; and administer preferred pricing contracts in each of the Veteran Affairs' Veterans Integrated Service Networks. Through these various programs, we have helped the Department of Veterans Affairs save over $150 million since 1999.

Throughout our 19 years of providing managed care services for the Department of Defense, we have continuously focused on improving, tailoring and integrating our services to be most responsive to our government customer, meeting the ever changing needs of the Military Health System and the beneficiaries we serve. As you well know, the health care needs of military service members and their families – active, retired and reservists – as well as the requirements of the Military Health System, are unique and distinct from commercial health care in several ways.

The dual mission of the Military Health System – medical combat readiness and peacetime health care delivery – is a dramatic departure from the stability experienced in the commercial health care marketplace. The Military Health System is a very unique blend of military treatment facilities and contractor health care delivery systems. This unique blend of complementary and interdependent delivery systems must deal with the significant, concurrent stresses of on-going military deployments and the pressures brought about by the global war on terror. The "one of a kind," synergistic Military Health System has consistently demonstrated its ability to integrate and to tailor mutually supportive best practices to support and respond to the varied needs of its diverse beneficiary population. This very nature of the Military Health System forms the foundation for the success of the TRICARE program; it is a standard unmatched by commercial health plans.

State of the Partnership

I am pleased to report that the state of our partnership with the Military Health System is very strong. The collaboration between the TRICARE Management Activity, TRICARE Regional Offices, the military services and the managed care contractors, the solid performance levels, the high level of beneficiary satisfaction, and the positive survey results of military treatment facility commanders and staff clearly illustrate the strength of this partnership.

Partnership

In collaboration with the TRICARE Management Activity, the TRICARE Regional Office-North and the North Region military treatment facilities, substantial programmatic improvements have been achieved and all stakeholder groups continue to validate an ever-increasing level of confidence and satisfaction with the quality of service delivery. Health Net continues to focus on performance excellence and on initiatives that advance the TRICARE program and contribute to the full realization of the contract objectives in the North Region.

Health Net and the TRICARE Regional Office-North have fostered a strong, collaborative relationship, ensuring open, honest and transparent communications, a clear understanding of goals and expectations, and the proper prioritization of initiatives to attain and even exceed the contract objectives. Health Net, the TRICARE Regional Office-North, and TRICARE Management Activity are actively working in concert on numerous initiatives to improve health care cost management and enhance the quality of care for TRICARE beneficiaries. To this end, in the fall of 2006, Health Net and the TRICARE Regional Office-North cosponsored four Medical Directors Conferences. Participation in these conferences helped to foster improved clinical relationships, communications and understanding between the military treatment facility, TRICARE Management Activity, TRICARE Regional Office-North and Health Net clinical teams. During these conferences, participants engaged in discussions of local health care best-buy and best patient management decisions and focused on improving the interoperability of the direct care and contractor systems in terms of patient and clinical information management.

To further advance collaboration, Health Net has employed an "on the ground" organization with staff co-located at military treatment facilities and in Multi-Service Market Offices, facilitating

face-to-face accountability. This local operational integration is also the centerpiece for ensuring effective customer service relationships with the beneficiary community. This "on the ground" operational integration of support services and relationships with military treatment facility commanders and the beneficiary community is a key driver for enhancing optimization initiatives, market level planning and stakeholder satisfaction.

We strongly believe these regional and local partnerships are crucial for program success. For example, in the most recent quarterly award fee survey, Health Net achieved an overall 94 percent level of satisfaction, as measured by military treatment facility commander surveys. We were able to achieve this level of satisfaction by making collaboration a top priority and by being closely aligned with the priorities of our government partners – TRICARE Management Activity, TRICARE Regional Office-North and the military treatment facilities.

Not only do we place a high priority on our customer relationships at TRICARE Management Activity, TRICARE Regional Office-North and the military treatment facilities, we also maintain collaborative relationships with the military beneficiary associations, communicating with them on a frequent basis. These interactions help us to gain insights into how best to meet the unique needs of the population we serve, to identify areas for increased beneficiary and provider education, and to address individual beneficiary and provider concerns. Working with the military associations also provides us with forums for discussing the current state of TRICARE and for providing information and updates on the program. We believe this collaborative relationship is a win-win: We share valuable program information that the associations share with their members – TRICARE beneficiaries – and we in return learn how we can improve our services to better meet the needs of those we serve.

In addition to our collaborative efforts with the government and beneficiary groups, this past year Health Net formed a TRICARE Advisory Committee composed of retired service members with extensive senior leadership experience within the Department of Defense and the Military Health System community. The Advisory Committee's strategic guidance is particularly valuable in our efforts to develop operational and customer relation solutions to provide those who serve, and their families, with unsurpassed health care.

Health Net remains committed to fostering and maintaining these collaborative relationships with all key stakeholders. Our mission is to complement and maximize, not circumvent, the existing military health infrastructure and to deliver coordinated, quality health care.

Performance Excellence

In addition to the strength of the partnership with the government customer and TRICARE beneficiaries, the levels of contract performance also validate our assertion that the state of the TRICARE program is strong.

Claims Processing – Under the current TRICARE contracts, significantly greater emphasis has been placed on minimizing administrative costs associated with claims processing. Health Net now obtains nearly 78 percent of network provider claims electronically and almost 62 percent of all TRICARE North claims – network and non-network. We also promote the use of web-based claims processing by providers, and now receive over eight percent of all claims over the web. As the volume of claims being submitted continues to increase – claims processing receipts for 2006 were seven percent higher than 2005, and we expect 2007 claims to exceed 2006 total – our continued pursuit of electronic claims will be vital to controlling program administrative costs.

Additionally, Health Net also has placed great emphasis on paying providers promptly. We recognize that many providers view TRICARE reimbursement rates as being lower than commercial rates. To help mitigate this concern and to encourage provider participation in TRICARE, we try to improve providers' cash flow by promptly processing and paying claims. Of the more than 1.1 million claims we receive a month, more than 99.99 percent are adjudicated and paid within 30 days of receipt. In fact, Health Net requires only an average of 5.6 days from receipt to process and pay claims submitted electronically, 12.7 days for paper claims and 2 days for web-based claims. In promptly processing and paying more than 13 million claims annually, Health Net has not compromised accuracy for speed – we maintain error rates that are consistently better than contract standards.

Customer Service – Health Net's toll-free telephone service is the primary source for beneficiaries and providers to obtain TRICARE program information and to seek resolution to difficulties being experienced. This toll-free customer service line provides beneficiaries and

providers with direct access to company representatives 12 hours a day, 5 days a week (Monday through Friday, excluding federal holidays). Additionally, most services offered by Health Net's representatives are available 24 hours a day, 7 days a week using an integrated voice response system. Through this system, callers can obtain program information, check the status of claims and referrals/authorizations, verify eligibility, pay enrollment fees and more, whenever it is most convenient for them to do so.

In 2006, Health Net received nearly 4.4 million calls from TRICARE North Region beneficiaries and providers. The majority of these calls were routine requests regarding benefit information, coordination of care, including authorizations and referrals, and claims status. On average, callers were connected to a customer service representative in 4 seconds. Moreover, more than 95 percent of all calls received were answered by a representative within 30 seconds. Health Net's immediate availability to beneficiaries and providers is complemented by its content management program that ensures information provided is current and accurate. Consistent, reliable and accurate information is made possible through the use of scripts, hyperlinks and decision tree formats with indexing and taxonomy to expedite information searches.

Enrollment – The TRICARE enrollment application and process are complex and occasionally the source of frustration for beneficiaries. Health Net has introduced web-based tools that lessen the complexity of the enrollment process, improve the accuracy of submitted information and expedite completion time. These web-based tools are available 24 hours a day, 7 days a week, 365 days a year. Through these tools, beneficiaries have the ability to select or make a change to their primary care manager. They also can determine whether they live within a Prime service area and if so, identify the enrollment requirements of their Prime service area. This latter tool incorporates the enrollment criteria specific to each military treatment facility and includes military treatment facility addresses and telephone information.

Promptly enrolling beneficiaries in TRICARE Prime helps to ensure they have quick access to comprehensive health care services. To that end, Health Net processes complete enrollment applications and other related transactions within 5 business days of receipt. Portability transactions – when a beneficiary transfers or moves from another TRICARE region to the North Region – are processed within 4 days of receipt. As with claims processing, not only do we

process enrollment applications quickly, we do so with great accuracy. In 2006, Health Net processed nearly 375,000 enrollment requests with accuracy rates hovering near 99 percent, well above health care industry standards. We continue to work closely with our government partner to further refine the enrollment process to enhance beneficiary service and satisfaction.

Referrals and Authorizations – In another effort to improve provider relations and to minimize the "hassle factor," Health Net processes referral and authorization requests promptly. We continue to process referral and authorization requests within contract standards, and often exceed them. By way of example, more than 99 percent of all routine physician referral requests are completed within 2 days against a standard of 85 percent. Similarly, over 97 percent of requested authorizations for medical procedures are processed within 2 days against a contract standard of 90 percent.

As a part of our commitment to support the Military Health System in its medical readiness and Graduate Medical Education missions, based on an military treatment facilities capability and capacity, 100 percent of all appropriate referrals that occur within the military treatment facilities service area are forwarded to that military treatment facility for first right of refusal. For the past 12 months, nearly 4.5 of every 10 opportunities for military treatment facility recapture were successful because the military treatment facilities' capability and/or capacity could accept the care, thereby supporting the Military Health System mission and providing quality care in the most efficient setting.

Case Management – Our case management program provides individualized assistance to beneficiaries experiencing complex, acute or catastrophic illnesses or that have exceptional needs. Health Net's case management program focuses on early identification of high-risk beneficiaries and applies a systematic approach to coordinating all aspects of care. It is common for case managers to address a myriad of issues with the patient beyond their medical needs, including behavioral, psychosocial, environmental, cultural and financial.

There are typically 650 ongoing comprehensive cases under our management in the program. These are split between physical health and behavioral health cases – approximately 85 percent are physical health cases and 15 percent are behavioral health. Approximately 80 cases are

opened each month, and a similar number are closed out after the patient achieves the mutually determined goals for return to health that the patient and case manager set when the case was opened.

In terms of outcome, 95 percent of beneficiaries say their expectations were met or exceeded under this program. And in a 2006 study of the program to a control group, the quality of care was sustained or improved while the cost of care was 18.8 percent less than in the comprehensively case managed group. This cost efficiency is due to reduced readmissions to facilities, appropriate use of urgent or emergent care sites, enhanced beneficiary education and better coordination of care with the patient's care providers.

Transitional Care – Health Net's Transitional Care program minimizes gaps in care and supports beneficiaries with episodic care needs as they transition from one level of care or service to another. This concurrent review activity often begins with the interaction between Health Net's RN and an inpatient facility's caseworker or discharge planner.

In 2006, Health Net's Transitional Care nurses assisted more than 42,000 beneficiaries with a range of services – from being available for questions or help when asked, to comprehensive care coordination with the patient and family to ensure the best outcomes possible for the patient.

Provider Access – Our managed care network is robust. Currently there are nearly 100,000 contracted TRICARE providers servicing nearly 2.9 million eligibles and 1.4 million enrolled beneficiaries. The number of network providers has increased by 35, 000 since the start of service delivery in September 2004 -- a 53 percent increase.

Network adequacy is measure monthly, by specialty and service types, to identify any need for expansion or enhancement of specialties, which in turn, ensures access goals are being met. During 2006, 97 percent of all civilian generated referral requests within Prime service areas were completed to network providers or to a military treatment facility.

Every instance of a non-network referral is tracked, explained and used to understand and enhance the North Region network through ongoing development. As a result of this effort, the

overall network grew by 14 percent in 2006. New, sophisticated mapping software in Health Net support systems is materially improving provider access by enabling better referral decisions using actual drive times to provider offices. Using this tool, Health Net has committed to reducing drive times for enrolled beneficiaries in Prime service areas by 50 percent, thereby improving their access to care and improving satisfaction with the program.

Our Prime service areas contain 80 percent of all contracted network providers and cover 83.6 percent of the eligible TRICARE population. Although Prime enrollment is not offered in non-Prime Service Areas, Standard beneficiaries still benefit from our robust network. Since nearly 17 percent of the total contracted provider network is in non-Prime service areas, this makes the Extra plan option more attractive to them. Having a viable Extra benefit in non-Prime service areas benefits both the beneficiary and the government by offering quality, cost-effective services. The balance of the network (three percent) is outside the North Region but provides services to North Region beneficiaries in special care circumstances, or in adjacent urban markets, such as Nashville, Tennessee and St. Louis, Missouri.

Beneficiary Satisfaction

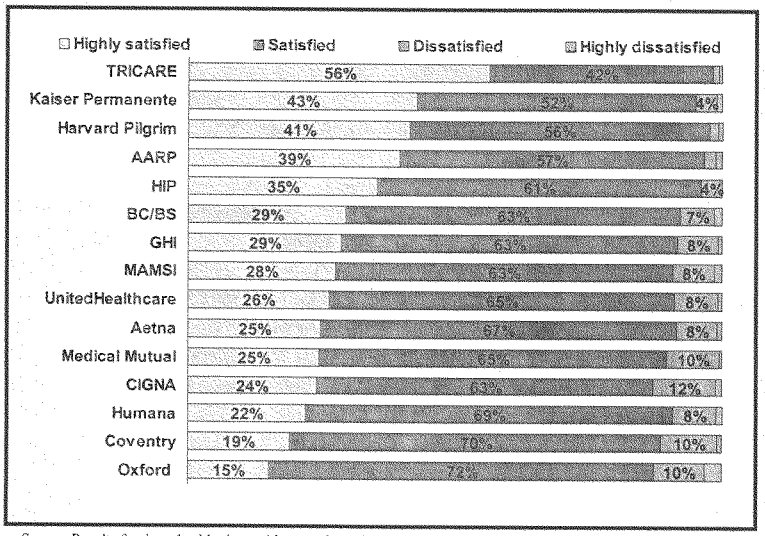
Beneficiary satisfaction with the TRICARE program remains very high, higher than with commercial or other government agency health programs, according to a recent survey by Wilson Health Information.

In September 2006, Wilson Health Information announced results from the 2006 WilsonRx® Health Insurance Satisfaction Survey. Of all the plans and programs included in the Wilson Survey, TRICARE was the top rated health insurer in member satisfaction for the fourth straight year.

The survey found that nearly all TRICARE enrollees are satisfied with their health insurance, with 56 percent surveyed indicating they are highly satisfied. In fact, overall satisfaction with TRICARE was higher in 2006 than in previous years. Specific areas of service in the TRICARE program that received the highest marks include:

- Re-enrollment
- Overall quality of medical care received
- Overall quality of health care providers
- Choice/coverage of hospital care
- Claims paid in a timely/hassle-free manner
- Courteous/helpful plan representatives
- Plan representatives answer questions/solve problems

Overall Beneficiary Satisfaction with Health Insurance Plan



Source: Results for those health plans with more than 100 respondents in the WilsonRx survey sample for the 20 complete states in the North Region. Health Insurance Satisfaction Survey (2006) Wilson Health Information, LLC, New Hope, PA – All Rights Reserved. Used with permission.

In addition to the Wilson Survey results, the regional director for the TRICARE Regional Office-North office determines our quarterly performance rating through a variety of surveys, which

include three key stakeholder groups – beneficiaries, military treatment facility commanders and TRICARE Regional Office-North division chiefs. Beneficiaries selected to participate in the quarterly survey are those that have had contact with Health Net's administrative touch points (claims, TRICARE Service Centers, enrollment, etc.) within the past quarter. For the past five quarters, overall beneficiary satisfaction levels have averaged in the 87 – 88 percent range, meaning that beneficiaries are either somewhat satisfied, very satisfied or completely satisfied with Health Net's administration of the program.

Military Treatment Facility Commander Satisfaction

The TRICARE Regional Office-North surveys of military treatment facility commanders have shown the North Region military treatment facility commander satisfaction continues to grow and currently is very strong. For the past five quarters, overall military treatment facility satisfaction has averaged 86 percent. However, we are pleased to note that during the most recent performance rating quarter (October – December 2006), Health Net received a record 94 percent satisfaction rate from North Region military treatment facility commanders. In three of the past five quarters, Health Net's Northeast sub-region was recognized for providing 100 percent commander satisfaction.

Customer Tailored Services

Through our 19 years of experience in working with the Department of Defense and our 8 years of providing services to the Department of Veterans Affairs, we have learned the value of aligning our services with the objectives and specific needs of our government customer. Our emphasis on tailoring services for the specific customer and population we serve, coupled with our emphasis on integrating best practices, allows us to deliver the most effective, most efficient services possible.

Support for Active Duty Service Members

While active duty service members receive most of their health care from the direct care system, we do provide a number of important support services.

National Capital Area, Multi-Service Market Area – As the TRICARE North Region managed are support contractor, Health Net has been actively engaged with the Walter Reed Army Medical Center and the other eight military treatment facilities located in the National Capital Area, Multi-Service Market Area. We provide an extensive network of civilian health care providers to augment services at each military treatment facility. Health Net operates a TRICARE Service Center on site at each military treatment facility to provide customer service, including enrollment, claims and referral assistance. The TRICARE Service Center at Walter Reed Army Medical Center averages over 600 beneficiary visits, including active-duty service members, per month. We provide a full range of medical management support to Wounded Warriors and all other Military Health System beneficiaries referred outside of Walter Reed Army Medical Center or other military treatment facilities for care within the civilian network. These services consist of general civilian care coordination, benefit review and customer support, care coordination and tracking with Walter Reed case management, transitional care, case management and discharge planning.

In support of the Army's response to recent concerns at Walter Reed Army Medical Center, Health Net volunteered and was invited to participate in various committees and "Tiger Teams" with responsibility to assess processes and develop solutions for implementation where appropriate. Additionally, our medical management and field operations team is assisting with training Wounded Warrior Training Brigade case managers. In addition, MHN Government Services, our sister company, has readied three licensed clinical social workers to provide additional social service support at Walter Reed. MHN has identified additional experienced consultants who can be made available on short notice. These social work consultants are experienced in providing non-medical, supportive consultation to service members and their families, including Reserve Component members, throughout the United States and at military installations overseas.

At the Department's request, Health Net is prepared to provide additional services to support Walter Reed Army Medical Center and our nations Wounded Warriors.

Reintegration – In response to reintegration and redeployment needs, increased regional support has been provided within key Military Health System areas (Ft. Drum and Ft. Campbell) where significant numbers of returning troops necessitated greater support for health care access and coordination (for active-duty members and their families).

In the summer of 2006, over 75 percent of the 101st Airborne Division (Air Assault) returned to Ft. Campbell and began the process of reintegration. An intensive joint planning process – military treatment facility, Health Net and TRICARE Regional Office-North – resulted in an efficient use of soldier time in accomplishing the "must do" tasks en route to a well-deserved period of block leave. Family members also were assisted during 17 jointly conducted Reintegration Dependent Briefing Fairs.

Mental Health Support – Our sister company, MHN, provides behavioral health services to active duty and Reserve Component members and their families. Through its Military Family Counseling Services contract, MHN provides short-term, face-to-face problem resolution for military personnel and their families with over 150 counselors on site at military installations across the United States and overseas. The program strives to empower them to manage the stress of the deployment cycle, high op-tempo and changing military environment. The program offers positive support for the readiness and retention of service members and their families, as well as supporting reintegration to home base, civilian community or their next deployment.

MHN also serves as the contractor for the Department of Defense's Victim Advocacy Program. Through this program, MHN places victim advocates at or near over 50 military installations throughout the United States.

Collaboration with the Direct Care System

One of the methods we use to tailor our services to meet the customer's objectives is the development of strong, collaborative relationships with each military treatment facility commander in the North Region. This collaboration and tailoring of services is critical to our mutual success.

The central focus of our network design is the military treatment facility. To achieve military treatment facility optimization – the number one program objective under the current TRICARE contracts – we need to ensure military treatment facilities are used most appropriately, whenever clinical capability and capacity exists. Health Net's local, on-site teams, which we discussed earlier, help us to achieve these optimization goals by working closely with the military treatment facility commander and staff.

Our goal is to fill every appointment and bed available within the military treatment facility with the appropriate patient based on the capacity and capabilities of the military treatment facilities readiness and training requirements, as defined by the military treatment facility commander. The ultimate optimization focus is the increased use of the military's direct care system to achieve mission readiness. Our civilian network is designed to enhance and augment each military treatment facilities capacity.

Some specific examples of our efforts to collaborate with our military treatment facility partners to help them optimize their facility, as well as the overall Military Health System, include helping to develop a cardiology recapture initiative in the National Capital Area Multi-Service Market, assisting in expanding the capacity of the Camp Lejeune birthing center, helping Ft. Campbell with their comprehensive reintegration effort for returning members of the 101st Airborne Division, and coordinating the first joint base health care forum between all of the military services providing care in the New Jersey and eastern Pennsylvania communities.

Guard and Reserve Component Outreach and Support

Educating the Reserve Component about TRICARE benefits is an important aspect of Health Net's responsibilities. There are a number of venue in which we interact with Guard and Reserve members and their families, but among the most important are pre- and post-deployment "just in training" sessions.

Outreach – In the past 14 months, over 55,000 Guard and Reserve members and their families throughout the TRICARE North Region have been briefed on their TRICARE benefit. Health Net's staff at TRICARE Service Centers communicate and liaison with the Family Readiness

Coordinators/Family Readiness Groups and State Benefits Advisors to support the present level of Guard and Reserve briefings and support requirements.

Health Net encourages Reserve Component units to request TRICARE briefings for their members and families to ensure they are well informed about their TRICARE benefit prior to even being activated for deployment. In addition, though, we provide TRICARE benefits briefings and reinforce training at mobilization and demobilization sites. Although the focus is on mobilization and demobilization, there are many opportunities for Reserve Component members and their families to learn about their TRICARE benefit.

In addition to support outreach efforts, we recently appointed a retired senior non-commissioned officer to the Health Net Federal Services TRICARE Advisory Committee to better help us with our Reserve Component outreach and understanding. The TRICARE Advisory Committee was formed to provide guidance and support in achieving and maintaining operational excellence to Health Net Federal Services' leadership.

Command Sergeant Major John J. Leonard, Jr. was appointed to the committee in March of this year. Command Sergeant Major Leonard served as the first Senior Enlisted Advisor assigned to the Office of the Chief, National Guard Bureau and Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs. Command Sergeant Major Leonard brings a wealth of Reserve and National Guard experience and expands the breadth of the committee's expertise.

Support – We remain flexible in meeting the needs of this unique population. One example of our efforts to support the Reserve Component was the addition of a TRICARE Service Center at Westover Air Reserve Base (ARB) in Springfield, Massachusetts. Westover ARB is the largest Guard and Reserve installation in New England. Health Net identified 3,000 TRICARE beneficiaries who are enrolled in TRICARE Prime out of 16,331 who are eligible in the Springfield expanded Prime service area. We believe that expansion of this TRICARE Service Center at Westover ARB will better serve the TRICARE eligible, Reserve and Guard beneficiaries in the Springfield area.

Rapid Response Counseling – Our sister company, MHN, provides on-demand consultants that coordinate services with unit commanders to support National Guard and Reserve members and

their family members. Primarily through 1- to 2-day events that occur during drill weekends, these consultants provide group and individual consultation, presentations and informal support typically focusing on how to best cope with the stresses of deployment or reintegrate to civilian lives after deployment.

Some examples of this rapid response counseling include:

- **January 2007** - Within minutes of receiving the requirement, multiple counselors were dispatched to deliver services to the National Guard in the Virgin Islands to help cope with the anxiety that stemmed from the deaths of two comrades, coupled with the prospect of redeployment.
- **January 2007** - Within 12 hours of receiving the request to support the Minnesota National Guard Family re-integration program in Brainerd, Minnesota, MHN provided counselors to help cope with the sudden and unanticipated extension of the 34th Infantry Division. The extension was a 125-day extension of National Guardsmen that already had been deployed for 15 months. MHN immediately sent six consultants and MHN leadership to Brainerd to provide support to the family members of the deployed service members.

Cost and Quality Initiatives

Health Net has a quality program that supports performance excellence through application of the industry best practices for quality management and continuous quality improvement. The framework for our quality program is based on the International Organization of Standardization (ISO) 9001:2000 standard and is complemented by the standards established by URAC. Health Net Federal Services has been an ISO 9001:2000 registered company since 2004. We also hold three URAC accreditations –Health Network, Utilization Management, and Case Management. We have a dedicated Quality Office that is responsible for the program and for deploying quality practices throughout the organization. At Health Net, quality is an "everybody" responsibility.

Ft. Drum Regional Health Planning Organization

In response to Northern New York's persistent health care issues, issues that impact the Ft. Drum community, Congress authorized a pilot project to study how military and civilian health care

resources can best deliver high quality care to all patients in the Ft. Drum community. Created in Section 721 of the Fiscal Year 2005 National Defense Authorization Act, the Ft. Drum Regional Health Policy Organization, a not-for-profit corporation, is carrying out the pilot program's regional healthcare approach to meet the needs of the expanding military population, building on existing relationships between Ft. Drum and the local community.

A Board of Directors guides the Ft. Drum Regional Health Policy Organization. In addition to the Board, the Ft. Drum Regional Health Policy Organization has four committees:

- Behavioral Health, including chemical dependency
- Emergency Medical Service and disaster preparedness
- Access to care and manpower needs
- Quality standards

From the start of the project, Health Net has provided support to the Ft. Drum Regional Health Policy Organization and its committees:

- Health Net leadership partnered with the Ft. Drum leadership to host a "Doctors' Day" and "Provider Summit" at Ft. Drum in April 2005. These events were key "Primers" for future Ft. Drum Regional Health Policy Organization activities.

- Health Net's Field Operations Director is an active member on the Behavioral Health Committee. Additionally, the entire local field team serves as a continual resource for the Ft. Drum Regional Health Policy Organization.
- Health Net provided a $15,000 charitable donation to the Ft. Drum Regional Health Policy Organization on April 6, 2006, marking the first time funding was provided to the organization. On April 16, 2007, Health Net will make an additional contribution of $20,000.
- Our staff has educated the Quality Committee on TRICARE network quality standards. The Committee will use these standards to assist with developing community quality standards to the Ft. Drum Regional Health Policy Organization Board of Directors.
- In our continued support of the Ft. Drum Regional Health Planning Organization, Health Net developed a comprehensive provider gap analysis for the entire community –

TRICARE and non-TRICARE – in the Ft. Drum Prime service area. Health Net employed Milliman Consultants and Actuaries to assess medical assets needed to adequately serve the Ft. Drum community. Health Net's analysis compares a complete inventory of all available providers in the area against the calculated need determined by the Milliman report. This analysis is being used today by the Ft. Drum Regional Health Policy Organization to improve the community's health assets, which will directly improve the care provided to all TRICARE beneficiaries in the Ft. Drum Prime service area.

- In collaboration with the Ft. Drum Medical Department Activity, MHN and the local community, Health Net is developing a behavioral health solution for the Prime service area.

All committees are working diligently towards providing substantive reports to the Ft. Drum Regional Health Policy Organization Board of Directors in support of the final report due to Congress in July 2007. Health Net appreciates the opportunity to be a part of a program that greatly benefits both the military and civilian communities.

Pharmacy Initiatives

Responsibility for the administration and operation of the retail and mail order pharmacy programs was "carved out" from the managed care support contracts and separate pharmacy contracts were procured and awarded. This resulted in the unintended consequence of limitations on the ability to manage beneficiary prescription drug utilization. Health Net was invited to participate in support of a Department of Defense initiative to increase TRICARE Mail Order Pharmacy utilization by decreasing reliance upon the retail venue. Health Net implemented a multifaceted approach at no cost to the government in support of this important initiative.

The Health Net approach consists of the following components:

- Educational efforts targeted to beneficiaries in our disease management, case management, and transitional care programs.
- Adding an informational message to all Explanation of Benefits explaining the benefit of using the TRICARE Mail Order Pharmacy.

- An educational program that is targeted to our high volume providers with low TRICARE Mail Order Pharmacy penetration.
- Offering e-prescribing tools to a select group of network physicians.

These efforts have resulted in a demonstrable increase in TRICARE Mail Order Pharmacy utilization within the North Region – TRICARE Mail Order Pharmacy usage in February 2007 was 25 percent higher than the TRICARE Mail Order Pharmacy usage was in February 2006. We have begun discussions with Department of Defense representatives to discuss other joint activities that could be undertaken to better manage the prescription drug benefit.

Disease Management - Decision Power

Health Net has participated in active discussions with Department of Defense, TRICARE Management Activity and TRICARE Regional Office-North senior leaders to explore new approaches to improving the quality of health care provided to TRICARE beneficiaries while reducing health care costs. As part of these discussions, Health Net has provided information concerning our commercial Decision Power℠ program. Decision Power℠ is an enhanced disease management and consumer empowerment service offering from Health Net, Inc., which has over 3 years of practical application in our commercial managed care markets across the country.

As a Decision Support program, Decision Power℠ leverages Shared Decision-Making® based health coaching and the supporting educational materials (including telephonic, internet, mail, and video) to foster individual skills and confidence. This allows members to manage their own health, navigate the healthcare system, and have productive interactions with their physicians. When fully informed and acting as partners with their physicians in decision-making, beneficiaries tend to choose more appropriate interventions relative to their individual situation, compared with beneficiaries who do not receive this information or collaborate with their physicians.

Health Net will continue to work with Department of Defense in setting up an appropriate pilot and control group in order to test the concepts of this commercially proven service in a TRICARE setting. In doing so, it will be paramount that a pilot of Decision Power[SM] be structured in a way that allows for effective evaluation. Appropriate metrics need to be determined in advance and outcome measurements shared, along with lessons learned for broader application to the TRICARE program if it is proven effective in conjunction with the TRICARE's other disease management programs.

Recommendations for Program Enhancements

Notwithstanding the current strong state of the TRICARE program, we believe there is more that can be done to further strengthen and improve upon service delivery and to ensure that the Military Health System is realizing full benefit from industry best practices in support of goals and objectives of the TRICARE program. We have three primary recommendations – to increase program integration; to enhance the alignment of the design of the TRICARE program with industry best practices; and to adopt adequate incentives for innovation.

Program Integration

TRICARE is a complex program, and a comprehensive integrated approach is critical to ensuring the effective coordination of all beneficiary health care and support services. Under the existing program, the managed care support contractor is a partner with the Military Health System, responsible for service delivery excellence across a range of functional areas necessary to achieve the Government's program objectives. The main service areas that make up the managed care support contract and the functional requirements within these areas (such as the call center that is part of Customer Services, the Claims Processing that is part of Administrative Services, or the Disease and Referral Management functions that are part of Managed Care Services), all work together as one service delivery system. It is this array of interdependent, complementary support services – encompassing managed care services, administrative services, customer services, information services and program management – that makes partnership and the alignment of incentives between the managed care support contractors and the direct care system crucial.

The managed care support contractor is the Government's single point of accountability for the functioning of this complementary system. In recent years, the TRICARE Management Activity has experimented with "carving out" key areas of program support (TRICARE pharmacy management, TRICARE for Life claims processing) from the managed care support contractor's scope of operation. This "dis-integration" of the service delivery model has reduced the managed care support contractor's ability to effectively manage the entire spectrum of purchased care and has had unforeseen consequences in terms of diminished quality and increased costs by erecting unnecessary barriers and creating gaps between important program elements. It also has caused beneficiary confusion and frustration.

For the next generation of TRICARE managed care support contracts, we strongly believe the Department of Defense should strengthen and maintain the current integrated service model. In addition to maintaining the current set of integrated services, some services that were carved out should be added back in and some new services should be included in order to ensure the Military Health System receives full value from the managed care support contracts. Health Net strongly recommends that patient appointing, pharmacy management and marketing/education services, as well as TRICARE for Life customer support and claims processing be reintegrated into the next generation of contracts. New services to be added should include expanded disease management programs, enhanced services for Guard and Reserve members and care management strategies for TRICARE for Life.

Enhanced Alignment with Industry Best Practices

We believe the program should be designed to best incorporate proven industry cost and quality initiatives such as consumer empowerment and health management support tools, pay for quality programs, and use of capitation models. We also recommend that provider administrative requirements be more consistent with common commercial office practices, and that performance standards should be reasonable with objective performance indices.

Incentives for Innovation

Lastly, we recommend the adoption and incorporation of incentives to encourage program enhancements and innovation. It is imperative that the TRICARE program must be sufficiently

flexible to evolve and adapt to new technologies and new strategies to improve patient management and to invest in health care cost reduction activities. Doing so not only ensures the best health outcomes for TRICARE beneficiaries, it also enables the Department of Defense to benefit from the most efficient and effective programs and services possible.

To encourage innovation, we specifically recommend a minimum 7- to 10-year term for the next generation of contracts. The procurement cycle for a program this size is lengthy and costly both to the government and to contractors. Longer contract terms would allow the government and contractors to recoup more of their investments in the procurement; it probably also would foster greater competition in the program. Moreover, a longer contract term would eliminate a source of potential disruption in this strongly performing program. It also would provide a greater opportunity for the Department of Defense and its contractors to work jointly on significant program issues over sustained periods of time, allowing for greater collaboration on refinement of current operations and activities.

In addition to longer contract terms, we recommend the testing of new services through pilot or demonstration projects over the contract lifecycle. Using the TRICARE contract vehicle to pilot test proof of concept innovation would significantly advantage the Department and the program. To facilitate this, the Department of Defense should encourage the use of proven contractual provisions such as Value Change Engineering proposals. And, to enable faster implementation across the broader TRICARE program, we recommend the Department of Defense develop new models for evaluate pilots and demonstrations quickly and efficiently.

So in closing, let me just restate the fact that, based on our 19 years of service to Department of Defense beneficiaries, we believe the TRICARE program is working better than ever. That said, we do see opportunities to enhance the program and to take it to an even higher level, enabling the Department of Defense to better meet its health care goals and objectives while also ensuring the highest levels of service to military beneficiaries.

Thank you for inviting me to share our thoughts with you this morning. I look forward to your questions.

DISCLOSURE FORM FOR WITNESSES
CONCERNING FEDERAL CONTRACT AND GRANT INFORMATION

INSTRUCTION TO WITNESSES: Rule 11, clause 2(g)(4), of the Rules of the U.S. House of Representatives for the 110th Congress requires non-governmental witnesses appearing before House committees to submit in their written statements, a curriculum vitae, and a disclosure of the amount and source of any federal contracts or grants (including subcontracts and subgrants) received during the current and two previous fiscal years either by the witness or by an entity represented by the witness. This form is intended to assist witnesses appearing before the House Armed Services Committee in complying with the House rule.

Witness name: Steven D. Tough

Capacity in which appearing: (check one)

___ Individual

_X_ Representative

If appearing in a representative capacity, name of the company, association or other entity being represented: Health Net Federal Services LLC

FISCAL YEAR 2007

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0011	DoD	2,376 Million	Managed Health Care
Various	VA	30 Million	Managed Health Care
W81K04-05-D-7001	DoD	5 Million	Appointing Services

FISCAL YEAR 2006

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0011	DoD	2,290 Million	Managed Health Care
Various	VA	27 Million	Managed Health Care
W81K04-05-D-7001	DoD	5 Million	Appointing Services
BPA-01802 BEA-002638	DoD	0.7 Million	Behavioral Services

FISCAL YEAR 2005

federal grant(s) / contracts	federal agency	dollar value	subject(s) of contract or grant
MDA906-03-C-0011	DoD	2,257 Million	Managed Health Care
Various	VA	22 Million	Managed Health Care
W81K04-05-D-7001	DoD	5 Million	Appointing Services
BPA-01802 BEA-002638	DoD	23 Million	Behavioral Services

Federal Contract Information: If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) with the federal government, please provide the following information:

Number of contracts (including subcontracts) with the federal government:

Current fiscal year (2007):	33
Fiscal year 2006:	36
Fiscal year 2005:	36

Federal agencies with which federal contracts are held:

Current fiscal year (2007):	DoD/VA
Fiscal year 2006:	DoD/VA
Fiscal year 2005:	DoD/VA

List of subjects of federal contracts(s) (for example, ship construction, aircraft parts manufacturing, software design, force structure consultant, architecture and engineering services, etc.):

Current fiscal year (2007):	Managed Health Care Appointing Services
Fiscal year 2006:	Managed Health Care Appointing Services Behavioral Services
Fiscal year 2005:	Managed Health Care Appointing Services Behavioral Services

Aggregate dollar value of federal contracts held:

Current fiscal year (2007):	2,411 Million
Fiscal year 2006:	2,323 Million
Fiscal year 2005:	2,307 Million

Federal Grant Information: Health Net Federal Services has not received any federal grants.

DOCUMENTS SUBMITTED FOR THE RECORD

MARCH 27, 2007

ZNet | Activism

The Women's War

by Sara Corbett; The New York Times Magazine; March 18, 2007

On the morning of Monday, Jan. 9, 2006, a 21-year-old Army specialist named Suzanne Swift went AWOL. Her unit, the 54th Military Police Company, out of Fort Lewis, Wash., was two days away from leaving for Iraq. Swift and her platoon had been home less than a year, having completed one 12-month tour of duty in February 2005, and now the rumor was that they were headed to Baghdad to run a detention center. The footlockers were packed. The company's 130 soldiers had been granted a weekend leave in order to go where they needed to go, to say whatever goodbyes needed saying. When they reassembled at 7 a.m. that Monday, uniformed and standing in immaculate rows, Specialist Swift, who during the first deployment drove a Humvee on combat patrols near Karbala, was not among them.

Swift would later say that she had every intention of going back to Iraq. But in the weeks leading up to the departure date, she started to feel increasingly anxious. She was irritable, had trouble sleeping at night, picked fights with friends, drank heavily. "I was having a lot of little freakouts," she told me when I went to visit her in Washington State last summer. "But I was also ready to go. I was like, 'O.K., I can do this.'"

The weekend before the deployment was to start, however, Swift drove south to her hometown, Eugene, Ore., to visit with her mother and three younger siblings. The decision to flee, she says, happened in a split second on Sunday night. "All my stuff was in the car," she recalls. "My keys were in my hand, and then I looked at my mom and said: 'I can't do this. I can't go back there.' It wasn't some rational decision. It was a huge, crazy, heart-pounding thing."

For two days after she failed to report, Swift watched her cellphone light up with calls from her commanders. They left concerned messages and a few angry ones too. She listened to the messages but did not return the calls. Then rather abruptly, the phone stopped ringing. The 54th MP Company had left for Iraq. Swift says she understood then the enormity of what she'd just done.

For the remainder of that winter, Swift hid out in the Oregon seaside town of Brookings, staying in a friend's home, uncertain whether the Army was looking for her. "I got all my money out of the bank," she told me. "I never used my credit card, in case they were trying to trace me. It was always hanging over my head." At her mother's urging, she drove back to Eugene every week to see a therapist. In April of last year, she finally moved back into her family's home. Then, on the night of June 11, a pair of local police officers knocked on the door and found Swift inside, painting her toenails with her 19-year-old sister. She was handcuffed, driven away and held in the county jail for two nights before being taken back to Fort Lewis, where military officials threatened to charge her with being absent without leave. As Army officials pondered her fate, Swift was assigned a room in the barracks and an undemanding desk job at Fort Lewis.

Despite the fact that military procedure for dealing with AWOL soldiers is well established - most are promptly court-martialed and, if convicted, reduced in rank and jailed in a military prison - Suzanne Swift's situation raised a seemingly unusual set of issues. She told Army investigators that the reason she did not report for deployment was that she had been sexually harassed repeatedly by three of her supervisors throughout her military service: beginning in Kuwait; through much of her time in Iraq; and following her return to Fort Lewis. She claimed too to be suffering from post-traumatic stress disorder, or PTSD, a highly debilitating condition brought on by an abnormal amount of stress. According to the most recent edition of The Diagnostic and Statistical Manual of Mental Disorders, used by mental-health professionals to establish diagnostic criteria, PTSD symptoms can include, among other things, depression, insomnia or "feeling constantly threatened." It is common for those afflicted to "re-experience" traumatic moments through intrusive, graphic memories and nightmares.

Swift's stress came not just from the war and not just from the supposed harassment, she told the investigators, but from some combination of the two. In a written statement to investigators, Swift asserted that her station, Camp Lima, outside Karbala, was hit by mortar attacks almost nightly for the first two months of her deployment. She reported working 16-hour shifts, experiencing the death of a fellow company member in an incident of friendly fire and having a close friend injured in a car bombing. What Swift said distressed her most, however, was a situation that involved her squad leader, the sergeant to whom she directly reported in Iraq. She claimed that he propositioned her for sex the first day the two of them arrived in Iraq and that she felt coerced into having a sexual relationship with him that lasted four months - the relationship consisting, she said, of his knocking on her door late at night and demanding intercourse. When she finally ended this arrangement, Swift told me, the sergeant retaliated by ordering her to do solitary forced marches from one side of the camp to another at night in full battle gear and by humiliating her in front of her fellow soldiers. (The sergeant could not be reached, but according to an internal Army report, he denied any sexual contact with Swift.)

As it often is with matters involving sex and power, the lines are a little blurry. Swift does not say she was raped, exactly, but rather manipulated into having sex - repeatedly - with a man who was above her in rank and therefore responsible for her health and safety. (Some victims' advocates use the term "command rape" to describe such situations.) Swift says that the other two sergeants - one in Kuwait and one back home in Fort Lewis, both a couple of ranks above her - made comments like "You want to [expletive] me, don't you?" or when Swift asked where she was to report for duty, responded, "On my bed, naked."

In the wake of several sex scandals in the 1990s, the U.S. military has tried to become more sensitive to the presence of women, especially now that they fill 15 percent of the ranks worldwide. There are regular mandated workshops on preventing sexual harassment and assault. Each battalion has a designated Equal Opportunity representative trained to field and respond to complaints. Swift said she initially reported what she characterized as an unwanted relationship with her squad leader in Iraq to her Equal Opportunity representative there, who listened - she claims - but did nothing about it. (According to the internal report, the E.O.

representative told investigators that he asked Swift if she had a complaint to make but that she declined at the time.)

Swift made it clear that since enlisting in the Army when she was 19, she'd grown accustomed to hearing sexually loaded remarks from fellow enlisted soldiers. It happened "all the time," she said. But coming from her superiors, especially far away from the support systems of home and against a backdrop of mortar attacks and the general uncertainties of war, the overtones felt more threatening. "You can tell another E-4 to go to hell," she said, referring to the rank of specialist. "But you can't say that to an E-5," she said, referring to a sergeant. "If your sergeant tells you to walk over a minefield, you're supposed to do it."

I went to see Swift last July as I was immersed in a series of interviews with women who'd gone to Iraq and come home with PTSD. I was trying to understand how being a woman fit into both the war and the psychological consequences of war. The story I heard over and over, the dominant narrative really, followed similar lines to Swift's: allegations of sexual trauma, often denied or dismissed by superiors; ensuing demotions or court-martials; and lingering questions about what actually occurred.

Swift and I - along with her mother, Sara Rich - met at a run-down sushi place in Tacoma, Wash., not far from Fort Lewis. Swift has blond hair, milky skin and clear green eyes, which lend her the vague aspect of a Victorian doll - albeit a very tough one. She curses freely, smokes Newports and, when she's not in uniform, favors low-cut shirts that show off an elaborate flower tattoo on her chest. "Suzanne is not some passive little lily," explained her mother. "She's a soldier."

By midsummer of last year, the two women had settled into a ritual: once a week Rich would pick up her daughter at the base and take her out for a meal, and then the two would check into a nearby Holiday Inn, talking and watching television and finally going to sleep. At 6:30 the following morning, Swift would put on her uniform and Rich would drive her back to Fort

Lewis in time to report for work. Rich, who is 41, is a social worker who specializes in family therapy and operates with a certain type of mama-bear verve. She was in frequent touch last summer with her daughter's Chicago-based lawyers, who were then negotiating with the Army to get Swift medically discharged for her PTSD so that she could avoid being court-martialed and convicted for going AWOL. In the six weeks since Swift's arrest, Rich marshaled both legal funds and public sympathy for her daughter's defense, largely by tapping into the outrage fulminating inside the antiwar movement. One of Rich's friends from Eugene built a Web site devoted to Suzanne, taking both donations and online signatures for a petition to have her released from the Army without punishment. Someone else started selling T-shirts, tote bags and teddy bears that read "Free Suzanne" and "Suzanne's My Hero" to benefit the cause.

At that point, the hullabaloo was doing little good. A week before I arrived in Washington, the Army's investigation determined that Swift's charges against two of her higher-ups, including the one Swift said demanded sex from her, could not be substantiated because of a lack of evidence. (Both men denied Swift's allegations. By the time the investigation began, in June

2006, her squad leader had already finished his military service, which put him beyond the reach of punishment by the military anyway.) There was a third sergeant against whom Swift filed a formal harassment complaint in the spring of 2005, nearly a year before she went AWOL. In it she maintained that immediately following her unit's return from Iraq, he began making frequent suggestive remarks to her and at one point, during the course of a normal workday, "grinded" his body against hers in an inappropriate way. That man received a stridently worded letter of reprimand on May 25, 2005, from a lieutenant colonel and was transferred away from Fort Lewis.

What still remained to be determined was whether Swift would be held accountable for going AWOL or whether the Army would accept the idea that her failure to report was, as she saw it, an instinctive act of psychological self-preservation. Whatever the case, Swift was quickly becoming a symbol - though of what it was hard to say. Among the antiwar crowd, thanks in part to the fiery speeches Swift's mother was delivering at local rallies and antiwar gatherings, she was being painted as a martyr, a rebel and a victim all at once. Meanwhile, others deemed her a traitor, a fraud or simply a whiny female soldier who'd been too lazy or too selfish to return to war.

Swift herself seemed stunned by the attention. "Look at me, a poster child," she told me wryly, making it clear that she was not enjoying it. She did not make the kind of grandiose anti-military statements her mother did but rather seemed to be trying to shrug off what happened to her. She told me she was having nightmares and was sometimes waylaid by fits of hysterical crying. But she described these flatly, seeming almost unwilling or unable to express anger or hurt. Overall, she seemed strikingly detached.

I had read enough about PTSD to know that "emotional numbing" is one of the disorder's primary symptoms, but it made understanding Swift and what she'd been through a more difficult task. "Avoidance" is another commonly recognized symptom in people with PTSD, especially avoidance of those things that bring reminders of the original trauma. If the Iraq war and the men she encountered there and afterward traumatized Swift, then perhaps going AWOL could be seen as a sort of meta-avoidance of all that plagued her.

That night after dinner, Swift lay on her hotel bed with her shoes kicked off, staring blankly at the ceiling. She was thoughtful and willing to answer questions. A few times, describing her deployment, she hovered close to tears but then seemed promptly to swallow them. She told me that she came home from Iraq feeling demoralized and depressed. She resumed her stateside duties with the Army for the 11 months between deployments and in general "just tried to deal."

She was not, however, formally given a diagnosis of PTSD until after she went AWOL - first by a civilian psychiatrist within days of her failure to report for deployment and later, Swift says, through the Army's mental-health division at Fort Lewis. (The Army could not confirm this, citing privacy issues.) The timing raised a serious question: Was the PTSD a legitimate disability or a hastily crafted excuse for skipping out on the war? Nobody, perhaps not even Swift, could say for sure.

II. The "Double Whammy"

No matter how you look at it, Iraq is a chaotic war in which an unprecedented number of women have been exposed to high levels of stress. So far, more than 160,000 female soldiers have been deployed to Iraq and Afghanistan, as compared with the 7,500 who served in Vietnam and the 41,000 who were dispatched to the gulf war in the early '90s. Today one of every 10 U.S. soldiers in Iraq is female.

Despite the fact that women are generally limited to combat-support roles in the war, they are arguably witnessing a historic amount of violence. With its baffling sand swirl of roadside bombs and blind ambushes, its civilians who look like insurgents and insurgents who look like civilians, the Iraq war has virtually eliminated the distinction between combat units and support units in the military. "Frankly one of the most dangerous things you can do in Iraq is drive a truck, and that's considered a combat-support role," says Matthew Friedman, executive director of the National Center for PTSD, a research-and-education program financed by the Department of Veterans Affairs. "You've got women that are in harm's way right up there with the men."

There have been few large-scale studies done on the particular psychiatric effects of combat on female soldiers in the United States, mostly because the sample size has heretofore been small. More than one-quarter of female veterans of Vietnam developed PTSD at some point in their lives, according to the National Vietnam Veterans Readjustment Survey conducted in the mid-'80s, which included 432 women, most of whom were nurses. (The PTSD rate for women was 4 percent below that of the men.) Two years after deployment to the gulf war, where combat exposure was relatively low, Army data showed that 16 percent of a sample of female soldiers studied met diagnostic criteria for PTSD, as opposed to 8 percent of their male counterparts. The data reflect a larger finding, supported by other research, that women are more likely to be given diagnoses of PTSD, in some cases at twice the rate of men.

Experts are hard pressed to account for the disparity. Is it that women have stronger reactions to trauma? Do they do a better job of describing their symptoms and are therefore given diagnoses more often? Or do men and women tend to experience different types of trauma? Friedman points out that some traumatic experiences have been shown to be more psychologically "toxic" than others. Rape, in particular, is thought to be the most likely to lead to PTSD in women (and in men, in the rarer times it occurs). Participation in combat, though, he says, is not far behind.

Much of what we know about trauma comes primarily from research on two distinct populations - civilian women who have been raped and male combat veterans. But taking into account the large number of women serving in dangerous conditions in Iraq and reports suggesting that women in the military bear a higher risk than civilian women of having been sexually assaulted either before or during their service, it's conceivable that this war may well generate an unfortunate new group to study - women who have experienced sexual assault and combat, many of them before they turn 25.

A 2003 report financed by the Department of Defense revealed that nearly

one-third of a nationwide sample of female veterans seeking health care through the V.A. said they experienced rape or attempted rape during their service. Of that group, 37 percent said they were raped multiple times, and 14 percent reported they were gang-raped. Perhaps even more tellingly, a small study financed by the V.A. following the gulf war suggests that rates of both sexual harassment and assault rise during wartime. The researchers who carried out this study also looked at the prevalence of PTSD symptoms - including flashbacks, nightmares, emotional numbing and round-the-clock anxiety - and found that women who endured sexual assault were more likely to develop PTSD than those who were exposed to combat.

Patricia Resick, director of the Women's Health Sciences Division of the National Center for PTSD at the Boston V.A. facility, says she worries that the conflict in Iraq is leaving large numbers of women potentially vulnerable to this "double whammy" of military sexual trauma and combat exposure. "Many of these women," she says, "will have both." She notes that though both men and women who join the military have been shown to have higher rates of sexual and physical abuse in their backgrounds than the general population, women entering the military tend to have more traumas accumulated than men. One way to conceptualize this is to imagine that each one of us has a psychic reservoir for holding life's traumas, but by some indeterminate combination of genetics and socioeconomic factors, some of us appear to have bigger reservoirs than others, making us more resilient. Women entering the military with abuse in their backgrounds, Resick says, "may be more likely to have that reservoir half full."

Over the last few years, I've spoken at length with more than a dozen trauma specialists, questioning them about the effect this war will have on the psyches of the women who have fought in it. The prevailing answer is "We just don't know yet." The early reports for both sexes, though, are troubling. The V.A. notes that as of last November, more than one-third of the veterans of Iraq and Afghanistan treated at its facilities were given diagnoses of a mental-health disorder, with PTSD being the most common. So far, the V.A. has diagnosed possible PTSD in some 34,000 Iraq and Afghanistan veterans; nearly 3,800 of them are women. Given that PTSD sometimes takes years to surface in a veteran, these numbers are almost assuredly going to grow. With regard to women, nearly every expert I interviewed mentioned the reportedly high rates of sexual harassment and assault in the military as a particular concern.

The Department of Defense in recent years has made policy changes designed to address these issues. In 2005 it established a formal Sexual Assault Prevention and Response program, and trains "Victim Advocates" on major military installations. The rules have also been rewritten so that victims are now able to report sexual assaults confidentially in "restricted reports" that give them access to medical treatment and counseling without setting off an official investigation. The results could be viewed as both encouraging and disturbing: comparing figures from 2005, when the restricted reporting began, to those of 2004, the number of reported assaults across the military jumped 40 percent, to 2,374. While victims may be feeling more empowered to report sexual assault, it appears that the number of assaults are not diminishing.

If Suzanne Swift's why-bother approach to telling her superiors about the harassment in Iraq initially struck me as curious, it began to make more sense as I spoke with a number of other female Iraq veterans. There was a pervasive sense among them that reporting a sexual crime was seldom worthwhile. Department of Defense statistics seem to bear this out: of the 3,038 investigations of military sexual assault charges completed in 2004 and 2005, only 329 - about one-tenth - of them resulted in a court-martial of the perpetrator. More than half were dismissed for lack of evidence or because an offender could not be identified, and another 617 were resolved through milder administrative punishments, like demotions, transfers and letters of admonishment.

Unaware of the actual numbers, many of the women I talked to seemed, in any event, to have soaked up a larger message about the male-dominated military culture. "Saying something was looked down upon," says Amorita Randall, who served in Iraq in 2004 with the Navy, explaining why she did not report what she says was a rape by a petty officer at a naval base on Guam shortly before she was deployed to Iraq. "I don't know how to explain it. You just don't expect anything to be done about it anyway, so why even try?"

III. The Pressure of Being a Woman

Many of the women I spoke with said they felt the burden of having to represent their sex - to defy stereotypes about women somehow being too weak for military duty in a war zone by displaying more resiliency and showing less emotion than they otherwise might. There appears to have been little, too, in the way of female bonding in the war zone: most reported that they avoided friendships with other women during the deployment, in part because of the fact that there were fewer women to choose from and in part because of the ridicule that came with having a close friend. "You're one of three things in the military - a bitch, a whore or a dyke," says Abbie Pickett, who is 24 and a combat-support specialist with the Wisconsin Army National Guard. "As a female, you get classified pretty quickly."

Many women mentioned being the subject of crass jokes told by male soldiers. Some said that they used sarcasm to deflect the attention but that privately the ridicule wore them down. Others described warding off sexual advances again and again. "They basically assume that because you're a girl in the Army, you're obligated to have sex with them," Suzanne Swift told me at one point.

There were women, it should be noted, who spoke of feeling at ease among the men in their platoons, who said their male peers treated them respectfully. Anecdotally, this seemed most common among reserve and medical units, where the sex ratios tended to be more even. Several women credited their commanders for establishing and enforcing a more egalitarian climate, where sexual remarks were not tolerated.

This was not the case for Pickett, who arrived in Iraq early in 2003, having been sexually assaulted, she said, during a humanitarian deployment to Nicaragua less than two years earlier, when she was just 19. When I spoke to her by phone in December, she recalled being too afraid to report the incident, particularly given the fact that the supposed perpetrator was an

officer who ranked above her. During her 11-month stint in Iraq, stationed mostly outside Tikrit in a company of 19 women and 140 men, Pickett claimed her male peers thought nothing of commenting on her breast size or making sexual jokes about her. She regularly encountered porn magazines sitting in the latrines and in common areas. None of this behavior was particularly new to her; it was life as she knew it in the military. Yet in a war zone the effect seemed more corrosive. "The real difference is that over there, there's never a break from it," Pickett told me. "At home, you can go out with your girlfriends and get a beer and talk about the idiots who were cracking jokes. Over there, you're a minority 24 hours a day, seven days a week. You never get that 10 minutes to relax or even cry. Sometimes you just need to let it all out."

One night in the fall of 2003, Pickett recalled, her unit endured a mortar attack. Trained as a combat lifesaver, she spent part of the night tending to bleeding soldiers by flashlight in a field tent. Once the experience was over, the memory kept replaying in her mind. "For a long time, I wished I had died that night," Pickett told me, adding that she returned to her home in Wisconsin and was "barely functioning"- unable to sleep or concentrate. She spent days alone inside her apartment, not talking to anyone. "I was draining everyone around me," she says. A year after her deployment, a V.A. clinician formally diagnosed PTSD, which Pickett says she thinks stems from the stress of combat, harassment and the earlier sexual assault. If Vietnam became notorious as a war that combined violence and sex, with Southeast Asian brothels being the destination of choice for soldiers on temporary leave from the war, the sexual politics of the Iraq war are, as of yet, unclear.

Joane Nagel, a sociology professor at the University of Kansas, is studying sex and the military as it pertains to the Iraq war. What she has found, she told me recently, is that "when you take young women and drop them into that hypermasculine environment, the sex stuff just explodes. Some have willing sex. Some get coerced into it. Women are vulnerable sexually." The specter of childhood abuse in military men and women potentially adds another layer of combustibility to gender relations. Tina Lee, a psychiatrist at the V.A. Palo Alto Health Care System in California, works with both male and female PTSD patients. She points out that traumatic experiences in childhood may increase the risk of developing PTSD when exposed to another trauma in adulthood. Experiencing childhood trauma can also produce opposing behaviors in adult men and women. Male survivors of childhood abuse are more likely to act aggressively and angrily, while some women appear to lose their self-protective instincts. A female patient, she says, once offered up an apt description of this tendency to end up in hurtful situations, saying that her "people picker" had been broken.

"So you have young women joining the military who have the profile of being victimized, who don't have boundaries sometimes," Lee went on to say. "And then you have a male population that fits a perpetrator profile. They are mostly under 25, often developmentally adolescent, and you put them together. What do you think will happen? The men do the damage, and the women get damaged."

Being sexually assaulted by a fellow soldier may prove extra-traumatic, as it represents a breach in the hallowed code of military cohesion - a concept that most enlistees have drilled into them from the first day of boot camp.

"It's very disconcerting to have somebody who is supposed to save your life, who has your back, turn on you and do something like that," says Susan Avila-Smith, the director of Women Organizing Women, an advocacy program designed to help traumatized women navigate the vast V.A. health-care and benefits system. "You don't want to believe it's real. You don't want to have to deal with it. The family doesn't want to deal with it. Society doesn't want to deal with it."

Pickett, who since returning from Iraq has become active in Iraq and Afghanistan Veterans of America, a nonpartisan advocacy group, says she believes that the stress of just worrying about this puts a woman in danger. "When I joined the military, a lot of people at home said things like, 'Oh, are you really going to be able to handle it?"' she said. "So then you're in Iraq, driving down Highway 1 with an M-16 in your hand. You have those doubts people had about you in the back of your head. You're thinking 5,000 things at once, trying to be everything everybody wants you to be. And you still have to take the crap from the men. You're 20 years old and growing into your own body, having an actual sex drive. But you've got 30 horny guys propositioning you and being really disgusting about it." She added: "Women are set up to fail in a very real way, in an area where they could get killed. If your mind isn't 100 percent on the battlefield, you could die. That's the bottom line."

IV. Flickers of a Larger Fire

Three years ago, while researching an article for this magazine on injured soldiers who fought in Iraq, I happened to have a phone conversation with a woman from Michigan who served as a reservist in the gulf war. Like many people, she'd been watching coverage of the war in Iraq with concern. At the time, I was focused on the early waves of soldiers returning home with horrendous, debilitating injuries - the amputees, the paraplegics, the brain-injured - but she was worried about something entirely different, equally devastating but far less visible.

She used her own story as an example: While serving in a mostly male reserve unit in Kuwait, she told me, she was sexually assaulted. After returning home to Michigan, she began exhibiting symptoms of PTSD - jumpiness, intrusive thoughts and nightmares - and promptly went to her local V.A. hospital for help. She was then put into group therapy - which has long been shown to be an economical and reasonably effective way of helping trauma survivors process their experiences - but her "group" was made up entirely of male Vietnam vets, some of whom were trying to work through sex crimes they committed during military service. Others came home from war and beat their wives. "I freaked out," the female reservist told me. "It sent me into a complete tailspin."

She began to drink heavily. She lost her job, moved away from her family and toyed with the idea of suicide. Few PTSD stories are happy stories, but this one eventually took a positive turn: a therapist at her local V.A. hospital finally referred her to a 10-bed residential program for women with PTSD located in Menlo Park, Calif. Desperate for help, she spent a number of weeks there, receiving daily therapy and learning coping skills in the company of a small group of other female veterans and a staff of mostly female therapists. The experience, she told me, saved her life.

Following the early coverage of the Iraq war, however, she was feeling her PTSD begin to stir again. Jessica Lynch - who, it was reported, might have been sexually assaulted as a prisoner of war in the first weeks after the invasion - was being celebrated as a hero. TV news reports showed female soldiers bidding farewell to their spouses and children. All this woman in Michigan could think about, though, was what things would look like on the other side, whether the V.A. would know what to do with these women if they later turned up needing help - whether, in particular, sexual-assault victims would be retraumatized trying to find their way in a system that was built almost entirely around the needs of men.

Thomas Berger, national chairman of Vietnam Veterans of America's PTSD-and-substance-abuse committee, told me recently: "I think women are more likely to fall through the cracks. The fact is, if a woman veteran comes in from Iraq who's been in a combat situation and has also been raped, there are very few clinicians in the V.A. who have been trained to treat her specific needs."

As the Iraq war creates tens of thousands of female war veterans, surely we will begin to know more about the impact of PTSD on the life of a military woman. Female soldiers have flown fighter jets, commanded battalions, lost limbs, survived stints as P.O.W.'s, killed insurgents and also come home in flag-covered caskets. And many, too, have begun to experience the psychic fallout of war, a concept made famous post-Vietnam by a generation of now middle-aged men. "We're much more willing to acknowledge what guys do in combat - both the negative and the heroic," says Erin Solaro, author of the 2006 book "Women in the Line of Fire." "But as a culture, we're not yet willing to do that for women. Female combat vets tend to be very lonely people."

Sexual trauma by itself or in combination with combat stands to isolate a female vet further, says Avila-Smith, the veterans' advocate. "If you're in combat, you can talk about it in group therapy," she told me. "You can say, 'Yeah, I was in this battle and I saw my friends blown up,"' she says. "But nobody raises their hand and yells out in the middle of the V.A.: 'Yeah, I was raped in the military, was anybody else? Do we have something in common?"' Avila-Smith herself says she was sexually assaulted while stationed in Texas in 1992 and developed PTSD as a result. For a long time, everyday functioning was a challenge. "For two years I had a list on my bathroom mirror to brush my teeth, brush my hair, wash my face," she said as we sat at a sunny picnic table outside a V.A. hospital in Seattle. "Every morning it was like waking up in a new world. How did I get here? What's going on? Why is my brain not working?"

This kind of bewilderment is something I encountered again and again, talking to more than 30 military women who struggle with PTSD. Whether they had just returned from Iraq or were 25 years past their service, whether they'd been sexually assaulted, seen combat or both, most reported feeling forgetful and unfocused, alienated from their own minds.

Keli Frasier, an Army reservist living in Clifton, Colo., who said she did not experience sexual assault, told me that because of some combination of anxiety and memory loss, she'd been fired from three low-wage jobs and dropped out of college since returning from Iraq in May 2004. Like a few of the others I met, Frasier always kept a notebook close by to jot down

things she was afraid she'd forget. "Half the time," she said, sounding genuinely confused, "I don't understand why I lose the jobs." According to her account, while driving a fuel truck in Iraq, she watched her squad leader die in a roadside ambush and another peer have his leg blown off with a grenade. "In all those situations, your mind just goes on autopilot, and you just do what you're trained to do," she said, sitting on a couch in a warmly decorated trailer she and her husband own. She bounced her 8-month-old son on one knee as she talked. "I didn't really start having any mental issues until we got home," she said, adding that it was four or five months before PTSD was diagnosed by a V.A. counselor.

Research has shown that exposure to trauma has the potential to alter brain chemistry, affecting among other things the way memories are processed and stored. To vastly simplify a complex bit of neurology: If the brain can't make sense of a traumatic experience, it may be unable to process it and experience it as a long-term memory. Traumas tend to persist as emotional - or unconscious - memories, encoded by the amygdala, the brain's fear center. A trauma can then resurface unexpectedly when triggered by a sensory cue. The cerebral cortex, where rational thought takes place, is not in control. The fear center rules; the brain is overwhelmed. Small tasks - tooth-brushing, grocery-shopping, feeding your children - start to feel monumental, even frightening.

"I was not scared a single day I was in Iraq; that's what baffles me most," Kate Bulson, a 24-year-old former Army sergeant, told me by phone not long ago from her home in Muskegon, Mich. She developed PTSD after completing the first of two tours in Iraq, she said, adding that she had not experienced sexual trauma. "I did everything the male soldiers did: I kicked in doors, searched people and cars, ran patrols on dangerous highways," she said. "Over there, I would hear an explosion at night and sleep through it. Now I hear the slightest sound and I wake up."

Just last month, The Journal of the American Medical Association published the results of a study sponsored by the V.A., which endorsed the use of "prolonged exposure therapy" in treating female veterans with PTSD. The process calls for a patient to visit and revisit traumatic memories in order to lessen their power over the mind. "It becomes an organized story rather than a fragmented story," says Edna Foa, who directs the Center for the Treatment and Study of Anxiety at the University of Pennsylvania and is considered a pioneer in trauma treatment. "They are able to put things together. They find all kinds of new perspectives to look at what happened to them."

Across the V.A., there appears to be an earnest recognition of the need for stepping up these innovative programs for veterans of both sexes. V.A.-financed researchers are working on everything from testing a drug normally used to treat tuberculosis on PTSD patients to developing virtual-reality war simulations that are meant to give veterans more emotional control over their traumatic memories. Of the some 1,400 V.A. hospitals and clinics, currently only 27 house inpatient PTSD programs, and of these, just 2 serve women exclusively. According to the V.A., several more women's residential treatment programs are in the planning stages.

Despite fighting wars in two far-off countries, the Bush administration recently announced that while it will increase V.A. health-care financing by

9 percent for 2008, it has proposed consecutive cuts of about $1.8 billion for 2009 and 2010. Moreover, as recent revelations of poor patient care at the military's flagship facility, Walter Reed Army Medical Center, have demonstrated, a federal health-care system built to serve soldiers and veterans is sagging under the load of those who fought in Iraq and Afghanistan, a significant number of whom struggle with mental-health issues. The V.A. currently has a reported backlog of 400,000 benefits claims, which can in turn lead to long waits for appointments or for approval for medications. When I met her in January, Keli Frasier, the Army reservist, described herself as "really having a hard time" but had been waiting two months to get an appointment to have an expired antidepressant prescription renewed.

It's possible, too, that female veterans suffer from more invisibility. Patricia Resick, at the Boston V.A. hospital, says she feels that women may perhaps take longer than men to recognize their symptoms and find their way into treatment. "They're more likely to have a primary parenting role," she told me. "When they get home, they're going to be trying to get back into their families, to re-establish their relationships." Lee, the psychiatrist in Palo Alto, says that in her experience, men are more likely to have been encouraged to seek help, usually by their spouses. "You don't hear as much about husbands saying, 'Honey, why don't you go into residential treatment for two months?'" she says. And those who feel shame following a sexual trauma, Lee went on to say, may keep it hidden from their health-care providers anyway.

The larger question is: How will this new crop of female war veterans respond, recover or act out the traumas of their military experience? While it is still too early to know, paying attention to small stories, usually tucked inside local newspapers, may indicate the early flickers of a larger fire. There is the story of Tina Priest, a 21-year-old soldier who, according to Army investigation records, shot herself with an M-16 rifle in Iraq last March, two weeks after filing a rape charge against a fellow soldier and days after being given a diagnosis of "acute stress disorder consistent with rape trauma." (The Army says that a subsequent investigation failed to substantiate the rape claim.)

There is the story of Linda Michel, a 33-year-old Navy medic who served under stressful conditions at a U.S.-run prison near Baghdad and was given Paxil for depression during the deployment. Returning home last October, she struggled to fit back into her life as a suburban mother of three in a quiet housing development outside of Albany. She shot and killed herself within three weeks of the homecoming. Her husband, also an Iraq veteran, wondered aloud to a reporter with The Albany Times-Union: "Why wasn't she sent to a facility to resolve the issues?"

More recently, there's Jessica Rich, a 24-year-old former Army reservist who one night early last month climbed drunk into her Volkswagen Jetta and drove south on a northbound interstate outside of Denver. She slammed head-on into a sport-utility vehicle, killing herself and slightly injuring four others. After a nine-month tour of Iraq in 2003 - and according to former soldiers who'd been in group therapy with her, having been raped during her service - PTSD was diagnosed. Her friends say she never got past those experiences. "She was having nightmares still, up until this point - flashbacks and anxiety and everything," one told The

Denver Post. "She said it was really hard to get over because she couldn't get any help from anybody."

V. "What's Wrong With Me?"

Earlier this winter, hoping to understand more about PTSD and its effects, I visited a couple of female Iraq vets who felt their postwar lives had been shaped - if not temporarily ruined - by the "double whammy" of combat and sexual stress. Both happened to live in Colorado, though each had deployed to war through units located in other states. I met Keri Christensen one morning at her home in a tidy subdivision outside of Denver, where she recently relocated from Wisconsin with her husband and two daughters. She had just taken her daughters to school, and her husband was away on a business trip.

Christensen is 33, blue-eyed and outwardly perky, with an easy smile. By the time she was deployed to war in 2004, she had finished 13 years of part-time service in the Wisconsin Army National Guard as a heavy-equipment transporter. Prior to her deployment in Iraq, she loved her role in the military. "Before we were married, my husband was in awe of it," she said, laughing. "He was like, 'I met this girl and she hauls tanks!'" She added that she was good at what she did, receiving several awards over the years. Beyond commitment to the Guard of one weekend a month and two weeks' training each summer, Christensen spent the previous six years as a stay-at-home mom. Her life, she said, had been a generally happy one.

But the stresses of deployment were surprisingly manifest: she agonized over leaving her daughters, who were then 6 and 2 years old. Stationed in Kuwait, Christensen's unit ran convoys of equipment back and forth from the port to inside Iraq. "It was really scary," she said, explaining that her convoy had been mortared during an early mission. "But it was like, Hey cool, we're on a mission." Then one day in February 2005, Christensen was accidentally dragged beneath a truck trailer and run over, breaking a number of bones in her foot and injuring her knee and back. She was assigned to a desk job in a tent in Kuwait, mostly working the night shift. It was there, she said, that a sergeant above her in her command - a man she'd known for 10 years - began making comments about her breasts and at one point baldly propositioned her for sex.

Something inside of her broke, she said. Christensen claims that she was punished for even mentioning the situation to her company commanders - written up for minor infractions; accused, she says falsely, of being intoxicated (for which she was demoted); and reassigned for duty to an airfield near a mortuary, where she occasionally helped load coffins of dead soldiers onto planes bound for the U.S. (The Wisconsin Army National Guard denied that Christensen was punished for making a sexual-harassment claim and stated that the claim was investigated and dismissed for lack of evidence.) Christensen says that a combination of war stress, harassment and the reprisals that followed were so upsetting and demoralizing that she considered suicide on several occasions. Her military records show that during her deployment, she was given a diagnosis of depression and PTSD.

After Christensen's experiences in Kuwait, she allowed her military

enlistment to expire, which given that she was six years short of receiving military retirement benefits, only added to her pain. "That was my career, and they stole it from me," she said, sitting on an overstuffed couch in the family room of her home, idly fiddling with one of her children's stuffed animals as she spoke. "They make you feel like you're crazy. And I'm not just the only one. There's other women out there this has happened to. Why is the attitude always 'Just shut up and leave it alone'?"

Christensen had been home from war then for just over a year, having returned to her life as a stay-at-home mother, yet she could not shake what the deployment had done to her - the accident, the confusion and shame of her sexual harassment, and then what she felt was an ignominious demotion and marginalization after reporting the incidents. And while there are those whose image of PTSD is still tied to Vietnam War movies - the province of men who earned their affliction only after having their best buddies die in their arms in a gush of blood - Christensen shares the same diagnosis. That is to say that no matter what constituted her war experience, the aftermath was much the same. She suffered from severe headaches and forgetfulness. "I feel like I'm always forgetting something," she said. "I leave the house and I don't know if I've left something on - the stove or a candle. I can't trust my memory." She told me that her 8-year-old, Madison, recently had to tell her the family's new phone number. She'd lost friends and had "rough spots" with her husband. Afraid of crowds, she started grocery shopping at 6 in the morning and was having her mother buy clothes for her children. Driving, too, made her fearful, since she felt "foggy" and more than once ran a stop sign or a red light with her kids in the car. Though she went for counseling and medical treatment at a local V.A. while living in Illinois after she returned from Iraq, Christensen had not yet found her way to the Denver V.A. for treatment. The thought of getting in her car and making the 20-minute drive petrified her.

Describing it, Christensen began to cry, wringing the stuffed animal in her hands. "What's wrong with me?" she said, more to herself than to me. "I have nightmares of being trapped underneath a trailer with body parts falling on me." Her body heaved with sobs as she continued: "Once when my kids were sleeping with me, I woke up suddenly, thinking it was an Iraqi person, and I almost tossed my kid across the room."

VI. "Nothing Is Ever Clear"

Amorita Randall lives across the state from Christensen, in a small town outside of Grand Junction. She is 27, a former naval construction worker who served in Iraq in 2004. Over the course of several phone conversations before visiting her in January, I grew accustomed to the way Randall coexisted with her memories. Mostly she inched up to them. On days she was feeling stable, she would want to talk, calling me up and abruptly jumping into stories about her six years in the Navy, describing how she was raped twice - the second rape supposedly taking place just a matter of weeks before she arrived in Iraq. Her experience in Iraq, she said, included one notable combat incident, in which her Humvee was hit by an I.E.D., killing the soldier who was driving and leaving her with a brain injury. "I don't remember all of it," she told me when I met her in the sparsely furnished apartment she shares with her fiance?. "I don't know if I passed out or what, but it was pretty gruesome."

According to the Navy, however, no after-action report exists to back up Randall's claims of combat exposure or injury. A Navy spokesman reports that her commander says that his unit was never involved in combat during her tour. And yet, while we were discussing the supposed I.E.D. attack, Randall appeared to recall it in exacting detail - the smells, the sounds, the impact of the explosion. As she spoke, her body seemed to seize up; her speech became slurred as she slipped into a flashback. It was difficult to know what had traumatized Randall: whether she had in fact been in combat or whether she was reacting to some more generalized recollection of powerlessness.

Either way, the effects seemed to be crippling. She lost at least one job and was, like a number of the women I spoke to, living on monthly disability payments from the V.A. Her fiance, an earnest construction worker named Greg Lund, at one point discovered her hidden in a closet in the apartment they share, curled in the fetal position, appearing frozen. "It scared the hell out of me," he said. "I'm like, am I in over my head here?"' On another occasion, shopping with Randall at Lowe's, he had to pull her away from a Hispanic man she mistook for an Iraqi. "She was going to attack him," Lund said. "She was calling him 'the enemy' and stuff like that." The biggest tragedy for her was that her daughter, Anne, who is 4, was taken from her custody by the Colorado child-welfare authorities after she was found playing in the road unsupervised one day last June. At the time, Randall and her daughter were living with another family in a halfway house. Randall was inside folding laundry, believing - she said - that Anne was being watched by older children in the other family.

There were days when Randall couldn't remember things, telling me her mind felt fuzzy. Accordingly, when she broached a subject that was difficult, her speech would slow down markedly and sometimes stop altogether. "Nothing is ever clear," she explained. "Sometimes I'll just have feelings. Sometimes I'll have pictures. Sometimes it'll be both." Her confusion could be both literal and moral. She blamed herself, in part, for the rapes, saying she felt peer pressure to drink heavily in the Navy, which made her more vulnerable.

Randall's life story was a sad one, though according to the V.A. psychologists I spoke with, it was not atypical. Growing up in Florida, she said, she was physically and sexually abused by two relatives - a condition that has been shown to make a woman more prone to suffer assault as an adult. Eventually she landed in foster care. She told me she joined the Navy at 20 precisely because she was raised in an environment where "girls were worthless." The stability and merit structure of the military appealed to her. Stationed in Mississippi in early 2002, Randall said, she was raped one night in her barracks after being at a bar with a group of servicemen. The details are unclear to her, but Randall says she believes that someone drugged her drink.

A couple of months later, she discovered she was pregnant. In November 2002, she gave birth to her daughter. Less than a year later, Randall's unit was deployed to the war, stopping first for several months on Guam. She put Anne in the care of a cousin in Florida. The second rape happened after another night of drinking. "I couldn't fight him off," Randall says. "I remember there were other guys in the room too. Somebody told me they took pictures of it and put them on the Internet." Randall says she has

blocked out most of the details of the second rape - something else experts say is a common self-protective measure taken by the brain in response to violent trauma - and that she left for Iraq "in a daze."

Given her low self-esteem and her tendency, as a trauma victim, to suffer from fractured memory, someone like Randall would make an admittedly poor witness in court. Randall claims that after returning from war, she told her commanders about the second rape but says she was told "not to make such a big deal about it." (The Navy says it knows of no internal records indicating that she had reported a sexual assault.) Since her daughter was removed from her custody last summer, she had been going for weekly hourlong therapy sessions with a civilian social worker, paid for by the V.A. She was also taking parenting classes at a social-services agency and petitioning to have the child returned to her care. Overall, she was feeling optimistic that through therapy, her PTSD was beginning slowly to subside. But she also felt it was a case of too little, too late, saying that before losing her daughter, she was receiving what for many women is considered to be a standard course of mental-health treatment in a V.A. system strapped for resources - a 60-minute counseling session held every month. Randall shrugged, describing it. "We never got very far with anything," she said, "The guy would just ask me, 'So, how are you doing?' And I'd look at him and say, 'Well ? I guess I'm fine."'

VII. "It Just Kept Building Up and Building Up ..."

The Women's Trauma Recovery Program is tucked into a small adobe-style building on one corner of a sprawling V.A. health-care campus in Menlo Park, Calif., about 20 miles south of San Francisco. Outside there is a sunny courtyard, where residents often gather to smoke and talk. Inside there are five dorm-style bedrooms, each with a pair of twin beds. The feeling is something less than homey but something more than institutional. Next door there is a larger and more established 45-bed program for male active-duty soldiers and veterans with PTSD.

When I arranged to visit the women's program for a couple of days last July, it was unclear whether any of the six female patients then in residence would speak to me. According to Darrah Westrup, the psychologist who leads the program, this group had only just begun its 60-to-90-day treatment program, which was devoted both to learning coping skills and to gradually doing exposure therapy for their traumas. For many of the patients, entry in the program - gained through a referral from a mental-health specialist and then a fairly intensive application process - felt like a last resort. Privacy, too, was paramount: some of these women had isolated themselves for years and, working with the program's therapists, were just beginning to rebuild some confidence, Westrup said.

So it came as a surprise when, one by one, each one surfaced at Westrup's office, ready to talk to me. (They requested that I protect their privacy by not using their full names.) Each asked too that Westrup be present for the interview, and I soon understood why: despite the fact that conversation revolved mostly around the impact of living with PTSD rather than the traumatic events that caused it, the danger of a flashback always lurked. "Are you here?" Westrup would ask gently when somebody appeared momentarily glazed or her speech slowed down. "Do you feel your feet on the ground?"

Some of the women served in previous decades and were only now dealing fully with their PTSD. They recognized themselves as harbingers, as cautionary tales of how bad it could get for those of the current generation of female soldiers if they left their PTSD untreated. And they repeated that sentiment again and again. "I'm only talking to you," one said, "because I want other sisters to know they're not alone."

I met six women, two of whom served in Operation Iraqi Freedom. Most hadn't seen combat, though three of them said they were raped by fellow soldiers during deployments in Germany, in Japan, in Qatar. The women - Johnnie, Kathy, Kathleen, Ann, Michelle and Sara - had served in the Army, the Navy or the Air Force. What ran through nearly every woman's story was a sense of things left unresolved. Nobody mentioned perpetrators being punished. Nearly everyone expressed having gone through relentless self-questioning: "What if I hadn't accepted that ride?" one wondered aloud. "What if I hadn't drank so much?" asked another.

According to Patricia Resick of the National Center for PTSD, being able to process trauma is the key to recovering from it. Those people who cannot make sense of what happened to them are more likely to continue reliving it through flashbacks and intrusive memories. "It's like a record that keeps getting stuck," she said. "They can't accept that it happened because of the implications of accepting it. It means that bad things - horrible things, really - can happen to good people."

The women in Menlo Park described, vividly, the aftermath of living with unresolved military trauma: Kathy was arrested more than once for drunken driving. Michelle tried to kill herself three times. Sara was put into a military psychiatric hospital. Ann raised children and had a successful career, but said that inside her home in rural Northern California, she was often so paralyzed by fear that she hid in the closet any time the phone rang.

The program required that the women spend time writing down their thoughts and then analyzing them on paper, rooting out the "distorted thinking" - things like feeling unworthy or guilty - and then reinterpreting them in a more healthful way. While each woman acknowledged that the work was painful, there seemed to be a kind of summer-camp camaraderie growing among them. Yet there was always the notion looming that at some point they, and their symptoms, would need to return home.

One of the two vets of the Iraq war on the V.A. campus was Kathleen, a 37-year-old Army nurse with dark hair and fair skin. She arrived at Menlo Park courtesy of a program sponsored by the Department of Defense, in which active-duty soldiers with severe PTSD are granted leave and financing to pursue residential treatment through the V.A. This is part of a larger effort across the military to find and address soldiers' mental-health issues as quickly as possible. Kathleen was a first lieutenant and a registered nurse based at Fort Sill, Okla. She was medevacked out of Baghdad less than three months earlier.

Sitting in a chair in Westrup's office, dressed in a pastel T-shirt and jeans, Kathleen knit her fingers together anxiously. Despite appearing nervous, she seemed eager to talk. For better or worse, Kathleen's trauma was still fresh. She was also one of the few female veterans I spoke with who were

suffering from PTSD who did not mention experiencing sexual harassment or assault in the military, though she did allude to "a bad childhood."

Speaking in a soft drawl, she described being stationed at a combat support hospital inside Baghdad's Green Zone, working 15-hour shifts in the intensive-care unit, often tending to burn patients who were helicoptered in from southern Iraq. "I expected some death," she said. "I was realistic. What I didn't expect was that we would be taking care of so many civilians, and those civilians would be children." She paused to add that she had five children of her own - all daughters, ages 9 to 18, who were back in Oklahoma with her husband, himself an Army man who'd been deployed to Iraq twice already.

In Baghdad, the stressors piled up quickly: helicopters kept arriving from the south, burn patients howled, children sometimes died. Lying in bed at night, Kathleen listened to mortars exploding and stray gunfire outside the Green Zone. "It just builds up and wears down on you," she said. "You're always in a heightened adrenaline rush."

Her hands started to tremble then. She mentioned a young boy named Mohammed who died in the Green Zone hospital early on in her time in Iraq, saying only that she felt responsible for his death. "I can't say more about that," she said, shaking her head. She then described caring for another young Iraqi who'd lost his legs because of complications from a gunshot wound. She started to understand that he might not survive outside the hospital. She described a creeping feeling of powerlessness. "You get to a point when you can't take care of everybody," Kathleen said, her voice quavering. "It's really tough." She knotted and unknotted her hands, appearing somewhat blank.

Westrup interjected softly, "Kathleen, are you here?"

"I'm here," she said. Then she continued: "It got to a point that I was having panic attacks all the time because we'd get a patient in, and I'd be thinking, Oh, my God, they're not going to survive, and how can I help them stop screaming and not be in pain? It just kept building up and building up. ..."

Then one day Kathleen's superiors barred her from visiting the young man who'd had his legs amputated, suggesting that she was becoming too emotional. Since the death of the boy named Mohammed, she had been taking Paxil for depression, and about the same time, she said, an Army doctor took her off the medication.

"I went crazy," she said plainly. "I had a major panic attack. I felt like I couldn't get enough air." On the night it happened, she climbed the stairs to the hospital's rooftop, which overlooked the Green Zone. "We sat up there millions of times, smoking our cigarettes or just shooting the breeze and watching the helicopters coming in and going out. It felt like a safe place." But when a hospital doctor turned up on the roof, startling her as she gasped for air, Kathleen began to cry. The doctor fetched the senior nurse on call. Believing that Kathleen was contemplating suicide, the nurse had her evacuated first from the roof, Kathleen said, and then from Baghdad altogether.

When I asked if she considered suicide during her deployment, Kathleen answered: "Oh, several times, but I was able to contain those thoughts. What kept me going was the thought of my children, and them not being taken care of if I killed myself." She did, however, rehearse some thoughts about what would happen if she wandered outside of the Green Zone and deliberately into enemy fire. "I was worried about how children of parents who commit suicide have a higher rate of suicide themselves. I have three teenagers, and I'm thinking, I can't do that. But if I died because of the enemy, then that would be acceptable. They would be sad, but they could hold their heads high and say, 'Yes, my mom served - she gave to this country.'"

Everything that happened to Kathleen - her feelings of compassion for her Iraqi patients, the powerlessness she felt in trying to save them, the depression, Paxil and ultimate breakdown - all very easily could have happened to one of her male colleagues. Indeed, she told me she was not the only soldier feeling great stress in the hospital: "We were all facing these struggles," she said. "There were people that were breaking down crying, nobody was sleeping well. There were a lot of nightmares." And yet it was Kathleen who was helicoptered out of the war on a stretcher on April 29 last year and returned to Oklahoma, to her three-acre property, her five girls and her husband.

Leaving Iraq and returning home to Oklahoma, Kathleen felt an instant change in her relationship with her daughters. "It was very difficult for me to see them," she told me. "I thought I would be excited and run to them and tell them I loved them, but instead I was scared. I was scared for them to hold me, to touch me. I don't know why, because I wanted to really bad. I was afraid for them to see me shake or stutter, not being able to communicate." She mentioned, with no small amount of heartbreak, that it was hard to reconnect with one particular daughter, who has dark hair and brown eyes, because "she looks like she could be Iraqi."

Two weeks after arriving in Menlo Park, she was still baffled by how excruciating family life had become. When her 9-year-old daughter had started shouting playfully while being chased by her 11-year-old in the yard outside, her mind flashed instantly to Iraq. Kathleen said: "It just goes through me and brings me right back. I have a lot of flashbacks. And then I'd have nightmares, afraid that they'd hear me talk in my sleep or yell out, moaning." She added, "Me and their dad have had nothing but conflict after conflict, because he wants me to be a certain way, and I can't." Her children, she said, had begun avoiding her in order not to upset her, asking their father to drive them places, speaking quietly in her presence.

Kathleen started seeing an Army psychologist daily, something she found to be extremely helpful. A social worker at Fort Sill introduced the idea that she might be further helped by the women's residential program in Menlo Park. Yet having already left her children for most of the last year, Kathleen was resistant to going.

And then came a turning point. One day, when her husband was not around to do the driving, she had the girls in the car on their way to somebody's team practice, when her 13-year-old daughter tried to offer some encouragement. "She said, 'Mama, you can get through this; it's not like you killed anybody,' " Kathleen recalled. "I started crying, and she

goes, 'Oh, my God, you killed somebody!' I went into another panic attack right in front of my kids." She welled up at the memory, saying: "That was enough for me. I was like, I'm ready to go. I'm getting through this."

So far, however, treatment had been a mixed bag for Kathleen, mostly because she was homesick and afraid. She had, however, fostered a great deal of empathy and respect for the other women she'd met, understanding that some had lived with debilitating PTSD for 20 years.

"I came close to leaving here the other day," she told me. "But the girls just surrounded me. They were like, 'Don't leave."' The women then went on to describe how they lived before treatment - one with security cameras and a security fence at her house, another locked away in her apartment, several having lost their marriages and distanced themselves from their kids. "They said: 'You don't want this life. I would give anything to go back to when my trauma was new and to get help with it,'" Kathleen recalled. "And I could see myself 20 years down the road; I would be them. And I don't want that," she said. "I love these girls, but I don't want that."

VIII. What the Future Holds

Six weeks later, I flew back to California to attend the Women's Trauma Recovery Program graduation. It was held on a Thursday morning in a wide recreation room on the building's ground floor. Someone had moved the Ping-Pong table to one side and dragged a number of chairs into neat rows. A modest buffet lunch was laid out along the room's back wall.

The residents took their seats at the front of the room, having clearly primped for the occasion. They then read poems, held hands, made grateful speeches to the staff and, at the end, played some pensive music on a boombox and bowed their heads, many of them weeping. It was, of course, impossible to know what was in store for any of them. Clearly, they had benefited from the cohesiveness of the group, having met others who were wrestling with the same demons.

There was one notable absence - Kathleen, who, it turned out, left treatment not long after I met her, presumably to return home to her family and military life in Oklahoma. Over the next few months I sent several letters to Kathleen, hoping to speak with her, but got no response. Finally, a couple of weeks ago, she called me, apologizing for her silence. She'd only just received a medical discharge from the Army and felt comfortable talking. She had mixed feelings about leaving the military, since she loved her work as an Army nurse, but felt that the PTSD symptoms kept interfering. She'd spent much of the fall giving vaccinations to soldiers, but after a soldier passed out one day, causing her to panic, she realized she was a long way from being able to handle an urgent medical crisis.

Kathleen also told me that she left Menlo Park last summer after one of her daughters was involved in a minor car accident. "I left treatment because my children were more important than my needs," she said.

What struck me again and again, meeting and talking to female Iraq veterans grappling with PTSD, was their isolation. So many, like Kathleen,

seemed uncertain of what to do next. It was as if their mistrust of the world had led them to mistrust themselves. Most were on antidepressants and were receiving some counseling through the V.A., but few had a sense that their symptoms were going away. In Colorado, Amorita Randall was working to regain custody of her daughter - a process that she found discouraging. "Just because I'm disabled doesn't mean I can't care for my daughter," she told me. Recently, after months of waiting, Keli Frasier, the mother in Colorado who had been struggling with depression, finally managed to schedule an appointment with a V.A. psychiatrist to obtain new antidepressants. Across the state in Denver, Keri Christensen said she was still haunted by nightmares and unnerved by driving.

And finally, there was Suzanne Swift, who in early December was given a summary court-martial at Fort Lewis, a hearing normally used for minor offenses. As part of a plea bargain, she pled guilty to "missing movement" and being absent without leave. Her rank was reduced to private, and she spent the next 21 days, including Christmas, in a military prison in Washington State. The Army ruled that in order to receive an honorable discharge, Swift was dutybound to complete her five-year enlistment, which ends in early 2009. After finishing her stint in prison in January, Swift says she checked herself into the inpatient psych ward at Fort Lewis's hospital for a few days but ultimately was released back to duty. She told me she was trying generally to ignore the PTSD but had taken to drinking a lot in order to get by. "I kind of liked the Army before all that stuff happened," she said in early February, on the phone from her barracks at Fort Lewis. "I was good at my job. I did what I was supposed to do. And then in Iraq, I got disillusioned. All of a sudden this Army you care so much about is like, well, all you're good for is to have sex with and that's it." She added, "I really, really, really, don't want to be here."

The Army had issued an order for Swift to be transferred to a base in California later this spring. Swift was unhappy about the change, because it would take her farther from her family in Oregon, but she was also considering other plans. "Did you know," she said, "that there's some program near San Francisco that's just for women who have PTSD?" She paused for a moment, surrounded by the silence in the barracks at Fort Lewis, then said, "I'm thinking about trying to get in there."

The Women's War

March 18, 2007, Sunday
By SARA CORBETT (NYT); Magazine
Late Edition - Final, Section 6, Page 42, Column 1, 12089 words

EDITORS' NOTE APPENDED

DISPLAYING ABSTRACT - I. Report to Duty - 'On My Bed, Naked' On the morning of Monday, Jan. 9, 2006, a 21-year-old Army specialist named Suzanne Swift went AWOL. Her unit, the 54th Military Police Company, out of Fort Lewis, Wash., was two days away from leaving for Iraq. Swift and her ...

Editors' Note: March 25, 2007, Sunday The cover article in The Times Magazine on March 18 reported on women who served in Iraq, the sexual abuse that some of them endured and the struggle for all of them to reclaim their prewar lives. One of the servicewomen, Amorita Randall, a former naval construction worker, told The Times that she was in combat in Iraq in 2004 and that in one incident an explosive device blew up a Humvee she was riding in, killing the driver and leaving her with a brain injury. She also said she was raped twice while she was in the Navy.

On March 6, three days before the article went to press, a Times researcher contacted the Navy to confirm Ms. Randall's account. There was preliminary back and forth but no detailed reply until hours before the deadline. At that time, a Navy spokesman confirmed to the researcher that Ms. Randall had won a Global War on Terrorism Expeditionary Medal with Marine Corps insignia, which was designated for those who served in a combat area, including Iraq, or in direct support of troops deployed in one. But the spokesman said there was no report of the Humvee incident or a record of Ms. Randall's having suffered an injury in Iraq. The spokesman also said that Ms. Randall's commander, who served in Iraq, remembered her but said that her unit was never involved in combat while it was in Iraq. Both of these statements from the Navy were included in the article. The article also reported that the Navy had no record of a sexual-assault report involving Ms. Randall.

After The Times researcher spoke with the Navy, the reporter called Ms. Randall to ask about the discrepancies. She stood by her account.

On March 12, three days after the article had gone to press, the Navy called The Times to say that it had found that Ms. Randall had never received imminent-danger pay or a combat-zone tax exemption, indicating that she was never in Iraq. Only part of her unit was sent there; Ms. Randall served with another part of it in Guam. The Navy also said that Ms. Randall was given the medal with the insignia because of a clerical error.

Based on the information that came to light after the article was printed, it is now clear that Ms. Randall did not serve in Iraq, but may have become convinced she did. Since the article appeared, Ms. Randall herself has questioned another member of her unit, who told Ms. Randall that she was not deployed to Iraq. If The Times had learned these facts before publication, it would not have included Ms. Randall in the article.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

MARCH 27, 2007

QUESTIONS SUBMITTED BY DR. SNYDER

Dr. SNYDER. General Pollock and Admiral Arthur and General Roudebush, the article that Ms. Davis called to my attention last week is from the New York Times Magazine March 18, 2007, "The Women's War" by Sara Corbett.

I have no expectation that you all read everything that is in the press out there about men and women at war and their families. But if you would respond for the record to this.

General POLLOCK. Sara Corbett's Article "The Women's War" published in The New York Times Sunday Magazine 18 March 2007 is a thoughtful, balanced, and detailed examination of unique problems facing some service women today. The Iraq war has seen unprecedented numbers of female Soldiers serving with many Combat Service and Service Support units. As the article highlights, both the military and Department of Veterans Affairs are devoting increasing attention to the unique problems of female service members. More attention needs to be given to studying the effects of combat on our female warriors. The development of effective treatment programs tailored to women should be a priority for our military Behavioral Health community.

The Army takes the issues of Sexual Harassment and Sexual Abuse very seriously and has set up an extensive program to encourage victims of harassment or sexual assault to seek help. The Army's Sexual Assault Prevention and Response Program (SAPR) provides confidential victim advocates who diligently work with victims to provide them with treatment resources and support. Annual training on the SAPR is required for all military personnel. A detailed explanation of the Army program can be found at: http://www.sexualassault.army.mil/.

In regard to the noted increase in reporting since the initiation of the SAPR program, we feel this is a positive development. It has long been understood that when one pays attention to a problem by encouraging reporting and offering protection to those who report, the rates of reporting will rise. This increase therefore likely reflects victims who previously did not report, rather than an actual increase in assaults. While no one believes we are reaching 100% of the victims of sexual assault, early intervention and the support of victim advocates are helping many women recover.

On the issue of PTSD, there has long been demonstrated a significant gender difference in willingness to seek help between males and females, with female personnel more open to doing so. Our data from the Mental Health Advisory Team studies do not show any gender difference, but more research needs to be done.

The Department of Defense is currently engaged in unprecedented efforts to find and help service members adversely affected by their deployment experiences. The Post-Deployment Health Assessment given immediately upon re-deployment and the Post-Deployment Health Reassessment, given 90–180 days after re-deployment bring soldiers into direct contact with Behavioral Health personnel and give them the opportunity to obtain immediate assistance. Additionally the physical examination process has been revised to a Periodic Health Assessment, which also looks for evidence of depression, anxiety or substance abuse. Although more can and needs to be done in this area, the Army is aware of the challenges faced by both male and female Soldiers and is doing everything possible to ensure their needs are met.

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Admiral ARTHUR. In reference to the article titled "The Women's War", the following comments are provided on Navy Medicine's efforts for providing medical care for the physical and psychological sequelae of women serving in the Navy and Marine Corps as a result of combat experience.

Navy Medicine seeks to proactively address the broad range of combat and operational stress injuries, to include PTSD, in a number of ways. In November 2006, Navy Medicine established a directorate at the Bureau of Medicine and Surgery led

by an experienced combat stress psychiatrist specifically dedicated to addressing mental health stigma, combat stress training needs, non-stigmatizing care of returning deployers, and support services for Navy caregivers. Other efforts include prevention, outreach, and early intervention to warfighters using Navy mental health providers trained in clinical best-practices related to combat and operational stress control. One specific example is Operational Stress Control and Readiness teams providing early intervention, outreach, and prevention at the unit levels in close proximity to operational missions in order to reduce stigma that can be encountered in conventional mental health care settings.

Navy Medicine plans to utilize existing data sets to study combat stress and gender. Naval Health Research Center's Millennium Cohort Study is addressing a variety of combat-related behaviors in both men and women. Additionally, the first phase of the Navy's in-theater Behavioral Health Needs Assessment (BHNAS) is complete, and analysis of gender differences associated with deployment stress is currently underway.

Service Members returning from deployment are screened using the Post Deployment Health Assessment (PDHA–DD Form 2796). A review of 261,008 PDHA forms completed from January 2003 to present demonstrate that 2.2% of male Marines and Sailors were referred for mental health services, compared to 2.6% of returning female Marines and Sailors (Defense Medical Surveillance System, 19 June 2007).

Researchers from Walter Reed Army Institute of Research (Hoge et. al., 2007) have reviewed recent studies of military personnel with service in Iraq and Afghanistan, and reported that "military duty in Iraq confers a similar risk of [Post Traumatic Stress Disorder] and depression by gender." The authors suggest that risk for developing significant combat stress disorders is a factor of intensity and frequency of combat exposure, rather than gender (Hoge CW, Clark JC, Castro CA. Commentary: Women in combat and the risk of post-traumatic stress disorder and depression. International Journal of Epidemiology 2007).

The issue of compassion fatigue among Navy Medicine personnel is also of significant interest. Navy Medicine has established a Care for the Caregiver mandate in order to address this concern. Assessment of operational and occupational stress of medical personnel, to include focus groups, will begin in summer 2007.

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General ROUDEBUSH. The Air Force is concerned about all Airmen with trauma-related mental health problems, regardless of gender. We have procedures to guide base helping agencies as they assist Airmen who are transitioning back to their home station from deployment. These procedures include education on the recognition of PTSD signs and symptoms and where to go for help. Upon redeployment and then 3 to 6 months later, we ask Airmen to complete a survey describing their current health status. This survey includes questions about PTSD; when Airmen screen positive, they are referred to their primary care provider for further evaluation and, if indicated, onto a mental health specialist. Ms. Corbett makes note of Dr. Edna Foa's Prolonged Exposure Therapy for the treatment of PTSD. I am pleased to tell you that the Air Force brought Dr. Foa to a number of our bases to train mental health professionals in her evidence-based treatment. To date, she has trained 100 mental health professionals. We are working with her currently to have her provide training to an additional 300 professionals. We are also working with Dr. Patricia Resick, another one of our nation's top PTSD clinician/researchers. Dr. Resick will be providing training in her Cognitive Processing Therapy, the other main evidence-based treatment for PTSD.

Dr. SNYDER. My final question is the bill that passed out of the full Armed Services Committee last week and will be on the floor this week that will be called the Wounded Warriors Bill. Have any of you had a chance to look at it and have any thoughts or criticisms about it. Would you share that with us today?

General POLLOCK. I'd like to thank the Congress for its commitment to care for our warriors in transition, as demonstrated by the wounded warrior legislation recently passed by the House. The attention of Congress at the strategic level and as an oversight body will help ensure that the Department addresses concerns regarding outpatient care and the Physical Disability Evaluation System with the right level of attention, enthusiasm, and resources. My major comment regarding your legislation relates to timing and specificity. The Army is moving forward very quickly to correct deficiencies and improve processes. There are currently a number of efforts and investigations underway within the Army, the DoD, and the executive

branch that will provide us with findings and recommendations to move forward. Legislating solutions now, before the commissions and reviews are completed, would be premature. We are in the process of developing a supporting infrastructure for our wounded warriors and would prefer to determine how all the pieces fit together before pursuing specific ratios. Furthermore, I am not comfortable with the thought that one solution suits the entire military health system. Depending on supporting structure, case complexity, and a variety of other factors, staffing ratios must remain flexible. We understand your interest in appropriate access and availability to case managers, physical evaluation board liaison officers (PEBLOs), and advocates. I would suggest establishing a reporting requirement so the Department can regularly update Congress on existing ratios and practices.

I would also like to comment concerning the provision for congressional notification. I believe that Members of Congress should be notified when a Soldier-constituent is evacuated from a combat theater to a hospital in the United States. The majority of evacuations out of theater, however, do not result in hospitalizations in the U.S. Many are returned to duty within a matter of days. I do not believe it is the intent of Congress to track these Soldiers. In addition, congressional notifications should be limited to those members of Congress who represent the district or state that includes the Soldier's home of record.

Dr. SNYDER. MG Pollock stated that she has asked the Department of the Army to re-look the efficiency edge figures for FY 2008–09. What is the status of this re-evaluation?

General POLLOCK. A decision was made on 19 June 2007 by the Under secretary of Defense, Personnel and Readiness, to establish a study group to re-evaluate the efficiency wedges. We look forward to participating in this re-evaluation.

Dr. SNYDER. MG Pollock agreed to provide written answers on the current status (process and numbers) of the Army's military to civilian conversions.

General POLLOCK. The initial analysis to select military billets for conversion considered availability of skill sets in the local market, projected costs, and historical fill rates. Billets linked to operational readiness were not targeted. The Army has certified to Congress that 1,504 of the 1,669 military-to-civilian conversions programmed for FY06 and FY07 will not increase cost or reduce access to care or quality of care. Of the 165 positions not certified for conversion, 52 were determined to be hard to fill. The Army is currently re-evaluating its strategy on medical military-to-civilian conversions and does not want to stop conversions when it makes sense due to operational demands, cost or level of care. During execution of programmed medical conversions, some hiring actions took longer than expected due to shifts in the health care market. Inability to backfill converted military billets in a timely manner with equally qualified civilian health care workers could impact mission capability. Therefore, we are reassessing our plans and program for medical military-to-civilian conversions. Military-to-civilian conversions play a key role in increasing Army operational capabilities. Backfilling medical positions in the Institutional Army with civilians and realigning military positions to the operational Army helps reduce stress on the force.

ARMY MEDICAL DEPARTMENT (AMEDD)
MILITARY TO CIVILIAN CONVERSIONS
(CUMULATIVE)

	FY06	FY07	FY08
AMEDD Officers	127	191	224
AMEDD Warrant Officers	4	8	15
AMEDD Enlisted	498	978	1210
AMEDD TOTAL	629	1177	1449
Non-AMEDD Officers	3	3	12
Non-AMEDD Warrant Officers	6	6	7
Non-AMEDD Enlisted	430	483	774
Non-AMEDD TOTAL	439	492	793
Total Programmed Conversions	1068	1669	2242
Total Certified Conversions	1068	1504	

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. Since the widely publicized problems at Walter Reed Army Medical Center, there has been much discussion on the MEB/PEB system. For several years

this committee has heard complaints about the timeliness and accuracy of both systems. I understand that only the MEB system is under the control of the Service medical departments. Please tell us what steps you have taken to ensure that the documents that are considered by the Medical Evaluation Board are complete and accurate. What mechanisms are in place for ensuring that a service member has gained the maximum medical benefit from the treatment provided before they are referred to the MEB?

General POLLOCK. Due to past complaints about the Physical Disability Evaluation System (PDES), several steps have been taken to ensure quality control and consistency of process, while still taking into account the requirements to respond to the individual Soldier's needs as well as the needs of the Army. The newly implemented "triad" of patient care: the primary care physician, the nurse case manager and the squad leader, are all to be involved in the determination of when maximum medical benefit is achieved. As a check/confirmation of this, as Soldiers enter the MEB process, they are each given a comprehensive physical exam. The purpose of this exam is to ensure that each and every condition the Soldier is adequately addressed prior to submitting his/her MEB to the PEB. One of the outcomes of this comprehensive physical may be additional consults to other specialties. Ideally, once initiated, an MEB should be processed efficiently and with care and compassion for the Soldier. However, every Soldier's case is unique and there are instances where the MEB process is actually stopped to provide additional treatment and/or surgery if deemed medically necessary.

As discussed above, additional dedicated medical resources (such as dedicated MEB physicians) have been and are in the process of being hired/assigned throughout the Army Medical Department to process MEBs and assist Soldiers in their healing and recovery. These dedicated personnel have received training on the evaluation and processing of Soldiers undergoing the physical disability evaluation process. We have enforced a corporate understanding of the process through standardization of MEB Physical Evaluation Board Liaison Officer (PEBLO) and physician training requirements.

In May 2007 a Worldwide PEBLO Conference was held, where physicians and counselors participated in dedicated training tracks, problem-solving breakout sessions and certification testing. There is a dedicated website repository, available for counselors and physicians to utilize as a resource for additional information. An Army Medical Action Plan (AMAP) was developed by Army agencies/activities involved in the PDES process to implement and execute new business practices as it pertains to clinical and administrative quality improvements.

To summarize, the PDES is designed with a number of checks and balances in place to ensure adequate due process. The senior clinical physician in the hospital is the local deciding authority for appeals to the MEB and any questions regarding maximum medical benefit. Soldiers also have the ability to appeal their MEB findings. Based on their appeal, the MEB can stand as written, be sent back to health care provider for further information, or be forwarded to the PEB with attachments or additional notes. Finally, the regional PEBs have the discretion to reject the MEB if they feel it is not complete and the Soldier has not reached optimal medical benefit.

Mr. MCHUGH. Since the widely publicized problems at Walter Reed Army Medical Center, there has been much discussion on the MEB/PEB system. For several years this committee has heard complaints about the timeliness and accuracy of both systems. I understand that only the MEB system is under the control of the Service medical departments. Please tell us what steps you have taken to ensure that the documents that are considered by the Medical Evaluation Board are complete and accurate. What mechanisms are in place for ensuring that a service member has gained the maximum medical benefit from the treatment provided before they are referred to the MEB?

Admiral ARTHUR.

Steps to Ensure Complete and Accurate Documentation

Accurate and timely submission of the Medical Evaluation Board Record (MEBR) to the Physical Evaluation Board (PEB) is a critical component of caring for the ill and injured sailors and Marines who have volunteered to serve their country. Steps to ensure that the documentation that is presented to the PEB is complete and accurate include the provision of thorough policy guidance, training, documentation review and program oversight.

Policy Guidance: Detailed guidance about documentation required in a medical board package is outlined in ManMed Chapter 18–12 through 18–16, including templates for a complete medical evaluation board report and non-medical assessment. This guidance was last updated in January of 2005, includes PEB policy guidance

contained in SECNAVINST 1850.4E, and has subsequently been reviewed to ensure that it continues to provide proper instruction on the scope and content of information required by the PEB.

Training: Navy Medicine has recently combined the Annual Patient Administration Conference with the Annual Physical Evaluation Board Liaison Officer Conference to ensure maximum participation and interaction between DON PEB Staff, BUMED staff, Patient Administration Officers and PEBLOs. This interactive conference serves as an opportunity to ensure proper training of administrative staff and counselors as well as to identify problems, and solutions, with all stake holders at one location. Patient Administration Officers receive additional training at the Quarterly Patient Administration Courses. Clinicians involved in the dictation of MEBRs or who serve on the Medical Evaluation Board receive training prior to assuming this responsibility and periodically throughout their career. The DON PEB provides training to clinicians and administrative staff upon request as well as during site visits to Military Treatment Facilities.

Documentation Review: The Convening Authority (the hospital's Commanding Officer) along with the involved service member has ultimate responsibility to ensure the accuracy and quality of the MEBR prior to sending it to the PEB. A minimum of two physicians trained in the MEB process will review the MEBR for accuracy and completeness. The Patient Administration staff reviews all documentation of the MEBR for completeness prior to presenting it to the Convening Authority for signature. The MEBR package presented to the service member for review must be complete, including all medical documentation, non-medical assessments and line of duty determinations that are to be submitted to the PEB. The service member has 5 days to review the MEBR and either sign it for submission as a complete package or provide a rebuttal. If they submit a rebuttal they can submit additional documentation that they feel should be included for the PEB's review.

Program Oversight: MedBOLT (Medical Board Online Tracking) is the database used by Navy Medicine to track efficacy in executing the MEB process. All parts of the MEB process can be tracked in this system to assist in ensuring completeness and timeliness of submission. The system also allows communication of historical MEB data across MTFs allowing for a complete and accurate picture of the individual's history. MedBOLT has technical safeguards in place that alert the user to ensure all necessary forms and supporting documentation are complete prior to submission to the PEB. The Patient Administration Officer is responsible for running periodic reports to ensure timely progress through the MEB process. Additionally, Navy Medicine Inspector General (MEDIG) performs reviews the MEB process during their periodic MTF inspections.

Mechanisms to Ensure Maximum Medical Benefit Prior to referral to MEB

The timing of referral to the PEB must be individualized for each service member to ensure maximum benefit to the patient. For instance, there are circumstances in which referral of the service member to the PEB early into medical treatment may be in the best interests of the member, as it could maximize the delivery of disability benefits and compensation. Examples of cases in which the member may desire early referral are very severely injured members whose disabling condition makes them ratable by the VA at 100%. Those members would be eligible for financial benefits not otherwise available while they are still in an active duty status. DoN ran a pilot program in conjunction with the VA last year, with a small sampling of eligible members to determine the best processes and develop procedures to streamline benefits delivery. There are other circumstances when it is in the best interest of the service member to defer referral to the PEB until the patient has reached maximum medical benefit and the condition is stable. Policy outlined in ManMed Chapter 18 allows for this provision. When a service member has a medical condition that limits their ability to fully perform their job and the condition is expected to persist for over 90 days, they are to be placed in a Limited Duty Status (LIMDU). While each period of LIMDU is for no more than 6 months, subsequent periods of LIMDU are authorized if the medical condition is not stable or maximum medical benefit has not been reached to make a determination of fitness for continued service/disability. The policy outlines procedures for requesting Service Headquarters approval of subsequent LIMDU to ensure that members do not linger in this status. However, if the clinician caring for the patient outlines reasons for continuation of LIMDU, including need for ongoing care prior to referral to the PEB, Service Headquarters can grant extended LIMDU until the condition is stable or maximum medical benefit has been achieved. Moreover, the PEB applies a separate assessment of completeness and clinical appropriateness upon receipt of an MEBR and does not hesitate to seek further documentation with respect to a variety of issues including diagnostic and treatment status as indicated from the referring MTF.

Mr. MCHUGH. Since the widely publicized problems at Walter Reed Army Medical Center, there has been much discussion on the MEB/PEB system. For several years this committee has heard complaints about the timeliness and accuracy of both systems. I understand that only the MEB system is under the control of the Service medical departments. Please tell us what steps you have taken to ensure that the documents that are considered by the Medical Evaluation Board are complete and accurate. What mechanisms are in place for ensuring that a service member has gained the maximum medical benefit from the treatment provided before they are referred to the MEB?

General ROUDEBUSH. In the AF, a service member's physician will start an MEB when the physician feels the member has obtained optimum benefit from treatment (in compliance with DODI 1332.38, paragraph E2.1.22). Once the physician feels there is enough information to determine the member's ability to return to duty, the physician submits a narrative medical summary to the MEB clerk. The AF requires three physicians to review each MEB package. If there is a psychiatric diagnosis (e.g. PTSD), a psychiatrist must be one of the three MEB physicians. If the physicians feel a member has not yet obtained optimum benefit, they can recommend additional treatment for the member. Additional medical specialty evaluations may be requested if the physicians are unsure about the member's fitness for duty. Once a MEB recommendation has been made, the senior MTF physician (SGH) reviews the case to provide senior clinical oversight. Additionally, the PEB Liaison Officer (PEBLO), while not typically a medical clinician, may also provide advice to the physicians based on the PEBLO's past experience with similar MEB cases. Every attempt is made to tailor the process to meet the individual patient's needs.

Mr. MCHUGH. Recent emphasis on traumatic brain injury suffered by service members in Iraq and Afghanistan has raised the awareness of Congress and the American public to this often deceptive medical condition. What mechanisms does each of you have in place to identify TBI in redeploying service members, including those who are not obviously wounded or injured? How are military health providers distinguishing TBI from other mental health conditions, such as PTSD? What additional resources do you need to identify and treat TBI?

General POLLOCK. We recently modified the Periodic Health Assessment (PHA) screening questions to include TBI specific questions. The PHA screen will be fully functional in July. If a Soldier answers "yes" to a potential traumatic brain injury event like a fall, a motor vehicle accident, or being near an explosion, then an additional more detailed questionnaire will open and be reviewed by a clinician. This tool will be used to "catch up" the entire Army by screening for TBI at the time of an annual health assessment. In addition, we will be using the recently revised Post Deployment Health Assessment (PDHA) (DD Form 2796) and Post Deployment Health Reassessment (PDHRA) DD Form 2900) as specified by Health Affairs. These revised forms include several TBI screening questions that have been recommended by the Defense Veterans Brain Injury Center (DVBIC) and other subject matter experts. Concurrently, we are compulsively performing TBI screening for Soldiers in theater following blast exposure even when no other wounds or injuries have occurred. We published an ALARACT, "Documenting Blast Exposure/Injury in Theater Medical Records" (15 June 2007) requiring documentation of exposure in the electronic health record (AHLTA–T), mandating specific International Classification of Disease (ICD–9) codes, and requiring the use of the Military Acute Concussion Evaluation (MACE) template.

This Blast ALARACT builds on the increased awareness and improved identification of Soldiers with potential TBI from the ALARACT published 27 July 2006, "Concussion in Soldiers on the Battlefield". The Concussion ALARACT delineated the signs and symptoms of concussion and provided guidelines for Commanders and staff to determine when to refer Soldiers for medical evaluation. In addition, we have recently initiated pre-deployment baseline neurocognitive testing of several deploying units, including the 101 st Airborne Division and the 1st Armor Division. We are using the Automated Neuropsychological Assessment Metrics (ANAM) TBI Battery as the instrument of choice at this point in time as the ANAM has military norms based on over 9000 Soldiers from Fort Bragg for comparison in the assessment of the Soldier's neurocognitive performance. We have established a process to test large groups of soldiers; transmit and store the baseline test results and subsequent test results on a central server; allow providers in theater and in fixed facilities to access the baseline data remotely and generate a results report; and conduct post-deployment testing. The ANAM output report is designed to meet the needs of primary care providers and will be included in the Soldier's electronic medical record. We are following the DVBIC Clinical Practice Guidelines for theater, specifically using the Military Acute Concussion Evaluation (MACE) immediately after an exposure or injury and using the ANAM if the Soldier is still symptomatic 24 hours

after the injury. Providers at all levels can administer the ANAM to get an objective assessment of cognitive functioning and performance to use in the overall evaluation of a Soldier's condition and to track the Soldier's recovery. In conjunction with the pre-deployment testing, we are providing TBI assessment and management training for providers as well as offering Neurology and Neuropsychology teleconsultation for providers seeking advice and assistance through the DVBIC. The demand for ANAM pre-deployment, post-injury, and post-deployment testing from both the medical unit and line Commanders is growing dramatically. All Service members medically evacuated through LRMC are also screened for TBI using the MACE if their condition permits. Since medically evacuated Soldiers may not receive a Post Deployment Health Assessment (PDHA) prior to departing the combat theater or they may not be in a condition to be screened for TBI at LRMC, I have directed Medical Treatment Facility (MTF) Commanders to ensure that all OIF/OEF medically-evacuated Soldiers receive or have received the following three evaluations: (1) the PDHA; (2) TBI screening and follow-up with a clinician if necessary, and (3) the Post Deployment Health Reassessment (PDHRA).

Traumatic brain injury is a neurologic injury with possible physical, cognitive, behavioral, and emotional symptoms. Like all injuries, TBI is most appropriately and accurately diagnosed as soon as possible after the injury. TBI is not a mental health condition. The range of TBI includes mild, moderate, severe, and penetrating. Well after the injury event, if the TBI was of mild severity and if the symptoms are primarily behavioral and emotional, the co-existence of or distinction from PTSD can be difficult to discern. Certainly some Soldiers have both residual symptoms from a TBI and new or emerging PTSD symptoms. If proper injury documentation is not available, a compassionately obtained description of the traumatic events in theater usually allows a well-trained clinician to make a distinction between TBI and PTSD or other mental health conditions. We are committed to the earliest identification and documentation of TBI. We provide education for our providers prior to deployment and while in theater. We are implementing a mandatory standardized web-based TBI training program for all health care professionals to include clinical support personnel.

Mr. MCHUGH. Recent emphasis on traumatic brain injury suffered by service members in Iraq and Afghanistan has raised the awareness of Congress and the American public to this often deceptive medical condition. What mechanisms does each of you have in place to identify TBI in redeploying service members, including those who are not obviously wounded or injured? How are military health providers distinguishing TBI from other mental health conditions, such as PTSD? What additional resources do you need to identify and treat TBI?

Admiral ARTHUR. As military spokesperson for consolidation of Traumatic Brain Injury (TBI) initiatives in the DOD and DVA, I am gravely concerned about our ability to diagnose and treat TBI, particularly the mild to moderate forms of TBI that may not be immediately apparent on initial examination. TBI in personnel who are exposed to a blast but do not suffer other demonstrable physical injuries is particularly difficult to detect. Redeploying servicemembers who have suffered such injuries may later manifest symptoms that do not seem to have a readily identifiable cause, with potential negative effect on their military careers. As many as 20% of injured servicemembers may have TBI as an additional diagnosis.

Navy Medicine uses a validated clinical assessment tool, the Military Acute Concussion Evaluation (MACE), in field settings to detect neuropsychological sequelae to blast exposure. MACE is used in assessing all concussion type injuries, including blast. Our standardized Emergency Treatment Record, that is a part of the Joint Trauma Registry, also has a series of screening questions about blast exposure and concussion symptoms. In October 2006, we deployed field devices at Navy Medicine Echelon II trauma facilities for neurotologic auditory-vestibular evaluation. We are actively pursuing full roll-out of a field tested computerized assessment, the Automated Neuropsychological Assessment, which can be administered via a hand-held device. In spite of these advances, much needs to be done to ensure that screening is comprehensive and accurate.

TBI often exists in the context of polytrauma, including psychological trauma, and its symptoms may overlap with those of behavioral disorders or diagnoses, such as Post Traumatic Stress Disorder (PTSD). Although PTSD is a less common problem than other psychological disorders such as depression or anxiety, it is a significant concern in our population. We screen all redeploying servicemembers for symptoms of combat stress on our Post Deployment Health Assessment/Reassessment devices. Those whose responses suggest some distress are referred for full evaluation. All returning combatants treated in our military treatment facilities receive a psychological evaluation to detect for comorbid symptoms of emotional disorders in conjunction with other injuries.

We urgently require research to better understand the etiology of TBI resulting from blast, as evidence suggests the resulting symptoms differ from those resulting from TBI from other injuries. We must examine universal pre-screening to assess for baseline levels of cognitive function. Clinically usable, hand-held computerized devices will also require significant test and development. On the treatment side, we have identified needs across all echelons of care, from enhanced recognition at the point of injury through definitive rehabilitative care. We have significant gaps in care when critically short critical specialty providers are required and we lack the capability to provide for a continuum of care for servicemembers and their families in all locations.

Mr. MCHUGH. Recent emphasis on traumatic brain injury suffered by service members in Iraq and Afghanistan has raised the awareness of Congress and the American public to this often deceptive medical condition. What mechanisms does each of you have in place to identify TBI in redeploying service members, including those who are not obviously wounded or injured? How are military health providers distinguishing TBI from other mental health conditions, such as PTSD? What additional resources do you need to identify and treat TBI?

General ROUDEBUSH. Screening patients for TBI can be challenging, especially when not accompanied by obvious physical injury. Airmen with moderate, severe, or penetrating brain injury are readily identified, entered into the Defense Veterans Brain Injury Center (DVBIC) registry, and treated according to established protocols. All service members aeromedically evacuated from theater are screened for TBI using a questionnaire developed at Landstuhl Regional Medical Center (LRMC). In addition, all airmen returning from deployment complete both a Post-Deployment Health Assessment (PDHA) within 30 days and a Post-Deployment Health Re-Assessment (PDHRA) at 3–6 months. Specific TBI screening elements are being added to each.

It is important when treating patients with mild TBI or PTSD to begin therapy early and it is possible to see patients with elements of both conditions. To distinguish between mild TBI and PTSD, our providers use clinical symptoms, physical examination, imaging studies (x-rays, CT scans, MRIs) and neuro-psychologic testing.

Mr. MCHUGH. In your written statements you mention the health care professionals who are deployed in support of our troops in the field. Between the Army and the Navy close to 16,000 medical personnel are deployed around the world on any given day. At the same time military medical personnel are working in military treatment facilities caring for our troops, their families and our retired beneficiaries. DOD and the military Services have testified on many occasions regarding the need for rotation policies for deploying troops. I am wondering about the rotation policy for medical personnel. Please describe the deployment policies each of you have for military medical personnel in support of OIF and OEF. How many medical personnel have been deployed once, twice, three times or more? Given the challenges in recruiting and retaining medical personnel, how long will you be able to sustain your current deployment policies?

General POLLOCK. We have various deployment policies under which Army Medical Department (AMEDD) personnel deploy.

MEDCOM MEDICAL AUGMENTATION Replacement Policy—all Medical Corps (MC) Dental Corps (DC) and Army Nurse Corps (AN) 66Fs (Nurse Anesthetists) in an Individual Augmentee (IA) or Medical Augmentee status will deploy for 180 days (90 days if the filler is an MC Program Director).

180-day AMEDD PROFIS Replacement Policy (APRP)—MC and DC (select AOCs) and 66Fs in a PROFIS or IA status at Echelons Above Division (EAD) units deploy for 180-days.

90-day Program Director Policy—Medical Corps Graduate Medical Education Program Directors in a Professional Officer Filler System (PROFIS)/IA status at EAD units will deploy for 90-days.

DA Policy—All other AMEDD, PROFIS/IA, TCS or assigned permanent party will deploy 15 months/until mission complete.

90-day Boots on the Ground—Reserve component MC, DC and Nurse Anesthetists (not in leadership positions) in an assigned status will deploy/mobilize for 90 days (boots on the ground, 120 days door-to-door).

DA Policy—All other AMEDD in an assigned status will deploy/mobilize for 365 days.

Mr. MCHUGH. In your written statements you mention the health care professionals who are deployed in support of our troops in the field. Between the Army and the Navy close to 16,000 medical personnel are deployed around the world on any given day. At the same time military medical personnel are working in military treatment facilities caring for our troops, their families and our retired beneficiaries.

DOD and the military Services have testified on many occasions regarding the need for rotation policies for deploying troops. I am wondering about the rotation policy for medical personnel. Please describe the deployment policies each of you have for military medical personnel in support of OIF and OEF. How many medical personnel have been deployed once, twice, three times or more? Given the challenges in recruiting and retaining medical personnel, how long will you be able to sustain your current deployment policies?

Admiral ARTHUR. There are three parts to Navy Medicine's deployment policy for medical personnel deployed away from Navy medical facilities in support of OIF/OEF. First, they should be onboard at least six months prior to deploying; second, they should return from deployment within 6 months of their PRD; and third, there should be 365 days dwell time after returning from a deployment. We strive to ensure that all qualified personnel have deployed once before we order someone to deploy twice.

Based on the FY06 OSD (Health Affairs) Tri-Service study, 14,677 (13,020 Active and 1,657 Reserve) Navy medical personnel were deployed to OEF/OIF. Of the 13,020 Active deployers, 9,451 (73%) were deployed once and 3,569 (27%) were deployed more than once. Of the 1,657 Reserve deployers, 1,430 (86%) were deployed once and 227 (14%) were deployed more than once. We plan to request this study be updated with FY07 data.

Based on current operational tempo, we expect to average 2,500 medical deployments per year to CENTCOM. About half, or 1,250, will be sourced from our medical facilities. We continue to closely monitor some high demand communities such as, surgery, mental health, preventive medicine and independent providers (nurse practitioners, independent duty corpsman and physician assistants).

Mr. MCHUGH. In your written statements you mention the health care professionals who are deployed in support of our troops in the field. Between the Army and the Navy close to 16,000 medical personnel are deployed around the world on any given day. At the same time military medical personnel are working in military treatment facilities caring for our troops, their families and our retired beneficiaries. DOD and the military Services have testified on many occasions regarding the need for rotation policies for deploying troops. I am wondering about the rotation policy for medical personnel. Please describe the deployment policies each of you have for military medical personnel in support of OIF and OEF. How many medical personnel have been deployed once, twice, three times or more? Given the challenges in recruiting and retaining medical personnel, how long will you be able to sustain your current deployment policies?

General ROUDEBUSH. Air Force medics deploy following the Air Expeditionary Forces (AEF) construct. The AEF involves deployment of personnel for 4 months, followed by 16 months at home station (**there are exceptions, particularly with those deploying in support of Army missions that have longer deployment cycles**). Non-traditional taskings extending up to a year or longer have to be worked outside of the AEF construct.

Since 2003, 25.5 percent of our medics have deployed. Of those deployers, 8 percent have deployed twice and one percent have deployed three times. Some service members have deployed as many as 8 times but most do so voluntarily. We continue to monitor our personnel being deployed, its impact on our members and their families, and our recruiting and retention. At this time, we believe we can sustain our AEF rotation policy for the foreseeable future.

Currently we have 1,464 Air Force medics deployed around the world. DHP medical assets are also assigned to garrison and are heavily involved in providing direct beneficiary care every day. When one looks at Service-specific deployed DHP (only) medical assets, Air Force, Army and Navy are almost equal in their contributions to supporting GWOT operations (see chart below).

Military Medical Service Deployment History

Billets with Program Element Codes = Defense Health Program

Service	Estimated Full Time Equivalents				
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Army	369	1,419	1,139	1,147	1,375
Navy	39	1,952	882	908	1,205

Military Medical Service Deployment History—Continued

Billets with Program Element Codes = Defense Health Program

Service	Estimated Full Time Equivalents				
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Air Force	1,078	1,275	1,105	1,141	1,134

ASource OSD/HA

QUESTIONS SUBMITTED BY MRS. BOYDA

Mrs. BOYDA. We hear that funding for TBI research has been cut back. Can you address that? Do you know anything about that? Is that true? And is there something that Congress can do?

General POLLOCK. Army core research programs on Traumatic Brain Injury (TBI) did not suffer a cut in funding in Fiscal Year 2007. Congress expressed some concern that the Defense and Veterans Brain Injury Center (DVBIC), a major contributor to military TBI initiatives both clinical and research, would lose funds as the result of an organizational realignment. The Defense Appropriations Act for FY06 directed the transfer of the full amount of DVBIC funds from the Uniformed Services University of Health Sciences (USUHS) to the US Army Medical Research and Materiel Command (MRMC). This transfer of funds coincided with DVBIC's move from USUHS to MRMC. Additionally, in FY06 MRMC provided the DVBIC approximately $12M of Defense Health Program funding, including congressional adds. In FY07, MRMC provided $19.8M of DHP funding. Research on traumatic brain injury and the effects of blast injuries is a high priority for MRMC and the Army. We will continue to dedicate resources to this critical research.

QUESTIONS SUBMITTED BY MRS. DAVIS OF CALIFORNIA

Mrs. DAVIS. I wanted to ask you about the article in the New York Times Magazine the other day by Sara Corbett. I don't know if you happened to see that about women in combat and women in theater and the impacts of PTSD on women, particularly as primary care givers, but also some of the instances that were cited in the article, abuse to women in theater and how that is being dealt with and how the services are providing the kind of care and support that the women need and being certain that they get that while in theater and then they certainly get that when they return home.

Could you speak to that?

General POLLOCK. Sara Corbett's Article "The Women's War" published in The New York Times Sunday Magazine 18 March 2007 is a thoughtful, balanced, and detailed examination of unique problems facing some service women today. The Iraq war has seen unprecedented numbers of female Soldiers serving with many Combat Service and Service Support units. As the article highlights, both the military and Department of Veterans Affairs are devoting increasing attention to the unique problems of female service members. More attention needs to be given to studying the effects of combat on our female warriors. The development of effective treatment programs tailored to women should be a priority for our military Behavioral Health community.

The Army takes the issues of Sexual Harassment and Sexual Abuse very seriously and has set up an extensive program to encourage victims of harassment or sexual assault to seek help. The Army's Sexual Assault Prevention and Response Program (SAPR) provides confidential victim advocates who diligently work with victims to provide them with treatment resources and support. Annual training on the SAPR is required for all military personnel. A detailed explanation of the Army program can be found at: http://www.sexualassault.army.mil/.

In regard to the noted increase in reporting since the initiation of the SAPR program, we feel this is a positive development. It has long been understood that when one pays attention to a problem by encouraging reporting and offering protection to those who report, the rates of reporting will rise. This increase therefore likely reflects victims who previously did not report, rather than an actual increase in assaults. While no one believes we are reaching 100% of the victims of sexual assault, early intervention and the support of victim advocates are helping many women recover.

On the issue of PTSD, there has long been demonstrated a significant gender difference in willingness to seek help between males and females, with female personnel more open to doing so. Our data from the Mental Health Advisory Team studies do not show any gender difference, but more research needs to be done.

The Department of Defense is currently engaged in unprecedented efforts to find and help service members adversely affected by their deployment experiences. The Post-Deployment Health Assessment given immediately upon re-deployment and the Post-Deployment Health Re-Assessment, given 90–180 days after re-deployment bring soldiers into direct contact with Behavioral Health personnel and give them the opportunity to obtain immediate assistance. Additionally the physical examination process has been revised to a Periodic Health Assessment, which also looks for evidence of depression, anxiety or substance abuse. Although more can and needs to be done in this area, the Army is aware of the challenges faced by both male and female Soldiers and is doing everything possible to ensure their needs are met.

Mrs. DAVIS. I wanted to ask you about the article in the New York Times Magazine the other day by Sara Corbett. I don't know if you happened to see that about women in combat and women in theater and the impacts of PTSD on women, particularly as primary care givers, but also some of the instances that were cited in the article, abuse to women in theater and how that is being dealt with and how the services are providing the kind of care and support that the women need and being certain that they get that while in theater and then they certainly get that when they return home.

Could you speak to that?

Admiral ARTHUR. In reference to the article titled "The Women's War", the following comments are provided on Navy Medicine's efforts for providing medical care for the physical and psychological sequelae of women serving in the Navy and Marine Corps as a result of combat experience.

Navy Medicine seeks to proactively address the broad range of combat and operational stress injuries, to include PTSD, in a number of ways. In November 2006, Navy Medicine established a directorate at the Bureau of Medicine and Surgery led by an experienced combat stress psychiatrist specifically dedicated to addressing mental health stigma, combat stress training needs, non-stigmatizing care of returning deployers, and support services for Navy caregivers. Other efforts include prevention, outreach, and early intervention to warfighters using Navy mental health providers trained in clinical best-practices related to combat and operational stress control. One specific example is Operational Stress Control and Readiness teams providing early intervention, outreach, and prevention at the unit levels in close proximity to operational missions in order to reduce stigma that can be encountered in conventional mental health care settings.

Navy Medicine plans to utilize existing data sets to study combat stress and gender. Naval Health Research Center's Millennium Cohort Study is addressing a variety of combat-related behaviors in both men and women. Additionally, the first phase of the Navy's in-theater Behavioral Health Needs Assessment (BHNAS) is complete, and analysis of gender differences associated with deployment stress is currently underway.

Service Members returning from deployment are screened using the Post Deployment Health Assessment (PDHA–DD Form 2796). A review of 261,008 PDHA forms completed from January 2003 to present demonstrate that 2.2% of male Marines and Sailors were referred for mental health services, compared to 2.6% of returning female Marines and Sailors (Defense Medical Surveillance System, 19 June 2007).

Researchers from Walter Reed Army Institute of Research (Hoge et. al., 2007) have reviewed recent studies of military personnel with service in Iraq and Afghanistan, and reported that "military duty in Iraq confers a similar risk of [Post Traumatic Stress Disorder] and depression by gender." The authors suggest that risk for developing significant combat stress disorders is a factor of intensity and frequency of combat exposure, rather than gender (Hoge CW, Clark JC, Castro CA. Commentary: Women in combat and the risk of post-traumatic stress disorder and depression. International Journal of Epidemiology 2007).

The issue of compassion fatigue among Navy Medicine personnel is also of significant interest. Navy Medicine has established a Care for the Caregiver mandate in order to address this concern. Assessment of operational and occupational stress of medical personnel, to include focus groups, will begin in summer 2007.

Mrs. DAVIS. I wanted to ask you about the article in the New York Times Magazine the other day by Sara Corbett. I don't know if you happened to see that about women in combat and women in theater and the impacts of PTSD on women, particularly as primary care givers, but also some of the instances that were cited in the article, abuse to women in theater and how that is being dealt with and how the services are providing the kind of care and support that the women need and

being certain that they get that while in theater and then they certainly get that when they return home.

Could you speak to that?

General ROUDEBUSH. The Air Force is concerned about all Airmen with trauma-related mental health problems, regardless of gender. We have procedures to guide base helping agencies as they assist Airmen who are transitioning back to their home station from deployment. These procedures include education on the recognition of PTSD signs and symptoms and where to go for help. Upon redeployment and then 3 to 6 months later, we ask Airmen to complete a survey describing their current health status. This survey includes questions about PTSD; when Airmen screen positive, they are referred to their primary care provider for further evaluation and, if indicated, onto a mental health specialist. Ms. Corbett makes note of Dr. Edna Foa's Prolonged Exposure Therapy for the treatment of PTSD. I am pleased to tell you that the Air Force brought Dr. Foa to a number of our bases to train mental health professionals in her evidence-based treatment. To date, she has trained 100 mental health professionals. We are working with her currently to have her provide training to an additional 300 professionals. We are also working with Dr. Patricia Resick, another one of our Nation's top PTSD clinician/researchers. Dr. Resick will be providing training in her Cognitive Processing Therapy, the other main evidence-based treatment for PTSD.

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