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THE STATUS OF THE IMPLEMENTATION OF THE ARMY'S MEDICAL ACTION PLAN AND OTHER SERVICES' SUPPORT FOR WOUNDED SERVICE MEMBERS

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THE STATUS OF THE IMPLEMENTATION OF THE ARMY'S MEDICAL ACTION PLAN AND OTHER SERVICES' SUPPORT FOR WOUNDED SERVICE MEMBERS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Friday, February 15, 2008.

The subcommittee met, pursuant to call, at 10 a.m., in room 2212, Rayburn House Office Building, Hon. Susan Davis (chairwoman of the subcommittee) presiding.

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

Mrs. DAVIS. Good morning everyone. Thank you for being here with us today. The purpose of the hearing today is for members to get an update on the implementation of the Army Medical Action Plan (AMAP) for—are we calling that AMAP?—and hear how the Navy, Marine Corps, and Air Force are caring for their wounded warriors.

At our last hearing on this subject, back in June of last year, the Army's Vice Chief of Staff, General Cody, suggested that we have him back in October and January to testify on the progress of AMAP toward full operational capability. Unfortunately, he is not able to join us this morning. I believe he is just on his way back from Iraq. But we are going to push forward and learn how far the AMAP has come and how far it still has to go.

I want to also be clear that while we have spent a great deal of time focusing on the Army, we also are concerned about the Navy, the Marine Corps and the Air Force and how they are insuring that their wounded warriors and their families receive the appropriate care and the support needed.

The subcommittee started to raise concerns about the quality and completeness of care provided to wounded warriors back in 2005 and we will certainly continue to focus on this issue.

This hearing marks the first time that Vice Admiral Adam Robinson, Surgeon General of the Navy, has come before our panel. Welcome, sir. I am very happy to have you here.

I also wanted to mention that while we have had these Army leaders testify about Walter Reed Army Medical Center before this subcommittee previously, today they are here in new roles.

Lieutenant General Eric Schoomaker, formerly the Commander of the North Atlantic Regional Medical Command in Walter Reed Army Medical Center, became the Army's new Surgeon General in December.

And Brigadier General Michael Tucker, formerly the Deputy Commander of the North Atlantic Regional Medical Command in Walter Reed Army Medical Center, is now the Army's Assistant Surgeon General for Warrior Care and Transition.

In his opening statement last year, at the last hearing on this subject, Dr. Snyder remarked on the power of focus and about how true the revelations at Walter Reed and its aftermath almost all involved parties, including our wounded soldiers, family members, commissioners and advocates, and nothing but good things to say about the quality of inpatient care wounded soldiers have received at military hospitals.

The Army Medical Action Plan has strived to set up new focus, a new structure to focus on the unmet needs of wounded warriors so that hospitals could continue their focus on patient care.

Our challenge and our responsibility is to make certain that the military as a whole, and not just the military health care system, remains focused on the recovery and the rehabilitation of our wounded soldiers and their families, and that is what we are really here to do today and to see how that progress has occurred.

I want to turn the meeting over to Mr. McHugh, also, for an opening statement.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 45.]

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

Mr. MCHUGH. Thank you very much, Madam Chairman.

I would ask that my prepared statement be entered in its entirety in the record and in the interest of time, let me just make a couple of comments.

First of all, I want to add my words of welcome to our distinguished panelists this morning. As you noted, Madam Chair, we both appreciate and look forward to their participation here today, but more importantly, for the leadership and the concern they bring on behalf of all of us toward those who have worn the uniform and who have given so much in service to their country.

I think we have come a long way. I think, as the chair noted, with respect to the Army, the AMAP plan has begun to address, with some good efficacy, the challenges and problems we saw arising out of Walter Reed.

I think as you look at the other services, as well, notably the Air Force and the Navy, their programs are striving in directions that portend a lot of progress and a lot of help for those who need it.

I do think there are challenges that remain, some disturbing developments through the warrior transition units, that we look forward to General Schoomaker's comments upon, from a parochial perspective, some recent press reports with respect to the transitioning and the working of the veterans' benefits administrators and assistance providers and the Army at Fort Drum.

So we have tried to address those, but I am looking forward to General Schoomaker talking on a bit broader basis about those, as well.

So our interest, our concerns are all similar here and that is to do everything that is necessary, everything that certainly is appropriate and more to pay back in some small way those who find themselves in medical need after serving so proudly in the uniform of this Nation.

So thank you again, gentlemen, not just for being here, but for what you do, and we look forward to your testimony.

With that, Madam Chair, I would yield back.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 48.]

Mrs. DAVIS. Thank you, Mr. McHugh.

General Schoomaker, if you want to begin and we will go down the line, and then we will have plenty of time for questions.

Thank you, gentlemen, once again for being here.

STATEMENT OF LT. GEN. ERIC B. SCHOOMAKER, THE SURGEON GENERAL OF THE UNITED STATES ARMY, AND COMMANDER, U.S. ARMY MEDICAL COMMAND, U.S. ARMY; BRIG. GEN. MICHAEL TUCKER, ASSISTANT SURGEON GENERAL FOR WARRIOR CARE AND TRANSITION, U.S. ARMY; VICE ADM. ADAM M. ROBINSON, SURGEON GENERAL, U.S. NAVY; LT. GEN. (DR.) JAMES G. ROUDEBUSH, SURGEON GENERAL, U.S. AIR FORCE

STATEMENT OF LT. GEN. ERIC B. SCHOOMAKER

General SCHOOMAKER. General Tucker and I have a single statement for the Army.

Chairwoman Davis, Congressman McHugh and distinguished members of the subcommittee, thank you for providing the joint medical service Surgeon General and my Assistant Surgeon General and colleague, Brigadier General Mike Tucker, and me the opportunity to discuss warrior care and for us to discuss the total transformation that the Army is undergoing in the way we care for soldiers and families.

And, ma'am, I noted in your introductory comments that your focus is on our services and how we as an entire service are focused on that, and I would like to talk about that here today.

We as an Army are committed to getting this right and to providing a level of care and support to our warriors and families that is equal to the quality of their service.

February 18, 2007, almost a year ago to the day, is the day that a series of "*Washington Post*" stories began about problems in the care that were provided soldiers and their families at one of our premier medical centers.

It was a day that the Army will not soon forget. It was a painful day for us, as a proud institution, Army medicine, which truly prides itself in looking out for each other and for our brothers and sisters in arms.

But because of those revelations and the strong response of Army leaders by our Secretary of the Army, Pete Geren, our Chief of Staff, General George Casey, and our Vice Chief of Staff, General Cody, we truly are a better Army today with respect to how we care for our soldiers.

The Army remains committed to continuing to improve our care and support for those who have borne the battle and for their loved ones. We have instituted a comprehensive Army Medical Action Plan that you alluded to earlier, with which I believe all of you are familiar.

While we are continuing to move forward, I would like to highlight a few of our accomplishments as part of this truly unprecedented effort.

We now have more than 2,400 soldier leaders, 2,400 soldier leaders assigned as cadre to 35 warrior——

Mrs. DAVIS. Excuse me, General, if you could just bring the mike a little bit further. I think they were having a little trouble hearing you.

General SCHOOMAKER. Yes, ma'am. Is that better?

Mrs. DAVIS. Thank you.

General SCHOOMAKER. That is about as close as I can get it.

Mrs. DAVIS. We can hear you just fine here, but I think they were having trouble in the back.

General SCHOOMAKER. We now have more than 2,400 soldier leaders assigned as cadre to 35 warrior transition units, small units that exist throughout the Army today, collocated with our medical treatment facilities, that did not exist last February.

This is 2,400 small unit leaders in jobs where last year at this time we had fewer than 400 cadre for about the same number of patients, many with very complex injuries and illnesses.

The most significant feature of these warrior transition units is a triad, which consists of a primary care physician, a nurse case manager and the squad leader, where they work together to attend to the needs of each individual and the family.

The regular meetings and coordination between every leg of this triad really creates a web of overlapping responsibility and accountability that embraces every warrior for the duration of their treatment, their recovery and their rehabilitation, and then transition back into uniform and service or fully recover back into a productive civilian life or into continued care and rehabilitation in the Veterans Administration (VA) or into our network of private health care.

Our squad leaders, many of them are combat arms soldiers and former patients themselves, are trained and responsible for the well being of a small group of warriors in transition in their squad, just like any other Army unit.

In the room today, if I might, ma'am, I would like to introduce four of the warrior transition brigade small unit leaders at Walter Reed today. Colonel Terran McKendrick is a career infantryman who has the distinction of having stood up the first warrior transition unit in the Army. He and his Command Sergeant Major, Jeff Hartless, who is with him here today; Major Steve Gventer, one of our company commanders and First Company Commander in the Walter Reed warrior transition brigade; and, his First Sergeant, Matthew Dewsberry, are here with us today and I would just like to acknowledge them and the terrific work that all of them have demonstrated here.

These are the soldiers who really wrote the doctrine, wrote the training courses and taught us how to do this right, and I would like to thank them for being here today.

Thank you, gentlemen.

Mrs. DAVIS. Thank you.

General SCHOOMAKER. All four are combat tested leaders. They spend their busy day looking out for the best interests of their wounded, ill and injured soldiers. Two, in fact, have been wounded themselves in combat and were patients at Walter Reed. So they have tremendous insight into what could make that place work better and what they felt worked well for them and their families.

In less than one year, and this is noteworthy, in less than one year, the Army has funded, staffed and written the doctrine to establish these new organizations.

It is a significant change and it is the backbone of our Army Medical Action Plan.

Another improvement in the care of the soldiers is that a year ago, our wounded, ill and injured believed that their complaints were falling on deaf ears within the Army. Now, we have established a medical command-wide ombudsman program, with ombudsmen at 26 of our installations across the Army and we are hiring more every day.

Everyone at our treatment facilities knows who the ombudsmen are, they know how to find him or her. Many are retired NCOs, non-commissioned officers, or officers themselves with medical experience. They work outside of our chain of command, but they have direct access to the hospital commander, to the garrison commander, to the installation senior mission commander, to get problems fixed.

We have also established a 1–800 wounded soldier and family hotline, and I would draw your attention to a card that you have here. I encourage you to take it back with you.

In fact, we hand them out as often as we can to people who are interested in this, and Congressman McHugh may be interested, but when we worked with the VA recently in putting together our memorandum of understanding, we actually gave them these and they are setting up a similar hotline for the VA to solve problems for soldiers and families on the fly.

They can share concerns through this 1–800 line 24 hours a day about any aspect of their care or administrative concerns. We have fielded in excess of 7,000 calls to date and we answer that call and find a solution for them and get the process going to get it ultimately fixed within 24 hours.

Over the last year, we have developed multiple feedback mechanisms so that we can see ourselves from a variety of perspectives. This is one of the things that the "*Washington Post*" stories taught us, that we weren't seeing the full picture.

To accomplish this, we monitor and evaluate our performance through 18 internal and external means, including the ombudsmen and the hotline that I mentioned earlier.

We also use a contracted industry leader in patient surveys to provide us a very granular view of how our patients and families feel we are doing for them.

We host numerous visits from Members of Congress and your staff. In January alone, we opened our warrior transition unit doors to more than a dozen congressional visits.

These visits give us a valued external perspective and allow us the opportunity to be as open and as transparent in our operations as possible, and, quite frankly, your feedback on these visits and your staff's feedback has been instrumental in our success, and we extend our appreciation for that.

As you well know, despite these successes there is much progress still to be made. We still need more research into psychological health and traumatic brain injury.

Congress jumpstarted us last year with supplemental funding for both research and care, for which we are truly grateful, but research needs to be our continuing priority effort.

We must continue to look into the physical disability evaluation system and the ways to make it less antagonistic, more understandable and more equitable for soldiers and their families, and more user-friendly.

I can tell you that one of the most difficult aspects of being the commander at Walter Reed and going through this troubled period was as a physician who spent his career trying to help patients, standing in front of town hall meetings with patients and families and feeling that I was the enemy, that I wasn't there to help them, that I was hurting them in some aspect, and I would submit that that is a direct outgrowth of our divisive and antagonistic physical disability evaluation system between the Department of Defense (DOD) and the VA.

I believe that the pilot program that we have started in the National Capitol region is a good start, but I want to continue to pursue changes in the disability evaluation system as aggressively as possible and to get legislative relief for a single disability adjudication.

We need your continued support so that we can move forward together in 2008 as we have in 2007. This year's National Defense Authorization Act was very consistent with how the Army is approaching wounded warrior matters.

I truly appreciate the flexibility you provided us to develop policies and to achieve solutions and not to micromanage details of how we do that and how we develop and grow our warrior transition units.

Your bill not only helps our warriors, it helps our families, it helps health care providers in caring for them, and we truly thank you for the time you took to listen to us and to work with us.

The Army's unwavering commitment and a key element of our warrior ethos is that we never leave a soldier behind on the battlefield or lost in a bureaucracy. We are doing a better job of honoring that commitment today than we were at this date last year.

In February of 2009, I want to come back to you and report that we have achieved a similar level of progress as we have over this last year. I am proud of Army medicine's efforts over the last 232 years and especially over the last 12 months to help our warriors and their families.

I am convinced that, in coordination with the Department of Defense, my colleagues here at the panel today, the Department of Veterans Affairs, and the Congress, we have turned the corner.

Thank you for holding this hearing. Thank you for your continued support of our warriors and their families. We are truly honored to serve them.

I look forward to your questions.

[The joint prepared statement of General Schoomaker and General Tucker can be found in the Appendix on page 50.]

Mrs. DAVIS. Thank you.

Admiral Robinson.

STATEMENT OF VICE ADM. ADAM M. ROBINSON

Admiral ROBINSON. Good morning. Thank you, Chairwoman Davis, Ranking Member McHugh, and distinguished members of the committee.

Your unwavering support of our service members, especially those who have been wounded during Operations Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), is deeply appreciated.

In the last year or so, the interest and concern about the care and support being provided to our service members when they return from combat has increased dramatically.

From those with severe injuries to those whose significant injuries may not be visible to the naked eye, our Nation is providing care to a generation of veterans unlike those from previous conflicts.

For Navy medicine, the progress a patient makes from definitive care to rehabilitation and in the support of lifelong medical requirement is the driver of where a patient is clinically located in the continuum of care.

Medical and administrative processes are tailored to meet the needs of the individual patient and their family, whatever that may be. For the overwhelming majority of our patients, their priority is to locate their care as close to home as possible.

We learned early on that families displaced from their normal environment in dealing with a multitude of stressors are not as effective in supporting the patient in his or her recovery.

Our focus is to get the family back to normal or as close as we can possibly get it as soon as possible, which means returning the patient and their family home to continue the healing process.

Navy medicine takes into consideration family dynamics from the beginning and they are looked on as part of the care team. Their needs are also integrated into the care plan. They are provided with emotional support by encouraging the sharing of experiences among other families, that is, family-to-family support, and access to mental health services.

Also, families receive assistance dealing with administrative issues when necessary through the Marine Casualty Services Branch. I may say that we also have Army and Air Force liaisons that do the same thing.

One of the cornerstones of Navy medicine's concept of care is to capitalize on our longstanding and effective partnership with the Marine Corps in caring for injured and ill Marines. The Marine

Corps has always maintained a presence in our medical treatment facilities in the form of a Marine Corps liaison office staffed with Marine Corps personnel and Administration experts.

At the outset of OEF/OIF, the Marine Corps quadrupled the size of their liaison offices at key casualty receipt locations, anticipating the increased volume and the unique needs of this patient population and their families.

Working side by side with Navy medicine providers, the recently established wounded warrior regiment, in April of 2007, made Marine liaisons available immediately to the patient, their family and the clinical care team.

Navy medicine takes care of the patient's clinical needs and the wounded warrior regiment becomes an optimizing adjunct to the patient care plan.

Based on a concept of care of Marines taking care of Marines, the Wounded Warrior Regiment has ensured that the care provided to our wounded, ill and injured is not just a process, but a relationship with lifelong care.

Like the Wounded Warrior Regiment, Navy established a safe harbor program in 2005 to meet the needs of severely injured sailors from OEF/OIF. It is expected that approximately 250 sailors each year will need the services provided by this program, which will include non-clinical case management for the sailors and their families.

Safe harbor case managers are actively collecting feedback from program participants to closely monitor the program's successes and to make improvements where needed.

In Navy medicine, we have established a dedicated trauma team, as well as a comprehensive multidisciplinary care team, which works to maximize the interface with all of the partners involved in the continuum of care.

To move patients closer to home requires a great deal of planning, interaction and coordination with providers, case workers, and other health care professionals to ensure smooth movement across the continuum of care.

Our single trauma service admits all OEF/OIF patients with one physician serving as the point of contact for the patient and for their family.

Other providers serve as consultants, all of whom work on a single communication plan. In addition to providers, other key members of the multidisciplinary team include the service liaisons at the MTFs, the medical treatment facilities, the VA health care advisors, and the military service coordinators.

We also expanded our nurse case management capabilities, increasing the number of case managers from 85 in 2006 to 148 funded positions today. In addition, VA has established liaison offices at Navy hospitals and at Navy clinics for the purposes of coordinating follow-on care requirements and providing education on VA benefits.

Also, the newly created Federal recovery coordinators are located at National Naval Medical Center (NNMC) and Naval Medical Center San Diego.

The lessons learned at Bethesda, NNMC, the Navy facility that has treated most returning casualties, have been exported to other facilities, both in and out of the Navy, involved in casualty care.

The development of these lessons was a collaborative effort to improve processes and outcomes. Currently, weekly teleconferences between our hospitals, between NNMC and Balboa and others and the VA polytrauma rehabilitation centers is ongoing to ensure continuity of care.

One key issue for patients requiring care at another facility is the physical transition of leaving the protective environment of an acute care facility and moving to a rehabilitative environment.

When a patient is headed to a VA facility, there is significant coordination between the military, the VA liaison and the transferring Navy medicine MTF, medical treatment facility, and the electronic copies of medical records are transferred to the receiving facility.

We continue to make significant strides toward meeting the needs of military personnel with psychological health needs and traumatic brain injury related diagnoses, their families and their caregivers.

Service members who return from deployment and have suffered such injuries may later manifest symptoms that do not have a readily identifiable cause, with potential negative effects on their military careers and, of course, on their quality of life and most directly on their families.

Our goal is to establish comprehensive and effective psychological health and traumatic brain injury services throughout Navy and Marine Corps. This effort requires seamless programmatic coordination across the existing line functions, while working numerous fiscal, contracting and hiring issues.

Your patience and your persistence are deeply appreciated as we work to achieve long-term solutions to provide the necessary care.

Chairwoman Davis, Ranking Member McHugh, distinguished members of the committee, I again want to thank you for holding this hearing and continuing to shed light on these important issues.

Also, it is my pleasure to testify before you today and I look forward to answering any of your questions.

Thank you very much.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 57.]

Mrs. DAVIS. Thank you.

STATEMENT OF LT. GEN. (DR.) JAMES G. ROUDEBUSH

General ROUDEBUSH. Good morning. Madam Chairwoman, Ranking Member McHugh, distinguished members, it certainly is an honor and privilege for me to be here with this distinguished panel, my partners in providing individual and collective joint capabilities to our wounded warriors.

This is indeed important business and it is a pleasure to be here before you today to be able to discuss that with you.

Your Air Force is America's force of first and last resort to guard and protect our Nation. To that end, we Air Force medics—and when I use medics, I use that term broadly—our officers, enlisted,

all professionals within the Air Force Medical Service, we Air Force medics work directly for our line leadership in addressing our Air Force's top priorities—winning our Nation's fight today, taking care of our people and preparing for tomorrow's challenges.

No modern war has been won without air superiority and no future war will be won without airspace and cyberspace superiority. The future strategic environment is complex and uncertain. Be assured that your Air Force and Air Force Medical Service are ready for today's challenges and are preparing for tomorrow's.

It is important to understand that every Air Force base, at home station and deployed, is an operational platform and Air Force medicine supports war fighting capabilities at each of our bases.

Our home station military treatment facilities are the foundation from which the Air Force provides combatant commanders a fit and healthy force capable of withstanding the rigors and physical challenges associated with combat and other military missions today.

Our emphasis on fitness and prevention has led to the lowest disease and non-battle injury rate in history. Deployed forward, the Air Force Medical Service is central to the most effective joint casualty care system in military history.

Forward stabilization followed by rapid air evacuation has been repeatedly proven to be the gold standard in saving lives.

We have safely and rapidly moved more than 48,000 patients from overseas theaters to stateside care during Operation Enduring Freedom and Operation Iraqi Freedom. Today, the average patient arrives from the battlefield to stateside care within three days and, if required, within 18 to 20 hours.

This is remarkable given the severity and complexity of the wounds that our forces are sustaining and has directly contributed to the lowest died-of-wounds rate in history.

The daily delivery of health care at our medical treatment facilities is also critical to maintaining those critical skills that guarantee our readiness capability and success.

We care for our families at home. We respond to our Nation's call supporting our warriors and we also provide humanitarian assistance to countries around the world.

To execute these broad missions, all of our services, Air Force, Navy and Army, must work interoperatively and interdependently. Every day, together, those that you see before you here today, every day, together, we earn the trust of America's all volunteer force, airmen, soldiers, sailors and Marines and their families, and we hold that trust very dear.

Today we are here to address the health needs of our returning warriors. The Air Force is in lockstep with our sister services and Federal agencies to implement the recommendations from the President's commission on the care for America's returning wounded warriors. We will deliver on all those provisions, as well as those set forth in the 2008 National Defense Authorization Act (NDAA) and provide our war fighters and their families the help they need and deserve.

The Air Force Medical Service is focused on the psychological needs of our airmen and reducing the effects of operational stress. The incidence of post-traumatic stress disorder (PTSD) is low in the Air Force, diagnosed at less than one percent of our deployers.

For every airman affected, we provide the most current effective and empirically validated treatment for post-traumatic stress disorder. We have trained more than 200 psychiatrists, psychologists and social workers to recognize and treat PTSD in accordance with the VA/DOD PTSD clinical practice guidelines.

We hired an additional 32 mental health professionals for those locations with the highest operational tempo to enhance the care for our airmen and their families.

The Air Force is also an active partner with the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the VA, the Centers for Disease Control (CDC), industry and academia in collaborating on research in traumatic brain injury prevention, assessment and treatment.

We thank Congress for fiscal year 2007 supplemental funding, which strengthened our psychological health and traumatic brain injury program research, surveillance and treatment. It has improved access, coordination of care and the transition of our patients.

The Air Force wounded warrior program, formerly known as Palace Heart, continues to maintain contact and provide assistance to wounded airmen both on active duty and following separation from the Air Force for a minimum of five years.

We are committed to meeting the health needs for our airmen and their families and will continue to execute and refine those programs.

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

With your help and the help of this committee, the Air Force and partnering with our Navy and Army counterparts and comrades in arms will continue our focus on the health of our war fighters and their families.

Thank you for your enduring support and I look forward to your questions.

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

Mrs. DAVIS. Thank you very much. Thank you for all of your presentations. And you certainly stayed within a good time frame, as well.

What we are going to do, I am going to keep to my five minutes, and I think we can have at least two rounds and all questions from members that are here.

Let me start, General Schoomaker, with you, if I may. And I think that we are impressed by the changes, the response that you all have made and we would hope, certainly, that our men and women who are serving us today are feeling the impacts of the changes that have been made and in a very positive way.

Could you then speak to the sustainability of this effort, both as it relates to our budget and personnel, as well, because we seem to have very high caliber of those who are serving in the capacities

that you have outlined today, and, yet, how can we sustain that effort, as well?

But, first, on budget. Where is this in the budget, in the 2009 budget, and is that, do you think, where it should be?

General SCHOOMAKER. Yes, ma'am, and thank you for that question. I think that is one of the issues that the Army and the Department as a whole is very focused on right now, the sustainability, and many ask what evidence we can present that shows that this is going to be a long-term, sustainable process.

I would answer that in three forms. First of all, we respond in three ways to sustainability. First, through our organizations, do we have tangible evidence in our organizations that we have changed the way we do business.

And I would point to the assistant surgeon general for warrior care and transition who oversees a cell now that is codified in our organization, in the medical command, in the Office of the Surgeon General, as well as the warrior transition units that are embedded within each one of my regional medical commands and medical treatment facilities.

This is——

Mrs. DAVIS. I think, General, does that lie in the base or in the supplemental?

General SCHOOMAKER. Currently, most of the funding to support administratively and the barracks that would be built to support those warrior transition units are in supplemental.

They have been programmed—they have been placed in the Program Objective Memorandums (POMS) of our submissions and proposed supplemental adjuncts for both fiscal year—they went into the fiscal year 2008 budget and I am told they are in fiscal year 2009.

And we have some substantial requests for funding for barracks and the like. That is the second way that we are showing sustainability. And, third, of course, our policies, we are writing formal Army policy and doctrine that will be out there and will drive the way that these organizations and these soldiers are cared for.

Mrs. DAVIS. I think, though, in many ways, if we are thinking of this in an institutional way, we are looking to ask whether or not it should be in the base budget as opposed to the supplemental budget.

General SCHOOMAKER. And, ma'am, I think——

Mrs. DAVIS. Why does that work for you?

General SCHOOMAKER. I think you are echoing the Chief of Staff of the Army, whose challenge it is to migrate more of our funding in the supplemental into the base.

Mrs. DAVIS. More of the supplemental?

General SCHOOMAKER. Into the base.

Mrs. DAVIS. Into the base.

General SCHOOMAKER. Into the Army's base.

Mrs. DAVIS. And the Army has forecasted that it would need about $1.4 billion in fiscal years 2008, 2009 and 2010 to build the warrior transition complexes.

Is this the funding coming, again, out of other medical projects or is it new funding? You mention in the supplemental, but——

General SCHOOMAKER. It is new funding.

Mrs. DAVIS. It is all new funding.

General SCHOOMAKER. It is all new funding, and it is largely being carried not by the medical command, it is carried by the installation management command as a part of the building of our installations.

It provides barrack space, administrative space and all of those areas necessary to house the soldiers and the cadre that are going to be caring for them.

Mrs. DAVIS. Thank you. And if I could quickly just move to personnel and how we can expect the Army to fill the warrior transition unit positions, given the challenges that you face in Iraq and Afghanistan, and grow the Army.

How do we do that?

General SCHOOMAKER. The Army has been very forthcoming. We stood up the warrior transition units in June, and we had full operational capability in early January. We currently stand at in excess of 90 percent of the cadre necessary to run all of our warrior transition units on the documents that were provided, and we are at the projected ratios that we require for squad leaders, for nurse case managers and primary care managers for each one of those warrior transition units right now.

Mrs. DAVIS. In visualizing this and the large number of men and women that are required to fill these positions, I understand it is more than in a brigade combat team. Is that correct? As you look at the E–5s and E–6s or, I guess, the bulk of the 2,500 Warrior Transition Unit (WTU) cadre that are mid-grade and non-commissioned officers.

General SCHOOMAKER. Can you speak to that?

General TUCKER. No, ma'am. Although these are units that are representative of companies, battalions and brigades that we have in the Army, the amount of leadership, comparatively speaking, leader for leader, there are not as many leaders.

I will give you an example. At the lowest level, the squad, the squad leader is a staff sergeant. The 1-to-12 ratio on which we based it was based on FM–7–8, the infantry platoon, a longstanding document in our Army to which we have always based command and control.

In an infantry platoon, however—an infantry squad—excuse me—you have a staff sergeant commanding the squad, as we have in a WTU, but that squad leader also has two team leaders who are sergeant E–5s, and we don't have those sergeant E–5s, because you don't need those sergeant E–5s because it is not a tactically deployed unit.

They break off into rifle teams and deploy, so to speak, tactically. But we have the staff sergeant there where we didn't have the staff sergeant before. Before, we had a platoon sergeant, who, in most cases, was a staff sergeant, but it was 1-to-50. Now we have a staff sergeant 1-to-12.

And so the number of leaders, per se, to soldier in a WTU is not exactly the same numbers you would see in a brigade combat team, ma'am.

Mrs. DAVIS. Will we be able to look at those numbers soon as we would other readiness units, so we can determine the extent to which we have the people that are necessary to fill these positions?

General TUCKER. Yes, ma'am. And just to back up, if I could expound a little bit on it, the squad leader in this case is not standing alone. He has got a nurse case manager, a primary care manager alongside of him, a platoon sergeant to help, as well, and an entire arsenal of other medical care providers that work with the squad leader every day to take care of the social workers, occupational therapists, vocational education specialists, just to add a few that are part of the whole team.

General SCHOOMAKER. But to answer directly, we are currently doing exactly what you say, ma'am, and we will be holding quarterly training reviews of exactly these questions to make sure that we are sufficient for staffing.

The Vice Chief of Staff of the Army has, throughout the standup of these units, done that personally with all of the warrior transition teams.

Mrs. DAVIS. Thank you.

General TUCKER. And every 90 days, we review the table of distribution allowances (TDA), that has authorized our numbers per unit. We review that every 90 days and determine whether or not it is the right mix, at the right pay grade, at the right numbers for our population, to keep ourselves abreast of what is changing as we continue to progress.

Mrs. DAVIS. Thank you.

Mr. McHugh, beg my indulgence, I went over.

Mr. MCHUGH. Thank you, Madam Chairman.

Just another question on that point. General Schoomaker, you mentioned the vice chief. The vice chief had a directive that these units be fully manned up by January 2.

Your testimony and your comments, you are a little over 90 percent. When are we going to hit 100?

General SCHOOMAKER. In some cases, for particular roles within the cadre, we are over 100 percent. Across the board, I gave you the rollup. And by the way, when we gave the fully operational and capable briefing to the vice chief on or about that date, we were agreeing, that is, that we had achieved a 90 percent or above goal by that date.

And I say that is a grand rollup of all of those roles, squad leaders, company commanders, nurse case managers, physicians.

Mr. MCHUGH. So you are full up now.

General SCHOOMAKER. Yes, sir. For all intents and purposes, we are entirely staffed at the point we need to be staffed.

Mr. MCHUGH. Okay, because I know the directive said 100 percent. It didn't distinguish. But if you are full up, that was the question.

I thank you for bringing those soldiers that are heading up these transition units. They are the face of this program and its success is going to rise, as you know, General, from their dedication and I have every confidence they are going to do a great job.

But there have been some challenges lately, three deaths in warrior transition units just in the last three weeks, another apparent unintentional suicide from an overdose in Kentucky.

Can you give us any insight as to what you have done to look at the deaths and what, if anything, you have or hope to be able to do to respond to those?

General SCHOOMAKER. Yes, sir. Thank you for that question.

You are right, now that we are concentrating all of our wounded, ill and injured soldiers in our warrior transition units, we are beginning to have the visibility that we didn't have heretofore. All of us have experiences of soldiers within units, patients or non-patients, formerly within our hospitals, who may have inadvertently overdosed with either near lethal or lethal consequences.

But now what we are seeing is, having concentrated all of our soldiers within the units, we are seeing a pattern emerging, a trend. We have now had 11 deaths since June in our warrior transition units, three from accidental death from overdoses, four suicides, frank suicide, and I contrast the accidental overdoses with suicide.

I truly think these are unintentional. These are accidental, not unlike what the CDC, the Centers for Disease Control and Preventive Medicine has reported recently has become an almost epidemic problem in the United States with prescription drugs.

And we have had deaths from motor vehicle accidents and we still have several under investigation.

We have recently brought together a team of experts, epidemiologists, pharmacy specialists, some of our warrior transition unit leaders, physicians, nurse case managers, specialists from the Army's Combat Readiness Center or formerly our safety center to look at how—what are the root causes of these and near misses that we have had, because we have been able to find, again, through a better tabulation of clinical events in our electronic health record, that there are other near events that could have very easily resulted in death, as well.

The combination of multiple prescription drugs in patients who have chronic pain, and not always chronic pain from severe battle injuries, most of these, in fact, were training accidents or degenerative problems of a kind.

Compound that with behavior health or mental health challenges and then you add alcohol to that combination, especially on a weekend, if it is unsupervised, and you get a toxic combination that can result in death, and that is exactly what has happened in several of those accidental deaths.

We are now instituting some policies that are going to mitigate those risks from sole provider programs. So that as you begin to amass greater needs for prescription drugs that may obscure the sensorium or may be potentially lethal, that we have a single provider, a single physician or nurse practitioner prescribing those drugs so that they can monitor them effectively.

We have better accountability through our triad in the warrior transition units and that we create alcohol-free zones around the barracks and around the treatment areas that our patients are in.

Understand, sir, that these are not inpatient. These are outpatients. They are living, some of them, with families in guest homes and the like, and we have recognized that that is a problem.

Does that answer your question, sir?

Mr. MCHUGH. Yes, for the most part. Obviously, tighter control on the allocation of prescriptions and where you might have counter indications there, it would be important.

But it is something we want to follow and I just want to, I guess, add, for the record, that we are, as a committee as a whole, and I know you are, as well, I didn't mean to suggest you are not, are deeply concerned about this. So we will be watching you progress.

Thank you. Thank you, Madam Chair.

Mrs. DAVIS. Thank you, Mr. McHugh.

Mrs. Boyda.

Mrs. BOYDA. Thank you.

Thank you all for coming and for the soldiers that have come and joined us today.

I was out at Walter Reed a little while ago and what a difference a year makes. So thank you very much for how the Army has addressed this issue and moved forward.

I am going to have a couple rounds of questions, so I will just come back to what we were just talking about to get some additional information.

When you have a prescription drug that has the potential for abuse, is the soldier given a 30-day supply of that or a 15-day supply at a time or how is that actually administered?

General SCHOOMAKER. I think that is very dependent on the case, ma'am. Our soldiers are like any other patients that America has and they are treated by physicians, nurse practitioners and physician's assistants in accordance with clinical indication.

I think you may know that there has been a great deal of attention over the last few years to ensure that our patients aren't in pain. There isn't a patient who goes into any clinic or emergency room in America today that isn't asked by the staff, "Are you in pain? Is there anything we can do to mitigate pain?" And I think that has contributed to probably our being very aggressive about prescribing drugs.

That is not coordinated sufficiently, and especially if the patient isn't aware of the potential lethality of these combinations, you run into problems.

And as I said before, if you also are suffering from an emotional or psychological problem, that further drives you to take more than you might have. If you add alcohol in combination, then we have a problem.

Mrs. BOYDA. With the 1-to-12 ratio in that unit, is it possible then to just not give overdose quantities at a time?

General SCHOOMAKER. That is going to be part—that is part of our policy case.

The last thing I think that any of us wants to do is to take a patient who is on a stable course of medication for, say, pain relief and make them suffer because of draconian policies that we establish. But I think having the command and control that we now have, we can do a case by case assessment of what the risks are and do exactly what you are talking about.

Mrs. BOYDA. The 1-to-12, I mean, that is pretty close care.

General SCHOOMAKER. Yes, ma'am.

Mrs. BOYDA. And then the 1-to-18 on the nurse. The soldier that I had gone to visit at Walter Reed is doing well, saw him recently, and a good guy, a specialist, and I asked him how are things going and he couldn't say enough good about so many things.

He was getting better. The doctors were good. He went on about how well things are going.

There is a "but" coming.

General SCHOOMAKER. Yes, ma'am.

Mrs. BOYDA. And that "but" was he said, "The only problem is it takes me forever to see the doctor." So I said, "Is it 1-to-200?" He goes, "Well, I don't know about that. I just know that it takes me about a month and a half to see a doctor."

Now, I would like to just—at some point, we will follow up on his case specifically, and that was just an off the—with a 1-to-200 ratio of doctors, how often would you expect them to—how many times a day or how many patients a day does a doctor see? How many patients a day and how often would you expect to see a doctor at 1-to-200?

This is a man who is really so committed to his country, he is like so many of the other veterans, ready to get back just as soon as possible.

General SCHOOMAKER. Yes, ma'am.

Mrs. BOYDA. So he just said, "I don't need"—it didn't seem to bother him too much. It is just that he wants to get back.

General SCHOOMAKER. Yes, ma'am. And I don't want you to walk away from this, the committee to walk away thinking that we have a structure now that allows us to have one physician for every 200 patients throughout Army medicine.

We have——

Mrs. BOYDA. And he is part of the wounded transition. He is part of the wounded warrior transition.

General SCHOOMAKER. This program alone, we have set a very generous ratio of physicians and nurse case managers for our patients, 1-to-200. That is not typically the ratios that we have. They are more on the order of 1-to-1,000, 1-to-1,500 in most primary care models for, say, a family medicine doctor or general internist or pediatrician.

But for this group, we have given them an additional population of physicians.

We actually give patients within the warrior transition units accelerated access for care for routine, as well as specialty care. In fact, I am sure that the cadre who are in the room here today are cringing as you describe that patient and that he can't see his doctor very often.

I suspect, ma'am, that what you are hearing is from those that are anxious to get back, anxious to get as much attention as possible to his or her wounds and then anxious not to have to sit there and heal during the time and probably resisting what they have told them, "Listen, be patient, the time will come."

But if you will give us details after we——

Mrs. BOYDA. We will follow up, absolutely. I just feel it would be remiss to—again, this is a good guy that I have kind of been following and he can't say enough good about what is going on.

So we will follow up with that and just see where—but I wanted to make sure the 1-to-200 ratio would mean that we are—that there still is—you know, these are people who clearly need a fair amount of—they are wounded. So they are going to need care pretty often.

General SCHOOMAKER. And, ma'am, if I could add, just real quickly. It is a very important point.

We are returning most of two-thirds or three-quarters of our soldiers back into uniform after injuries and illnesses, combat-related or not. That is a very important part of this.

We are saving the equivalent of two combat brigades a year through our process of recovering and rehabilitating.

Mrs. BOYDA. We will go over the details and follow up again on it later.

General SCHOOMAKER. Yes, ma'am.

Mrs. DAVIS. Thank you.

Mr. Kline.

Mr. KLINE. Thank you, Madam Chair.

Thank you, gentlemen, for being with us today.

Admiral Robinson, could you tell us what your working relationship is, not your personal relationship, but your working relationship is with Colonel Boyle? How does that work?

Admiral ROBINSON. With Colonel Boyle, who is the Marine Corps liaison at Bethesda?

Mr. KLINE. No, sir, I am sorry. He is the Chief Officer (CO) of the Wounded Warrior Regiment, and we have been talking about how the Army does that. I am just trying to see how the Navy and the Marine Corps does that.

Admiral ROBINSON. Okay. The Wounded Warrior Regiment at Camp Lejeune or at Pendleton?

Mr. KLINE. Admiral, there is one wounded warrior regiment and it has battalions on each coast. I guess what I am hearing here is there is not—we are not very well plugged in there between the Navy Surgeon General and the Marines Wounded Warrior Regiment.

The Army, you seem to be under one hat here. General Schoomaker talked about the installations providing the funding, it comes under installations command for the barracks and so forth, but it looks like your wounded warrior program in the Army falls under you.

Is that right, General Schoomaker?

General SCHOOMAKER. Yes, sir.

Mr. KLINE. And with the Navy, you have a safe harbor program that treats 250 or so sailors a year. That falls under you, Admiral?

Admiral ROBINSON. No. That falls under the Chief of Naval Personnel.

Mr. KLINE. So for neither the wounded sailors nor Marines, you don't have any direct connection with that follow-on program, that outpatient program, that mentoring and caring for program that we are hearing about in the Army.

Is that what I am hearing from you?

Admiral ROBINSON. Well, other than doing the initial health care in the institution, then doing the medical case management and the non-medical case management, going through the continuum of care and transitioning them to the appropriate facility, such as the polytrauma or wherever they need to be, and then, when ready, getting them back as close as they can to their home unit, Lejeune or Pendleton, or wherever that may be, and we do that through the wounded warrior program.

I think that we have a very good hookup. The fact that Colonel Boyle, who I do know, and who does have the regiment and the fact that we have one at Lejeune and at Pendleton that I don't have daily cognizance over, doesn't mean that Chris Hunter at Balboa, who is the Commander at medical center at Balboa, and that Marl Olsen, who is the Commander, my Commander of the naval hospital at Camp Lejeune, aren't talking with them.

And for my three years at Bethesda as the Commander, the Assistant Commandant of the Marine Corps (ACMC) and the Commandant of the Marine Corps (CMC) and the Sergeant Major of the Marine Corps and the wounded warrior Marine liaison that was there were a daily occurrence, are hooked into the multidisciplinary team that I spoke about.

So those people are people that I have lived with on a day to day basis for the last few years.

Mr. KLINE. Thank you. I am a little bit concerned. Maybe it is time, and I would suggest, Madam Chair, that if we are going to look at this wounded warrior continuing care issue, that it would probably be helpful to have the Marines wounded warrior regiment, since that is an up and running organization that is connected.

And the Admiral is explaining some of what is connected, but I would like to explore that a little deeper and I could do it on my own. Perhaps, as a subcommittee, we ought to do that. We ought to take a look at that.

Admiral ROBINSON. Well, the deputy medical officer Marine Corps, Mike Anderson, who is sitting behind me, is here. The medical officer Marine Corps is Admiral Bill Roberts, who couldn't be here today, but that connection exists and it exists on a daily basis, and it has for a long time and it will in the future.

Mr. KLINE. It is not the same relationship, though, as what they have in the Army and I was just wondering——

Admiral ROBINSON. No. It isn't the same relationship for a number of reasons, not the least of which is we don't have quite as many people involved in terms of wounded.

But the relationship is a little different in terms of philosophy of how we manage the care.

Mr. KLINE. Exactly, and this is not meant as a criticism. I am trying to understand how it works. So I would like to explore that a little bit separately, because we have a different model here.

There are a lot of similarities. The Marines are assigning officers and staff non-commissioned officers and barracks in a model very much like what the Army is doing, I think, and the cadre members are back here in the audience, but I am—in the Army's case, it falls under the Surgeon General of the Army, I understand, all one uniform, and in the Navy and Marine Corps case, it is a little bit different, and I would just like to understand how that works. That is all I am suggesting.

I have got some other questions, Madam Chair, having to do with sort of an unrelated matter and I will wait for the second round.

I yield back.

Mrs. DAVIS. All right, thank you.

Mr. Wilson.

Mr. WILSON. Thank you, Madam Chairwoman.

And, Generals, Admirals, thank you for being here today.

I have a perspective that I am very grateful to share with Congressman Kline.

He is a distinguished veteran. As you can tell by his label pin, he is still a Marine, and I am really grateful that he has had a son serve in the Middle East. I have had two of my sons serve in Iraq.

I have had three sons in the Army National Guard. I am also very proud that one of my sons is a doctor in the Navy.

So, Admiral, thank you for being here.

I can also cover the Air Force. I have a nephew who is in the Air Force. My dad was in the Air Force.

I visited my nephew in Baghdad while he was serving there, and they are all very proud and grateful for their service overseas.

Additionally, I have had the extraordinary opportunity of visiting with the military medical personnel and patients in Baghdad, at Landstuhl, at Bethesda, at Walter Reed, at Fort Jackson, the naval hospital at Buford.

Everywhere I go, I am impressed by the quality of personnel. There is no question that, to me, American military medicine is the best in the world and is the best it has ever been in the world.

I also want to thank the persons here today with the warrior transition units, because we were all so disappointed in some of our troopers falling through the cracks, that we need one-on-one attention and persons who I see here today, I just have faith in their competence and ability to follow through.

I have also had the opportunity to meet a person I consider an American hero, Major David Rosell, who has lost a leg. He was able to go back on duty. Then he has come back to encourage other persons to go back on duty, and it is so awesome to me.

I have also seen the experience of Lieutenant Andrew Kinard, a Naval Academy graduate, who lost both legs, but, my goodness, when you are with him, his spirit is tremendous.

And so I can see firsthand the success. With this, with the warrior transition units, some concern has been that some of the persons who are placed in these units are somewhat offloaded problem soldiers. But, again, by working one by one, General Schoomaker, General Tucker, how is it determined what care is given and what is needed for each person?

General SCHOOMAKER. A very good question, Congressman, and, by the way, we thank you for your contributions to our force.

Mr. WILSON. I think all of us sitting up here are thankful. All the credit goes to my wife.

General SCHOOMAKER. Yes, sir. I think we can all relate to that, as well.

You are exactly right. We now have approximately 9,500 warriors in transition within warrior transition units. The directive of the Vice Chief of Staff and the Chief of Staff of the Army was go out into the Army at large, find those soldiers that are in long-term care or facing medical evaluation boards, and have the hospital commander, warrior transition unit commander, and line commander sit down and have a discussion.

And based upon a risk matrix that we have developed for whether they are safer to stay within the unit, the line unit, and have

a high probability of returning and being an active soldier with that unit or probability that they are going to have problems that they need to come into the unit, we do that.

There has always been, sir, a prospect of a line unit turning to the medical community to solve the problems of a problem soldier. But the fact now that it is a negotiation, that we have some objective criteria that center around their health and behavioral health problems I think helps with that discussion.

Mr. WILSON. Another interest I have, my National Guard unit, the 218th Brigade, 1,600 troops, are located in Afghanistan, training the Afghan police and army, they will be coming back this summer.

I am delighted at the services provided on base. What will be provided for Guard and Reserve persons who maybe live in rural communities?

General SCHOOMAKER. Sir, I think that is a challenge to all the services and it is a major focus of Secretary Peake, the new Secretary of the Veterans Administration. He talks often about the fact that especially those that aren't recognized at reintegration and demobilization, but may later turn up with problems in remote areas, are soldiers that we are focused upon within the direct care system, through our TRICARE network, and through the VA, as well, and I think that is part of the importance of this coordination with the VA.

Mr. WILSON. One thing that I saw, Madam Chairman, that was actually helpful, my sons, we still get their mail at home, and I was really impressed by the quarterly mailings that I just inadvertently see about—that service members receive who have been deployed overseas, with questions as to their care and suggestions.

So thank you for what you do.

General SCHOOMAKER. Thank you, sir.

Mrs. DAVIS. Thank you, Mr. Wilson.

General Tucker, one of the things we know about you is you are a bureaucracy buster. Is that correct?

General TUCKER. Yes, ma'am.

Mrs. DAVIS. Could you tell us, give us an example of some of those bureaucratic roadblocks that you overcame to make all these work?

General TUCKER. Ma'am, that is a great question.

First of all, I would ask myself—we came to a lot of impasses as we worked our way through the problems as we saw them and began to conduct mission analysis.

And when it came to a decision, we always basically erred on the side of healing. If this decision is going to result in allowing this soldier to heal, and his family, then unless it is illegal, immoral, unethical, we are going to take on the policy or regulation that is preventing that, and we have been able to create a book, it is about an inch thick, and I think that is testimony to how much bureaucracy was actually there that would prevent soldiers from—you know, these are—this is a population of people whose worlds have been taken off kilter by means out of their control.

We should probably do everything we can to get it right side up and not continue to allow it to list. A couple examples.

We authorize you a non-medical attendant if your activities of daily living are limited such to where you can't do some things on your own and you need an assistant.

The policy said that the non-medical attendant had to be a family member. Well, what if your mom works and your sister is in college and your dad can't do this, and why can't your best friend do it, why can't your fiance do it, why can't a father-like figure in your life do this for you?

So we got policy changed to allow that.

Some of the soldiers, in the initial stages of standing up the transition units, some soldiers were reluctant about coming to the warrior transition units because they were afraid they would never get to go back to their unit.

So here is a soldier in an infantry platoon who doesn't want to leave his platoon or his company because if he goes to the warrior transition unit, thoughts are "I will never come back."

And so we have published policy that says you will come back to the unit that you came from, regardless of even if it is an overstrength status, you are going to come back to the unit you came from.

We established permanent change of station policies so that a family can leave their children at home, say, at Fort Bragg and come to Walter Reed and still draw per diem payments there, regardless of the status that the soldier is in at Walter Reed.

We allow soldiers—soldiers do not want to wear this patch, the medical command (MEDCOM) patch in a warrior transition unit, even though they are assigned to the medical command under the Surgeon General, because their patch made them feel good. Feeling good is kind of what you could call healing, and so we authorize them to wear their patch, as well.

And I could go on and on and on, but it is about an inch thick, ma'am, and if we continue to find—as we move in concentric circles out from ground zero, so to speak, we continue to find other bureaucracies out there that we haven't seen.

I will give you another example. Our soldiers see drug counselors. The drug counselors and what they discover in counseling with soldiers, their information databases, so to speak, doesn't cross over to the physician that is also treating the soldier for their medical and their clinical condition.

These two professionals should be able to talk about this soldier and their family and try to help them. So we tripped into that last week as we were doing a tiger team on some unexplained deaths in our WTUs.

So we continue to protract this, ma'am.

Mrs. DAVIS. Is there anything that Congress can do to be supportive of that? Is there anything legislatively that you discovered that needs to be changed?

General TUCKER. Well, we are going to go back to the physical disability evaluation system, obviously, and I think NDAA is moving in that direction, ma'am.

The biggest challenge, ma'am, is culture. It is a cultural change. We have been having warrior transition units in the Army since 1778, when the first inspector general, von Steuben, said that we will stand up a regiment for the sick and the lame who cannot keep

up in the regiment and they would be cared for by our non-commissioned officers.

And so this is not new work. It is just work that we have got to get better at, and I think we are moving in the right direction.

Mrs. DAVIS. Thank you.

Admiral Robinson, perhaps along the lines of Mr. Kline's question earlier, has the Navy also had to break a few bureaucratic roadblocks in order to have their program work?

I think part of our question really is whether the nature of Safe Harbor and I think multiple programs, in many ways, that you all have put together really are like what is happening over on the Army side.

I mean, how will the comparisons work out and, in fact, if you had to create some of those opportunities, as well to change the way people look at this system?

Admiral ROBINSON. Yes, ma'am, and I think I understand your question. The Navy medical department is different from the Army medical department in one fundamental way, and that is we are the medical department to both the blue Navy and, also, to the Marine Corps.

So we have two services with distinctly different missions, but we provide care to both.

So the safe harbor program, one of the things that we have done—and we need programs for both groups of people, because they are completely different in terms of who they are, where they are and the cultures, et cetera.

One of the similarities, though, is to make sure that we take—I guess the phrase would be best of breed, because there are lots of parts of the wounded warrior program for the Marines that we have instituted in our safe harbor program to make sure that we are giving an equivalent level of care and concern for everyone.

Again, the numbers are vastly different, because the numbers on the Navy side are much, much lower and the Marines have much higher and, of course, the Marines are still lower than the Army.

In terms of rule sets, the Navy functions in a little different way. Our 232-year history is to get underway and to leave and for a long period of time, when communication was poor, we had to make decisions about how we were going to conduct affairs based upon the best circumstances that we found ourselves, very similar to what General Tucker was already talking about.

So our history and our tradition has been to make sure that we get to the crux of what the problem is. In this instance, the concept of care for Navy medicine has long been patient and family centered, and I think that one of the things that Navy medicine does well, one of the things that MHS, military health service, has to do better is to help patients integrate their care.

Integration of care is going to be a huge help in terms of people who are, in fact, injured, who are under tremendous stress, and I think we do that and we usually put patients and family concerns first when we have that.

Mrs. DAVIS. Thank you, Admiral.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair.

General Schoomaker, you and I have had the opportunity to talk several times during the past few weeks regarding the circumstances current in the national media, where apparently there was—well, for the moment, we will call them a misunderstanding between the veterans administrative personnel at Fort Drum and the Army as to the propriety of the VA, and the Vietnam Veterans of America (VVA) in providing guidance and assistance in the preparation of soldiers' medical evaluations board papers.

Since that time, you and Secretary Peake have—I guess it was Secretary Geren and Secretary Peake have executed an agreement that provides a way by which to approach that, those jurisdictional issues.

There has been some confusion, based on calls I have gotten, as to what this agreement allows the veterans, VVAs to provide to the soldiers. If I read from the agreement itself, it says "VA service representatives will assist and advise service members, but will not prepare documentation for other than VA benefit claims."

A lot of media representatives calling me were somehow interpreting that to mean that the VVAs were not allowed to provide any assistance.

What my interpretation of this is, and I would like you to state for the record what your understanding is, is that the VA representatives could continue to advise, provide oral suggestions and guidance, but, just in the vernacular, couldn't sit down at the typewriter and actually fill out the paperwork.

Can you help us understand exactly what your understanding is? Is VA assistance available now? And it is not just at Fort Drum, by the way. It will be anywhere where you have this nexus between the medical evaluation process and VA. True?

General SCHOOMAKER. Yes, sir. And my understanding is exactly yours, sir. Let me just go back real quickly and reconstruct what happened here.

As we stood up the first warrior transition units and General Tucker began to bust bureaucracies and formulate the Army Medical Action Plan, a team was sent out from the Surgeon General's office, under the Acting Surgeon General, Gail Pollock, to rapidly get as much information as possible out in those camps, posts and stations where this was occurring every day.

Where was it working well, where was it not? All facets of the care and transition into the VA system, to include the disability process. And Fort Drum happened to be the 11th place they visited and one of the last ones and they found really some of the best practices that they saw, very well embedded veterans benefits advisory group that there were giving good counsel to our families and soldiers.

But I think that there was confusion across all of these sites as to exactly what the interface should be.

When the stories surfaced about the exchange between the Army team and the VVA counselors at Fort Drum, Secretary Peake, with whom we were in pretty constant contact, said, "You know, it is very clear here that we have got some heterogeneity of how the process operates and if we have got that kind of a patchwork going on, we need to establish from the top how this should happen so there is no question out there in the field that VVA counselors and

the soldiers and their families should be working closely together," and that is exactly what that policy was intended to do.

My understanding is it spoke to the strengths that the VVA counselors had, which was understanding of veterans' benefits. Yes, sir.

Mr. MCHUGH. Absolutely. Thank you, General.

Admiral, before your presence in the subcommittee, the subcommittee staff had visited your mobilization processing site in San Diego and Norfolk and, at that time, we heard some complaints from ill and injured sailors in the units regarding demobilization.

And the complaints specifically were that they were being ordered to demobilize while still undergoing medical treatment and being told to go to VA or to TRICARE for transitional assistance management program for follow-on care.

We brought those concerns to the attention of your predecessor. We were assured by the Navy leadership that that practice would end.

Just this past week, the committee staff again has obtained information that suggests that soldiers, at least in some regard, are still being processed in that way and we have illustrations of sailors being demobilized a few days prior to scheduled surgery and told to obtain the surgery and recover while they are on training and leave and such.

And I would like to get your comments on that for the record.

Admiral ROBINSON. Sir, I have no information and no comments on any of the specific cases. I will tell you that from a physician and from a surgeon's perspective, and as the Surgeon General, I would like to make sure that all injured, ill personnel who are on active duty and who—and the folks that you are talking about are in the reserve capacity generally, but that they, in fact, have complete medical care before they leave the service or if the care isn't given to them before they leave the service, the condition that they have is something that can be cared for and that we know exactly how we are going to transition them to what provider for the proper treatment and for the proper care.

From the surgeon in me, I am telling you that most of the time, I don't think that anyone should leave the service until their medical condition has been eliminated or treated, but the specifics here I don't know.

Mr. MCHUGH. If I may, Madam Chair, I know the light is on, I will be very brief.

But clearly I don't expect that you can possibly respond to the specific cases. I don't know if it is appropriate, we could probably get those to you for resolution, if nothing else.

Admiral ROBINSON. I would like to have that, sir.

Mr. MCHUGH. I appreciate that.

But you have been clear, in general terms, it would not be the Navy policy to discharge a sailor who, a few days later, had surgery scheduled. Am I correct in that assumption?

Admiral ROBINSON. That is correct. If a sailor had surgery that is needed and who has been on active duty, particularly if that injury or whatever has occurred because of the—it has occurred during the period of duty, then I would expect that we would care for

them and, again, pending the particulars, I would say that that is what should occur.

Mr. MCHUGH. Thank you, Admiral.

Thank you, Madam Chair.

We will get that information to you.

Admiral ROBINSON. Fine, thank you.

Mrs. DAVIS. Thank you.

Mr. Kline.

Mr. KLINE. Thank you, Madam Chair.

Admiral, I got us kind of twisted around there with the Marine Wounded Warrior Regiment. I didn't mean to get us that twisted around. Let me just hasten to assure you that I have been, over many years of service in the Marine Corps, extremely pleased with naval medicine.

My son was born in a naval hospital. Of course, he is now an Army officer. I am not sure where I am going with that, except that every time I am with Mr. Wilson, I am thinking about if our families weren't as engaged as they were, the Department of Defense would have to increase its recruiting budget substantially.

I have three nieces in the Army, one of whom is an Army nurse, serving in Baghdad, and all of them very proudly. But, again, I didn't mean to imply, and I was talking to Mr. McHugh for a minute, come across that I had some criticism of naval medicine and, certainly, from my family's perspective, that is not so.

But I do want to get at the relationship between the Surgeon General's office and the Wounded Warrior Regiment, not here today, because we need to explore that when we have somebody from the Marine Corps who can talk about this.

I want to go back and pick up—I guess I am back in your lane again now, General—what Mr. Wilson was talking about, these members of the Guard and Reserve who are coming back and you expressed that that is a problem that all the services were having to face.

Mr. McHugh was just talking about it sometimes with sailors who are discharged. We put in statute now and we have been seeing for the last couple of years a pretty aggressive reintegration program by the National Guard, expanding to the reserves.

So we bring these soldiers back, we don't just demobilize them and sort of say good luck to them, we will see you in a few months. We are bringing them back after 30 days, 60 days, and 90 days to see how they are doing in a wide range of areas, are they getting their jobs back, house, family, life going, but part of it is medical, as well, and particularly in view of PTSD and perhaps some traumatic brain injury, where symptoms are a little bit slower coming.

How do you see your office, the Surgeon General's office relating to that? Do you have a direct input into that, direct relation, or is that sort of the guard comes back and then those reintegration efforts connect them with the VA? What is the relationship? Can you tell me that?

General SCHOOMAKER. Well, I have a good relationship with the leadership of the Guard and Reserve and with their surgeon, with whom we work very closely in trying to attend to exactly the point that you made here, sir.

And you have raised some very, very important points about the Guard and Reserves challenges once they finish their mobilization and are reintegrating.

The two areas that we see the biggest problems right now, first is dental. We have a real problem with dental readiness and dental health within the reserve component.

This is one of our biggest challenges for bringing reserve component soldiers into a state in which they can be medically deployed.

And so especially as we turn the reserves from being a strategic reserve into an operational reserve, we see their service as, in a sense, the preparation, the beginning of the preparation for the Army's force generation model of the next time that we mobilize and deploy.

And so it is very important for us to maintain their dental health and their dental readiness through programs that we are developing.

The second is, that you alluded to already, our studies now have shown, for the last five years of careful cohort studies, that the emergence of symptoms of post-traumatic stress of a reintegrating soldier don't appear at the moment of demobilization or at the moment of redeployment.

And so we have learned that 30, 90, 60, 180 days out, we should be re-interfacing, we should be reexamining, re-interviewing that soldier to see how they are doing.

We now have a standing policy across the entire military medical system that my colleagues in here and I, we all attend to and that is to 90 to 180 days out, perform a post-deployment reassessment of health that is focused on those symptoms.

The National Guard, Reserve and the Army have been very, very responsive to that.

Mr. KLINE. Thank you very much, General.

Madam Chair, I have got another line of questioning having to do with what we are doing in terms of research and treatment for extremity injuries. But if we don't have another round, I will just submit those for the record. If we do, I will raise it then.

Thank you very much. I yield back.

Mrs. DAVIS. Thank you.

Mr. Wilson, you are actually up by when you came in the room. So if you would like to ask a question now.

Mr. WILSON. I would be happy to. Thank you.

A concern that a lot of people have had, as the National Capitol regional medical command is being transformed, a concern would be for the ongoing program. What is planned and being done to make sure that indeed there is no one left behind?

General TUCKER. Sir, if I could take it. I know that the Warrior Transition Brigade at Walter Reed, they are transforming to what we see as a joint warrior transition unit at Bethesda.

It will also take on units in the National Capitol region. There will be a battalion—population size at Fort Belvoir, at Fort Meade, at Fort Myer, and at the eight medical treatment facilities around the National Capitol region will all have smaller, obviously, subunits of the joint warrior transition unit.

And within that, we would see the Wounded Warrior Regiment, the Air Force program and the Army program for this population, sir.

Mr. WILSON. So a concern that occurred last year was that as there was a movement of facilities, personnel, organizations from Walter Reed to Bethesda, that there, indeed, could be a problem. But you feel like this will be addressed.

General TUCKER. In terms of BRAC, yes, sir. Yes, sir. Our funding lines have come back up to keep us at full operational capability through the entire BRAC process, to the last day that we stay open, and we have got hiring authorizations to keep our people hired through the process, as well, sir.

Mr. WILSON. I wish you well, all of your coordinating.

General SCHOOMAKER. Yes, sir. I will point out that Admiral Robinson and I, he at National Naval Medical Center, Bethesda, and I at Walter Reed, actually were a part of that process before they stood up the joint task force capitol medicine under Rear Admiral John Madison and we have already begun pretty full integration of clinical services and training program, even though we are not collocated yet as a single campus.

And Admiral Madison has had full visibility of our efforts to integrate. It is deceptive to many people that even when the Secretary of Defense recently broke his shoulder, he may have been seen at Bethesda, but he was seen by an orthopedics and rehabilitation service that is actually shared between the two institutions.

We have had great success.

Admiral ROBINSON. I think that we have, and I just want to emphasize that the difference in the area, and I think the reason that there won't be anyone left behind, is that as Admiral Madison and as the joint task force capitol medicine becomes more mature, and it just began a few months ago, but as it gets more mature, I think we are making inroads to make sure that we have the right services not only at Bethesda, but also in the whole capitol area, including Belvoir, so that we end up in the National Capitol area, the National Capitol region, with a joint run military health system, which would be Air Force, Navy and Army.

And I think that we are, in fact, getting there.

General ROUDEBUSH. Yes, sir. I would add, from the Air Force perspective, certainly, with the very focused attention of the deputy secretary of defense, Mr. England, and the service Secretaries and Vice Chiefs, this has been a very focused and collaborative affair, both in BRAC integration and assuring that the care that is being provided to these wounded individuals coming back, there is not a decrement anywhere in that.

From the Air Force perspective, of course, a lot of focus, rightfully so, on Walter Reed, Bethesda and DeWitt, but Andrews plays a critically important part in that at Malcolm Grow, both in terms of a strategic asset located within the National Capitol area, but also as a focal point for ensuring that Air Force medical manpower is, in fact, committed and placed throughout the region to the best effect of the overall outcome of health care.

So I think this has been a very productive relationship and Rear Admiral Madison, I think, has done a very good job of assuring

that equities are addressed and met in all regards in a very demanding situation.

Mr. WILSON. Well, I wish you well and I know you have a success story with the Uniformed Services University being a joint facility.

It truly came to mind when I attended graduation of my son and to see persons from every service. It was just such a positive experience and the recent movie about the Uniformed Services University is just such an inspiration.

And, again, thank you again for what you have done and thank you for what you do for our troops.

Mrs. DAVIS. Thank you, Mr. Wilson.

Mrs. Boyda.

Mrs. BOYDA. Thank you, Madam Chair.

Last year we had a hearing with Surgeon Generals. It was after the Walter Reed had kind of settled into a plan. We just generally asked about how things were going and one of the main messages that we heard at that point was about the military-to-civilian conversions.

And basically their recommendation at that time was that those needed to be slowed down or even halted and in the NDAA last year, we said that we are going to put a halt to those.

And, yet, in your 2009 proposed budget, the military-to-civilian conversions are still in there and budgeted for. If you could help me understand what is going on with that. Are they going to be planned to be taken out? Do you still feel the same way? What impact does military-to-civilian conversion have?

I would like to hear actually from each one of you, if I could, each one of the branches.

General ROUDEBUSH. I will begin. The Air Force has been very focused on the military-to-civilian conversions and this has been going on for some time, really started laying them in back in 2004.

As far as the Air Force is concerned, we have done what we are confident in, is very good analysis, where it makes sense to do that, where it doesn't make sense, where the capabilities are, in fact, available to be hired.

So that was a part of our analysis and that allowed us to go through the subsequent years, four, five, six, seven and eight, and certify, according to the direction of this committee, in terms of those that we felt were suitable for conversion and would not decrement either access or quality of care.

So we, in fact, complied with that. When the Fiscal Year 2008 NDAA was signed in late January, that did, of course, cause us to move into a very concerted effort to be sure that we do comply with that law. And working with our Air Force A–1, our personnel, as well as our planners and programmers, the Air Force is fully committed to complying with the Fiscal Year 2008 NDAA, as it is written and as it is intended.

Mrs. BOYDA. So you see those budget items being deleted then?

General ROUDEBUSH. What you will see is those positions will be converted back to military in 2009. Those positions not filled will be converted back to military and we are working with our planners, programmers, and resourcers to assure that that, in fact, occurs.

Now, I will tell you, there is difficulty in that, because as early as 2004, when we began laying those in, our recruiting and training pipeline was adjusted accordingly to do that. So as we move these back to military positions, it is going to take some time to reconfigure both that recruiting and training pipeline to deliver those military personnel to fill those positions.

So this is not without challenge and we are looking at strategies to address that, as well.

But the bottom line is the same as the top line—we fully intend to comply with the Fiscal Year 2008 NDAA as it has been published.

Mrs. BOYDA. I will speak on my behalf and not the entire committee perhaps, but that was certainly done—that was what came out of the hearing, too.

So we need to make sure that that is meeting your needs and this is not the needs of the committee. We want to make sure that we are meeting your needs.

So, again, I will speak personally, not on behalf of the committee, but if there is—if we need to continue to look at that, I would be happy to do that.

General ROUDEBUSH. Yes, ma'am. And please rest assured, as we have worked very carefully with your staff members, they have been very helpful and very forthcoming in working through the challenges and working to assure that we understand on both sides precisely what the implications of that are.

Mrs. BOYDA. And speaking for myself, the objective is to give you the leverage to make the best decisions that you think need to be done for our military personnel.

General ROUDEBUSH. Yes, ma'am.

Mrs. BOYDA. General Schoomaker.

General SCHOOMAKER. Yes, ma'am. We will fully comply, as well, with law. There is no question that we will do that.

We have several challenges. One is to allow us to internally restructure our force for the kind of wounds, the kind of care, the kind of demands that we see now and we see over the horizon.

So, for example, in the mental health arena, we need the latitude to be able to restructure even the uniformed force to acquire more mental health support.

That the Army is allowing us to do and has been allowing us to do. We were using the military-to-civilian conversions actually to work within that conversion process or that remixing process.

The second is as the Army grows, we need a medical supplement, if you will, within our force to meet the Army's needs as it grows new modular brigades, as it pushes more trainees through its training pipeline and the like and grows more families, we need a greater medical force.

The Army, again, has been very generous in providing us a "Grow-the-Army" slice of the medical.

So we are complying with the law now. We are also getting the force mix conversions that we need to structure our medical force for the kind of needs that we have now and that we see on the horizon, and we are growing the medical force to respond to the growth of the Army.

Mrs. BOYDA. Thank you.

Admiral, is there anything that we need to add? My time has expired.

Admiral ROBINSON. Just that both parts of the Air Force and the Army are very similar and that we are going to comply with the same thing and at Chief of Naval Operations (CNO) and Configuration Management Program (CMP), we are fully engaged. We are going to do what the law says.

Mrs. BOYDA. All right. Thank you.

Mrs. DAVIS. Thank you, Mrs. Boyda.

I would say, as well, I appreciate the fact Mrs. Boyda raised the question, because there was concern that there is a disconnect here between what we were seeing coming forward in the budget and, in fact, what had been designated in the NDAA.

So I think we want to obviously work with you. We know that there are some needs and some challenges, but the overwhelming needs seem to be to have those billets available really to our military and to not do anything that would take away the need to have the kind of pipeline within the services that is going to be so critical to the future. And so I appreciate your concern.

Any additional thoughts on what the problem was, whether there was a miscommunication somewhere on whether the needs were just so different from what you were seeing?

General SCHOOMAKER. I think in the case of the Army, what we had done is negotiate with the Army to allow them to restructure military and civilian workforces, but to give us an additional workforce that we could rebalance the way we needed, and I think the legislation, ironically, has somewhat forced us to go back to the table with the Army and renegotiate how we are going to do that.

That may be what you saw from the Army, that was a part of it.

Mrs. DAVIS. Okay, thank you.

General Tucker, for just a second, if you could just talk to us a little bit more about how you bring together the Warrior Transition Unit cadre.

I know we have some outstanding men with us today, individuals, and women I think I see in the audience. Where are they really drawn from? And while I don't think we would have any question of their military leadership, I would want to know a little bit more about the training or what might be called the bedside manner.

We are dealing with some very vulnerable men and women who need that kind of service, and that is not always a natural ability that people have.

General TUCKER. Yes, ma'am, and that is a terrific question. They do come from all the ranks, all ranks in the Army, and they are assessed by human resources command.

They are two-year stabilized assignment, and we are looking for remarkable people, obviously. I often say, when I speak with them, that the skills that made you successful as a sergeant in an infantry platoon may not be the same skills that are going to make you successful in this organization, because these people are all individuals with individual needs and they are all on a different emotional plane.

And so we are looking for the sergeant who is probably the world's best father, a steady, but firm hand, but compassionate and has enormous depth for feeling and understanding and, also, to understand that standing behind that wounded soldier is probably a parent or a spouse who is going to tell you what they are thinking, as we would if someone—if we thought our loved one was not being cared for.

And so they have to absorb that, as well, while still maintaining their military bounds. And so we put them through a 40-hour course currently, we are moving it to a 3-week course, a resident course at Fort Sam Houston, the home of the Army Medical Center and School. They begin that course in Lewiston in October of 2008.

But right now, they are taking a 40-hour course and it takes them through the bedside manner, like you have spoken of, ma'am, but there are some things about Army medicine, about pharmacology, how to read a profile, how to read a pill bottle that says, "Hey, Jones, you got 30 Percocet on Monday, you take two a day or two every two hours and it is Thursday and you have one left, what is going on here."

So they also understand the effects of medications and what you can't have with certain medications and they have to understand the physical disability evaluation system, the entire world of what a warrior in transition is going through and, also, the world of the family and the finances, the special hazardous duty pays that they draw, Traumatic Service Members' Group Life Insurance (TSGLI), all the things, the benefits, so that they become a portal through which to guide these soldiers to.

And because we are looking for these special people and we expect them to offer an enormous amount of compassion, they spend a lot of hours on duty. And so we have also—another piece of busted bureaucracy is we have gotten authorization for them to have special duty pay.

Mrs. DAVIS. What role do you think that plays? I mean, if you didn't have the special duty pay——

General TUCKER. It does two things, ma'am. Number one, it tells them they are special. We give drill instructors special duty pay. We give recruiters special duty pay. These people are doing special duties, as well. They are unlike their peers.

There are no other units like this in the Army and they are doing the Lord's work, so to speak, with people who we should be paying pretty close attention to. So we are asking something more of them than we would a normal sergeant and they have to be trained in special skills.

And so we give them $225 extra a month for the first six months, six months to a year, it is $300, and then $375 after the first year.

And the second thing that it does is it tells the Army that these people are enormously special and we are only looking for the best you have and that sends a strong message and then coupled with that, the Secretary of the Army has instructed the Department of Army Secretariat to place special emphasis on selection boards and promotion boards to identify these cadre members as key and essential to the Army's mission to sustain itself.

General SCHOOMAKER. And if I could just say real quickly, Mike himself represents what we are looking for. When I was asked to

look at candidates by the Vice Chief of Staff of the Army for this role, I selected Mike.

He is a former non-commissioned officer himself. He has been a former drill instructor. And I needed someone who could look at a process like training soldiers and see a process that had regimentation and regularity and standardization, but, at the same time, could see human beings inside of that and knew that some needed a different kind of motivation than others, and you obviously see that in him today.

Mrs. DAVIS. Thank you. Are you able to keep the diversity in that cadre, as well, that represents the military, men, women, minorities, et cetera?

General TUCKER. Yes, ma'am, and also the diversity expands into the component.

They are our National Guard cadre. Half of the cadre are active component, one-fourth is National Guard and one-fourth is Army Reserve, because the warriors in transition themselves are kind of that mix of the population, as well.

Mrs. DAVIS. Thank you.

Mr. McHugh. We ought to be able to get around quickly for everybody.

Mr. MCHUGH. Thank you, Madam Chairman.

Just to the point that you and Mrs. Boyda were pursuing a couple weeks ago at full committee, we had Secretary DeSantis and the Chairman of the Joint Chiefs and the Comptroller General, Tina Jones, and we explored that very issue.

It is obviously a critical one. One of the problems I think the services face is, frankly, we didn't do a bill until January and they prepared their budgets, as you know, long before.

So they have got a big ship to turn around. I was pleased, in my conversations with the Comptroller General, that as a lady who kind of keeps her eye on the purse strings, which is going to be an important part of the rehiring that is required under this provision, if you haven't filled vacancies by, I believe, October 1st, that the dollars are going to be there, but I just wanted to underscore the concerns this panel has, and, Madam Chair, I know you will.

We are going to have to keep an eye on two balls here, both these good folks' efforts to comply with that, but also the Department of Defense trying to do some things that help them financially, because this has significant monetary impact, as well, even though it is absolutely the right thing to do for our men and women in uniform.

So I just want to get that on the record.

The other thing, General Schoomaker, the NDAA for this year gave to the Secretary of Defense the authority to do pilot programs to try to explore better ways for the functioning and the nexus of the VA and DOD and, in your case, the Army disability systems.

That comment that you made about how you stood as primarily a physician in front of people that you were there to help and felt as though you were the enemy was a very poignant one and I think one of the things that frustrates us all is that you have got two good systems manned by the military disability folks, who care very deeply about those who have come to them and are

transitioning through their process, and, of course, the VA that is modeled upon helping those who have done so much for us.

And, yet, when you put them together and you try to work, the soldier, sailor, Marine or airman or woman, through them, it becomes frustrating. All of a sudden, the two systems are the enemy.

So this pilot program I think can hold a lot of promise as to how can this system become more user friendly and, therefore, in the eyes of those who are using it, become more of a solution than a problem.

As I understand, you are the ball carrier, if you will, for the pilot program. Can you give us any insight on how far along you are in working out a plan with the VA or is that just too early?

General SCHOOMAKER. No, sir. Actually, the pilot began in November. I understand there are 100 soldiers or service members in it right now. I think two or three of them have cleared the process and have completed their adjudication and are into the VA system.

But I will also say, candidly, sir, that the Congress has not fully executed the Dole-Shalala recommendations. I think the Dole-Shalala commission and the independent review group both very thoroughly looked at the disability adjudication process and concluded, I think, what many of us in uniform have known for our entire careers.

We have a system that is over 50 years old that was devised for a World War II generation of soldiers, sailors, airmen, Marine, Coast Guardsmen, that when we had an all—not an all volunteer force, but a conscripted force, when we did not have a TRICARE health care benefit, when most of our soldiers, sailors, airmen were not married.

Now, in the Army, we have a largely married force, with an extraordinary health benefit called TRICARE that every soldier and his or her family is looking to get if they have a medical disability.

And we have a complexity of especially mental health challenges that are not well codified within the disability process.

So what we are doing right now through the pilot is essentially to speed up a process and reduce bureaucratic hurdles in a process which is fundamentally flawed, and the fundamental flaw is that the military, under Title 10, has got to determine the fitness for duty of the soldier, sailor, airman, Marine, Coast Guardsman and should, and it should retain that, but then adjudicates on a table very similar, in fact, it is an identical table to the VA, what the disability for that one disabling condition is.

And then we turn to the VA, using the same tables and the same physical exam, if we get a single exam to do that, and allow the VA to then use the whole person concept to determine how well will they be able to be employed, what is their quality of life.

And so the typical soldier sees the constellation of problems they have, arthritis, sleep apnea, an injury residue, determined by the Army, Navy, Air Force or Marines to have a disabling condition with a single set point for that disability and then go to the VA system, see the same constellation of systems, but then looked at from the standpoint of a whole person and being given more and ask themselves, "Why does the Army value me less than the VA system does?"

And especially when a threshold for receiving health care benefits is 30 percent, that can be a major difference. I can give you cases. A 10-year veteran military policeman trashes his ankle through duty while in Korea. He comes back. We can't fix his ankle above one that can't run long distances and certainly can't ruck 80 pounds for 12 miles.

And so he is determined to be unfit to serve as a combat Military Personnel (MP). He has got three children under the age of seven and a non-working wife and he will be separated from the Army with an unfitting condition for that ankle.

He also has shoulder arthritis and sleep apnea, 10 percent, 10 percent and 20 percent for the ankle. The Army separates him at 20 percent disability, no TRICARE benefits.

He goes to the VA. They say total person concept, 40 percent disability, but you have already been through the military assessment and you don't get TRICARE benefits. You get a separation bonus from the Army for $28,000.

He comes to my office and he says, "I have got three children under the age of seven. I have served ten years. I am not going to have a retirement from the Army. I can't do an Army job. But what am I going to do with the $28,000 and no health benefits?"

Sir, that is the centerpiece of our problem and that is the seam in the seamless system between the DOD and the VA.

Mr. MCHUGH. And I appreciate your saying that and it is important to say it, and I was heartened by the President's comments during his "State of the Union," a rededication of Dole-Shalala.

And I know everyone on this committee, both sides of the aisle, feel the same way as the timing came with respect to the military-to-civilian move within the medical health corps. The Dole-Shalala commission report didn't give us a lot of time to look at it.

But I know we are going to continue to do that. It is absolutely critical. The basis by which you are retired out of the Army is, as you have noted, far different than out of the VA. One is a lack of the ability to serve in a uniform. The other is a lack to survive in life.

But we have got to bring continuity to those two and this pilot program, as much as you have pointed out, absolutely correctly, the structural challenges that Congress needs to change, but the pilot program and the bureaucracy piece of that, I would argue, is important, too.

General SCHOOMAKER. Absolutely.

Mr. MCHUGH. We are looking forward to your development on that and we have just got to do better. I mean, that is the bottom line. And turn our images, if you will, all of our images into what we want it to be, and that is collectively individuals and organizations that are deeply appreciative for the sacrifices these people make and need to share that in very real ways.

General SCHOOMAKER. Yes, sir. My only concern here, I will be very straightforward, is when you speed up a bad process, all you have is a fast bad process.

Mr. MCHUGH. I agree.

Mrs. DAVIS. I think we all agree we need to solve this one and there isn't a consensus within the communities that are affected by it either.

General SCHOOMAKER. Yes, ma'am.

Mrs. DAVIS. We need to work toward that.

Mr. Kline.

Mr. KLINE. Thank you, Madam Chair.

I am going to switch directions quite a bit here.

We as a Nation, you as the Surgeon General have been placing a lot of emphasis on traumatic brain injury and PTSD and some of the stresses that have been associated with the combat in Iraq and Afghanistan, the nature of the weapons, all of those things, and I think that is very appropriate.

I know that members of this committee have also spent a lot of time looking at those issues. But, still, we have over 80 percent of our injuries are extremity injuries. I think 82 percent was the last number I saw. A lot of cases of legs, particularly, but legs and arms.

And we are putting some resources into that. I was talking to General Roudebush beforehand. I know there is some peer reviewed sort of joint effort going on between civilian orthopedic efforts and military to make sure that we are doing the best that we can for these wounded warriors, where so many of them have these wounds, and we have seen tremendous examples of—in fact, we had in this hearing, I think, a couple of years ago, we had a Marine and an airman who had artificial legs and they were in uniform and looking great and proud and the Marine had just come back from his second tour in Iraq and after he served with that artificial leg.

But my question is, have we let that emphasis on Traumatic Brain Injury (TBI) and PTSD pull us away from this orthopedic effort and should we look at putting some more emphasis and resources into that effort? I will just throw it out for any of you who have a comment.

General SCHOOMAKER. Let me just—and I certainly would welcome my colleagues' observations or thoughts about this, but let me just say something quickly, sir.

You often hear people talk about one wound or another wound being the signature injury of this war. I am here to tell you there is no single signature injury, in my view. There is a signature weapon. The signature weapon is blast. The signature weapon is blast.

It is very effectively used by an adaptive enemy and that blast takes off limbs. It blinds. It deafens. It burns. It causes traumatic brain injury from the mildest concussive form to the most severe penetrating form that, frankly, our Navy colleagues at Bethesda are leaders in the world in a combined team and getting better.

And the context of all of those physical injuries leads to post-traumatic stress later.

We have in the Department of Defense now, through the help of Congress, focused all of the work in blast injury in the series of research programs that are being administered through the United States Army Medical and Research and Materiel Command, under the Assistant Secretary of Defense for Health Affairs, the Principal Deputy Assistant Secretary of Defense for Force Health Protection, Ms. Ellen Embrey.

And that program of blast injury I think is answering the question that you just asked, and that is are we keeping balance, are we looking at all the gaps where research and where care needs to be administered and are we doing the appropriate things for all of the elements of the signature weapon, which is blast.

Mr. KLINE. Anybody else?

General ROUDEBUSH. Yes, sir. Congressman, I think you very rightly make a case for being sure that we keep track of all elements of the constellation of injuries that we are seeing.

In terms of the orthopedic extremity trauma research, the Army Institute of Surgical Research, with work with Air Force surgeons, Navy surgeons, Army surgeons, working collaboratively on the joint trauma system which exists today in Iraq and Afghanistan, have been instrumental in identifying both the wounding patterns, but also the treatment modalities that begin to allow us to salvage, if you will, at the first opportunity to resuscitate, to look at these injured men and women in a way that we begin thinking about recovery at the very first opportunity to resuscitate.

That kind of collaboration has been key. Dr. Andrew Pollock, a leading trauma surgeon at Baltimore Shock Trauma and a leader within the American Academy of Orthopedics, with a particular eye toward trauma, has, in fact, gone downrange to our Air Force theater hospital at Balad and participated with us in both providing that care, but also helping teach us, learning from our experience, collaborating with those folks forward.

It has been a very productive relationship. Now, research becomes the crux of this, because if we are, in fact, to take that experience and begin to translate that into opportunities to help us all do better in taking care of trauma, both in the military sense and in the civilian sense, the research is critical to that.

So I think to the extent that we can foster and encourage the research activities that are already present and put those forward, I think that would serve us all very well.

Thank you for your interest in that, sir.

Admiral ROBINSON. Thank you very much, also, for the question. I agree with both colleagues, General Schoomaker and General Roudebush.

I would only point out this one thing. Amputations are—and research needs to be done and the research needs to be done also in terms of the limbs and the biomechanics and the future is really abounding with opportunities.

So I think that, in the future, people are going to have even better modalities of extremity care and prosthetic care and both from the impact and both from the surgical research and tissue regeneration, these are all things that have to be done.

The emphasis I want to put is I think that, traumatic brain injury, and post-traumatic stress disorder is something that is unseen and we don't know what we don't know. With a limb, you do know there is an amputation. You don't necessarily know how far you can take that individual in recovery, but you still are starting with a little bit better understanding of what you have.

With post-traumatic stress disorder and with TBI, you don't know, and that compounded with the stressors of combat make for

mental health and mental conditions that we haven't really fathomed yet.

So I would only suggest that—and I would agree with General Schoomaker. I think blast is the signature weapon, but that is the emphasis and I think we can go back to Vietnam, because the PTSD that developed in the veterans who were not treated, because we didn't even look at that, and now we are seeing 25 and 30 years later, now 35 years later that that was a very important thing.

So I would only point that out.

Mr. KLINE. Thank you very much.

And thanks for your indulgence, Madam Chair.

Mrs. DAVIS. Thanks.

Mr. Wilson.

Mr. WILSON. Thank you, Madam Chairwoman.

Again, I want to thank you and I want to thank you and I want to thank your colleagues for your obvious genuine care and concern for our soldiers who have made—sailors and Marines who have made such a difference and they are heroes for all of us.

Also, Madam Chairwoman, this has just been a terrific meeting. I appreciate your leadership.

And I want to conclude my part with an invitation and that is for our colleagues, for you, for staff people, and that is that there is a movie that has been made about uniformed services called "Fighting for Life" and we have had a screening here on Capitol Hill. I was very honored with Congressman Chris Van Hollen to have this screening.

We are going to be doing it again, because it was such a wonderful movie and it is going to be released across the country. But in the promo, Madam Chairwoman, sometimes it is a bit exaggerated.

This is understated, and I want to read it. It is a new film by two-time Academy Award winner Terry Sanders, "a powerful, emotional and dramatic film about the fight that begins when the battle ends. It is today's story of young wounded soldiers, American military doctors and nurses in a time of war, and the West Point of military medicine, USU, the best medical school no one has ever heard of."

And so it is an extraordinary movie. I am very grateful here in the capitol area, at Bethesda, on March the 14th, Bethesda Road Theater, in Washington at the E Street Theater, and it will be shown across the country.

But it is an extraordinary, moving film of the success of military medicine.

Thank you very much.

Mrs. DAVIS. Thank you.

And thank you, gentlemen. We certainly want to acknowledge the great strides made in medicine, of course, but also in the last year in trying to make certain that the men and women who serve and who are injured get the kind of support and care that they need, and we greatly appreciate that.

I can assure you that this committee will provide continuing oversight on this issue and I am wondering when you feel it is an appropriate time to come back and look at some of the ongoing challenges, some of the gaps perhaps that you think still need to

be filled as we continue to move forward, and when we might be able to evaluate some of that continuing progress.

Is it six months, a year?

Admiral ROBINSON. From the Navy's perspective, I think a year is too long. I think a six-month timeframe would be very good.

General SCHOOMAKER. I would concur. I think one of the concerns we all have is about the transition that may take place in the enduring programs that have been established here. I think six months is a very good time. Yes, ma'am.

Mrs. DAVIS. Okay, we will certainly do that. And continue, please, to ask the questions, questions that we don't know yet, but we don't we don't, what we haven't asked, and particularly, as we move forward with research, that we are tapping really all the tools that we have to answer some of the questions that are out there.

Thank you very much. Thank you all for being here.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

A P P E N D I X

FEBRUARY 15, 2008

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 15, 2008

Opening Statement Chairwoman Davis
Hearing on Update on Army Medical Action Plan and Other Services' Support for Wounded Service Members
February 15, 2008

The purpose of today's hearing is for members to get an update on the implementation of the Army's Medical Action Plan (or, AMAP) and hear how the Navy, Marine Corps, and Air Force are caring for their wounded warriors. At our last hearing on this subject back in June of last year, the Army's Vice Chief of Staff, General Cody, suggested that we have him back in October and January to testify on the progress of the AMAP towards Full Operational Capability. Circumstances precluded such follow-up hearings, and we understand that General Cody has just returned from Iraq in the past few hours, but we will nonetheless push forward so that we may learn how far the AMAP has come, and how far it still has to go.

I also want to be clear that while we have spent a great deal of time focusing on the Army, we remain concerned about how the Navy, Marine Corps, and Air Force are ensuring that their wounded warriors, and their families, receive the appropriate care and support needed. This subcommittee started to raise concerns about the quality and completeness of care provided to wounded warriors back in 2005, and we will continue to focus on this issue.

This hearing marks the first time Vice Admiral Adam Robinson, Surgeon General of the Navy, has come before our panel. Admiral, congratulations on your not-so-new job, and welcome. I should also mention that while we have had these Army leaders testify about Walter Reed before the Subcommittee previously, today they are here in new roles. Lieutenant General Eric Schoomaker, formerly the Commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center, became in December the Army's new Surgeon General; Brigadier General Michael Tucker, formerly the Deputy Commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center, is now the Army's Assistant Surgeon General for Warrior care and Transition.

In his opening statement for the last hearing, Dr. Snyder remarked on the power of focus. That how throughout the revelations at Walter Reed and its aftermath, almost all involved parties (wounded soldiers, family members, commissioners, and advocates) had nothing but good things to say about the quality of inpatient care wounded soldiers have received at military hospitals. The Army's Medical Action Plan has strived to set up new structures to focus on the unmet needs of wounded warriors so that hospitals could continue their focus on patient care.

Our challenge and our responsibility is to make certain that the military as a whole, and not just the military health care system, remains focused on the recovery and rehabilitation of our wounded soldiers and their families.

Mr. McHugh . . .

Statement of Representative John McHugh for
Hearing on 'Update on Army Medical Action Plan and Other Services' Support for Wounded Service Members'
February 15, 2008

Today's hearing continues our efforts to assist the Department of Defense (DOD) to improve mental health services that are available to our military personnel and their families. I want to preface my statement by recognizing the tremendous work the Department of Defense and in particular the leaders of the military health system who appear before us today have done to respond to the mental health needs of our service members and their families. I understand that this has not been an easy task and I want to thank you for your efforts in this regard. With that said, clearly there is more work to be done.

Last year the DOD Mental Health Task Force published its findings that identified significant shortcomings in the Department's efforts to provide mental heath care. Of note, the task force found that the Department of Defense has not invested the resources and funding required to make the necessary services available when and where they are needed.

Following the report, Secretary Gates publicly committed to fixing the psychological health system stating that he had 'no intention of waiting' the full six months allotted by Congress for the development of a corrective action plan. The Secretary tasked DOD to complete a plan to address problems with the military psychological health system within 60 to 90 days.

While I commend Secretary Gates for sense of urgency in addressing the reported gaps in the system, unfortunately we continue to hear from service members and their families, particularly those who have returned from Iraq and Afghanistan about the difficulty of obtaining timely mental health services. We are told of active duty members having to wait several months between mental health appointments in military treatment facilities and in the TRICARE system. Clearly this calls into question whether the Department has invested the necessary funding and personnel resources. I am anxious to hear from the witnesses if this is the case.

I also want to hear from our first panel today about how DOD and the military services have addressed the resource shortfalls along with other task force findings such as:

- "A pervasive stigma among military personnel about seeking mental health care that keeps them from getting the help they need,
- "Gaps in the continuity of psychological health care which is often disrupted during transition among providers, and
- "The TRICARE network benefit for psychological health being hindered by fragmented rules and regulations, inadequate oversight and inadequate reimbursement.

With that said, I would like to again recognize the Army and Lieutenant General Schoomaker for continuing the commitment to assess the mental health system in theater and ensure that it is meeting the needs of the troops. While the Mental Health Advisory Team V findings clearly show positive trends in areas such as increased unit morale and decreased stigma associated with seeking mental health care, there are also some very disturbing findings. Soldiers on their third or fourth tour in Iraq report twice as many mental health problems as first-time deployers.

That coupled with the reported increasing difficulty in accessing mental health care again causes me to question whether the right resources in sufficient quantity are in place.

The report from Afghanistan is equally disturbing, where rates of mental health problems are significantly higher than in 2005 and soldiers are experiencing significant barriers to care. I would like to know how the Army plans to fix these problems.

In addition, I understand that the MHAT V included information obtained from Marines in theater as well as soldiers. I'm interested in Admiral Robinson's perspective on whether mental health services available to deployed Marines are meeting their needs.

With that, I would like to welcome our witnesses and thank them for participating in the hearing today. I would particularly like to thank the members of the second panel for their willingness to share their personal stories with us and their service to our nation.

UNCLASSIFIED

FINAL VERSION

JOINT STATEMENT BY

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

BRIGADIER GENERAL MIKE TUCKER
ASSISTANT SURGEON GENERAL FOR WARRIOR CARE AND TRANSITION

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 110TH CONGRESS

ARMY MEDICAL ACTION PLAN

15 FEBRUARY 2008

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Congressman McHugh, and distinguished members of the Subcommittee, thank you for the opportunity to discuss the total transformation the Army is undergoing in the way we care for Soldiers and Families. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service.

Secretary Geren, General Casey, General Cody, and the rest of the Army leadership are all actively involved with every stage of the Army Medical Action Plan and the transformation it embodies. Senior Army leadership has made it very clear that they are in lock step with the statement by Secretary of Defense Gates, "Apart from the war itself, this department and I have no higher priority."

What we would like to highlight for you today are some of the tangible impacts of the transformations made through the Army Medical Action Plan. In doing this, I would first point out that, in some aspects, the concerns reported at Walter Reed Army Medical Center (WRAMC) were an unintended consequence of the extraordinary success of modern battlefield medicine. Thanks to improvements such as the Joint Theater Trauma system, state of the art evacuation system, and improved body armor, over ninety percent of those wounded in Iraq and Afghanistan survive, making this the highest survival rate in the history of warfare. As a result, there are many more wounded soldiers with complex injuries struggling to recover. In today's highly motivated All-Volunteer Army, this translates to an unprecedented number of Soldiers determined to rejoin their units or to transition back to their communities as proud and productive veterans.

At Walter Reed Army Medical Center (WRAMC), where Soldiers are able to participate in the center's state-of-the-art rehabilitation programs, the result has been a population of outpatients six times greater than this premier medical center was designed to support. Many of these Soldiers or "Warriors in Transition" as we call them have displayed extraordinary courage and determination to return to the force or to become productive Veterans. To tap this extraordinary determination, the framers of the Army Medical Action Plan realized the need to provide injured Soldiers a mission of their own codified in the Warrior in Transition Mission Statement: "I am a Warrior in

Transition. My job is to heal as I transition back to duty or become a productive, responsible citizen in society." This is not a status but a mission. "I will succeed in this mission because I am a Warrior and I am Army Strong." As a result, WRAMC, Army Medicine, and other Army organizations have been reorganized to support Soldiers and their Families to accomplish this goal.

First, and foremost, wounded, ill, and injured Soldiers are members of newly designed military units under the command and control of the medical treatment facility commander. The new Warrior Transition Units (WTU) are patient-centered organizations, focused on the care, treatment, and compassionate disposition of its Soldiers. The WTUs exist to support the healing of our Soldiers. All 35 of our Warrior Transition Units (WTUs) are now at full operational capability with over 90% of manning authorizations filled. The WTUs set the conditions for Soldiers to heal in a structured, supportive environment.

Integral to the structure of the WTUs is the Triad of care established to support every Warrior. The Triad is composed of a primary care manager, nurse case manager, and squad leader trained to meet the unique needs of each Warrior and Family. We've assigned one squad leader for every 12 Soldiers, one Primary Care Manager for every 200 Soldiers, and one nurse case manager for every 18 or 36 Soldiers depending on the medical complexity of the WTU. Each unit also has a dedicated Ombudsman outside of the WTU chain of command who reaches out to Soldiers and Families as an extra resource and problem-solver.

The organizational changes have made a lasting imprint on wounded Soldiers and their Families throughout this Nation. According to Major Steven Gventer, a Soldier wounded in Iraq by a rocket propelled grenade round who is currently commanding one of the companies that make up the Warrior Transition Brigade at Walter Reed, the changes brought about as part of the Army Medical Action Plan, "...did a great service to Soldiers. We have done everything possible for these Soldiers and are continuing to get better every day."

There are now more than 2,400 individuals assigned as cadre to the 35 WTUs which contrasts with less than 400 when previously organized as "medical hold" and "medical holdover" units. WTU cadre are trained specifically for this mission and they

truly know the wounded, ill, and injured Soldiers and Families for whom they provide care and support. They escort troops to meetings, act as their advocates, field their calls, and even pick up relatives at the airport. As Major Gventer puts it, "It's a job that entails just about anything and everything that allows the Warrior in Transition to focus on his or her mission, which is to heal."

Staff Sergeant Michael Thornton is assigned to the Warrior Transition Battalion at Fort Sam Houston, Texas. While serving with the 4th Infantry Division near Baghdad in September of 2006, he sustained burns over 33 percent of his body when the vehicle he was traveling in hit a roadside bomb. He was transferred to what was then the Medical Hold Company to convalesce. In June 2007, the company to which he was assigned became a Warrior Transition Unit as the Army Medical Action Plan was implemented. Staff Sergeant Thornton states that, since then,

> *Things flow more efficiently. It seems more organized. It's good to have dedicated leadership who handle just our issues. In the past, some wounded Soldiers were also serving as squad leaders at the Medical Hold Company. They had appointments too, so it's better to have dedicated leadership. This is the best place I've seen in the Army. We've got great docs and so many people who care about us. I've seen issues like a pay problem I had that was resolved with their help the same day. They go out of their way to take care of you and they're good at it.*

It has also been meaningful to see how the civilian health care community views the changes we have made. One expert assessment was recently made by William H. Craig, a civilian health care executive with 17 years experience who currently serves as Vice-President of Clinical Support for Cook Children's Medical Center in Fort Worth, Texas. Mr. Craig spent a week with the Warrior Transition Brigade at WRAMC, viewing firsthand how the Army has improved the transition process for outpatient Soldiers and to see if the Army's way might have application in the civilian health care world. Mr. Craig observed:

> *From a professional standpoint, I was most impressed with the Army's organizational and leadership efforts through the Warrior Transition Brigade. The Army has taken a process-based approach to managing Soldiers from the time they arrive at Walter Reed until they leave to return*

to duty or to civilian life. The Army developed a system through the Warrior Transition Brigade that incorporates both daily people-management needs and medical care needs of the soldier into an organizational structure that brings significant improvement to the transition process. It is impressive to see an organization like the Army, which I have always perceived to be very command and control oriented in leadership style, actually be adaptive in its leadership style and incorporate a flexible approach based on the needs of this wounded Soldier population.

While my experience in the healthcare industry has shown we do a good job of case managing on the inpatient side, it seems to me our systems for outpatient case management are not as well developed as the Army's. When assessing the needs of their wounded Soldier population, the Army developed a concept I believe complements the medical resources of an organization like Walter Reed and effectively meets the Soldier's outpatient case management needs. This is referred to as the Triad of Care and incorporates three disciplines critical to managing the outpatient process once the soldier is discharged from inpatient status.

My week at Walter Reed with the Warrior Transition Brigade proved a point I have experienced many times in my career: if you give an organization the right level of resources combined with the right people to lead and execute, it can accomplish many great things.

We believe the Army Medical Action Plan is the right response at the right time and the right place for the United States Army. We are very proud of the hard work and committed effort to reach this point. We see the positive impact of our efforts every day as we encounter Soldiers and Families on the wards and in our clinics and across our installations. It is rewarding to see the progress and growth and we encourage you to visit our WTUs to meet and talk with our incredible Warriors.

Unfortunately, it can also be very frustrating when, despite all of our efforts, we have bad outcomes. We know that there are obstacles and bureaucracies that still must be overcome. We continue to face challenges that require blunt honesty, continuous self-assessment, humility, and the ability to listen to those in need. One

particular concern of ours is the number of unexplained deaths and suicides that have occurred in WTUs. Last week we assembled a cross-functional Tiger Team within Headquarters Department of the Army (HQDA) to examine these serious incidents and determine what steps we could take to reduce their frequency or eliminate them altogether. The team has completed their initial analysis of unexplained deaths and suicides and has recommended 81 initiatives, including a handful that can be implemented within 90 days. The team will continue this analysis and additional assessment of serious incidents not involving death. When they complete their work, I will be pleased to provide the committee with a briefing on their findings and recommendations.

This effort is an example of the Army's commitment to caring for our Warriors. We identified an area of concern and took swift action to address it. The same is true of a recent concern identified by National Public Radio (NPR). In a report first broadcast on January 29, 2008, NPR reported that the Army was blocking disability paperwork aid to Soldiers at Fort Drum. We immediately looked into these allegations with the Army team who participated in the March 2007 meetings with Veterans Benefit Administration (VBA) personnel supporting Fort Drum. Army team members indicated that they had issued no directives to VBA personnel and had been quite impressed with the level of support and cooperation from the VBA team at Fort Drum. These assertions are contradicted by VBA notes of the meeting uncovered several days after the initial report. Clearly there had been a miscommunication between Army and VBA personnel. Last week we worked directly with VA Secretary Peake to resolve the misunderstanding. This week Secretary Peake and Secretary of the Army Geren will sign a *Statement of Mutual Support* that reinforces our joint commitment to assisting service members and their families transitioning through the military Disability Evaluation System (DES). The *Statement* will clarify roles and responsibilities so that the best interests of the Soldiers are achieved.

Again, these actions illustrate that when problems are raised we are committed to taking swift corrective action as warranted by careful assessment. In an effort to uncover concerns and problems at the earliest stage possible, we monitor and evaluate our performance through over 18 internal and external means. We use third-party

surveys from industry leading survey firms, conduct unit surveys and regular Soldier sensing sessions, review weekly metric dashboards with over 400 data points, and provide monthly status reports to Secretary Geren. In addition, we host numerous visits from Members of Congress and your staffs—in January alone we opened our WTU doors to more than a dozen congressional visits. These visits give us a valued external perspective and allow us the opportunity to be as open and transparent in our operations as possible. Your feedback has been instrumental to our success.

In closing, we want to emphasize that it is the Army's unwavering commitment to never leave a Soldier behind on a battlefield...or lost in a bureaucracy. We want to ensure the Congress that the Army Medical Department's highest priority is caring for our wounded, ill, and injured Warriors and their Families. We are proud of the Army Medical Department's efforts over the last 12 months and are convinced that in coordination with the Department of Defense, the Department of Veterans Affairs, and Congress, we have "turned the corner" toward establishing an integrated, overlapping system of treatment, support, and leadership that is significantly enhancing the care of our Warriors and Families. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors that we are honored to serve. We look forward to your questions.

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

Statement of

Vice Admiral Adam M. Robinson, USN, MC

Surgeon General of the Navy

Before the

Subcommittee on Military Personnel

of the

House Armed Services Committee

Subject:

**Update on Navy Medicine's Efforts in Support
for Wounded, Ill and Injured Service Members**

15 February 2008

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

Thank you Chairwoman Davis, Ranking Member McHugh, and distinguished members of the committee. Your unwavering support of our service members -- especially those who have been wounded during Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) – is deeply appreciated. As the former Commander of the National Naval Medical Center (NNMC) in Bethesda, I witnessed first hand your tireless dedication and work on behalf of our wounded service members and their families.

In the last year or so the interest and concern about the care and support being provided to our service members when they return from combat has increased dramatically. From those with severe injuries, to others whose significant injuries may not be visible to the naked eye, our nation is providing care to a generation of veterans unlike those from previous conflicts. Our advances in battlefield medicine have improved survivability rates so the majority of the wounded we are caring for today will reach our CONUS facilities; this was not so during past conflicts. These advances, leveraged together with our current concept of care, provides Navy Medicine with the opportunities to effectively care for these outstanding heroes and their families.

Continuum of Care

The Military Healthcare System is one of the greatest and most valued benefits our great nation provides to service members and their families. Each of the services is committed and determined to providing our wounded, ill and injured with the absolute highest quality, state-of-the art medical care from the war zone to the home front. For Navy Medicine the progress a patient makes from definitive care to rehabilitation, and in the support of life-long medical requirements is the driver of where a patient is clinically located in the continuum of care and how that patient is cared for. Where a particular patient is in the continuum of care is driven by

the medical care needed instead of the administrative and personnel issues or demands. Medical and administrative processes are tailored to meet the needs of the individual patient and their family--whatever they may be! For the overwhelming majority of our patients, their priority is to locate their care as close to their homes as possible. We learned early on that families displaced for their normal environment and dealing with a multitude of stressors, are not as effective in supporting the patient and his or her recovery. Our focus is to get the family back to "normal" as soon as possible; allowing the patient and their family to return home and heal.

One of the cornerstones of Navy Medicine's concept of care is to capitalize on our longstanding and effective partnership with the Marine Corps in caring for injured and ill Marines. The Marine Corps has always maintained a presence at our MTFs in the form of a Marine Corps Liaison Office staffed with Marine Corps personnel and administration experts. At the onset of OIF, the Marine Corps quadrupled the size of their Marine Corps Liaison offices at key casualty receipt locations anticipating the increased volume and unique needs of this patient population and their families. Since the beginning of OEF/OIF, the Navy and Marine Corps team embraced the similarities and differences in their cultures. Working side by side with Navy Medicine providers, the recently established Wounded Warrior Regiment (April 2007) provided Marine liaisons immediately available to the patient, their family, and the clinical care teams from the moment of admission to an MTF through discharge. Navy Medicine takes care of the patient's clinical needs, and the Wounded Warrior Regiment becomes an optimizing adjunct to the patient care plan. The Wounded Warrior Regiment facilitates the development of a family readiness plan ensuring smooth transitions for the service members and those dedicated to their long term care. Based on a concept of care of "Marines taking care of Marines" the

Wounded Warrior Regiment has ensured that the care provided to our wounded, ill and injured is not just a process, but a relationship that will endure over a lifetime.

Like the Wounded Warrior Regiment, Navy established the Safe Harbor program in 2005 to meet the needs of severely injured Sailors from OEF/OIF. It is expected that approximately 250 Sailors each year will need the services provided by this program which will include non-clinical case management for the Sailors and their families. Safe Harbor case managers are actively collecting feedback from program participants to closely monitor the program's successes and where improvements are still needed.

In Navy Medicine we have established a dedicated trauma service as well a comprehensive multi-disciplinary team which works to maximize interface with all of the partners involved in the continuum of care. To move patients closer to home requires a great deal of planning, interaction and coordination with providers, case workers, and other related players to ensure nothing falls through the cracks. We work together from the day of admission to help the patient and the family know that we are planning to get them closer to home as soon as their medical needs allow the move. The patient's needs will dictate where they are, not the system's needs.

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

Another key component of the care approach by Navy Medicine takes into consideration family dynamics from the beginning. Families are looked as part of the care team and we integrate their needs into the planning process. They are provided with emotional support by encouraging the sharing of experiences among other families (family-to-family support) and mental health services are also made available. Also, families receive assistance dealing with administrative issues when necessary through the Marine Casualty Services Branch.

Concurrent with the establishment of the Wounded Warrior Regiment, the Wounded Warrior Barracks, Marine for Life, and other initiatives, we continue to coordinate with the Marine Corps to evaluate and expand where necessary USMC Liaison Offices at our major medical centers for the purpose of coordinating and supporting the needs of the Marines and Sailors, and their families. We have expanded our nurse case management capabilities, increasing the number of case managers from 85 in 2006 to 148 funded positions today. In addition, VA has established Liaison Offices at Navy MTFs for the purpose of coordinating follow-on care requirements and providing education on VA benefits and the newly created Federal Recovery Coordinators are also located at the NNMC and the Naval Medical Center San Diego (NMCSD).

Improvements and Enhancements to the Continuum of Care

Prompt and comprehensive medical treatment is a priority for service members suffering an illness or injury. As a result, the lessons learned at NNMC -- the facility that has treated most returning casualties -- have been exported to other facilities, both in and out of the military, involved in casualty care. The development of these lessons was a collaborative efforts to improve processes and outcomes. Currently, weekly tele-conferences between the MTF and the VA Polytrauma Rehabilitation Centers is ongoing to ensure continuity of care. One key issue for

patients requiring care at another facility is the physical transition of leaving the protective environment of an acute care facility and moving to a rehabilitative environment. When a patient is headed to a VA facility, there is significant coordination between the military, the VA liaison and the transferring Navy Medicine MTF. Before a transfer is imminent, direct communication occurs between the medical staff, including the caseworker, the patient and/or family members and the treatment team at the VA Polytrauma Rehabilitation Center. Also, electronic copies of medical records are transferred to the receiving facilities.

Psychological Health and Traumatic Brain Injury (TBI)

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

Delays in seeking mental health services increase the risks of developing mental illness and exacerbating physiological symptoms. These delays can have a negative impact on a service member's career. As a result, we remain committed to reducing stigma as a barrier to ensuring service members receive full and timely treatment following their return from deployment. Of particular interest is the recognition and treatment of mental health conditions such as PTSD and other related disorders. At the Navy's Bureau of Medicine and Surgery we established the position for a "Combat and Operational Stress Control Consultant" (COSC). This individual,

who reported on December 2006, is a combat experienced psychiatrist and preventive medicine/operational medicine specialist. Dedicated to addressing mental health stigma, training for combat stress control, and the development of non-stigmatizing care for returning deployers and support services for Navy caregivers, this individual also serves as the Director of Deployment Health. He and his staff oversee Post Deployment Reassessment (inclusive of Deployment Health Centers), Substance Abuse Prevention and Treatment, Traumatic Brain Injury, and a newly created position for Psychological Health Outreach for Reserve Component Sailors.

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

Recently Navy Medicine received funding for creation of a Navy/Marine Corps Combat and Operational Stress Control (COSC) Center at Naval Medical Center San Diego (NMCSD). The concept of operations for this first-of-its-kind capability is underway, as is the selection of a dedicated, executive staff to lead the Center. The primary role of this Center is to identify best COSC practices, develop combat stress training and resiliency programs specifically geared to the broad and diverse power projection platforms and Naval Type Commands, establish provider "Caring for the Caregiver" initiatives, and coordinate collaboration with other academic, clinical,

and research activities. As the concept for a DOD Center of Excellence develops, we will integrate, as appropriate, the work of this center. The program also hopes to reflect recent advancements in the prevention and treatment of stress reactions, injuries, and disorders.

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

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

Chairwoman Davis, Ranking Member McHugh, distinguished members of the committee, I again want to thank you for holding this hearing and continuing to shed light on these important issues. Also, it has been my pleasure to testify before you today and I look forward to answering any of your questions.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: Army Medical Action Plan and Support for Wounded Service Members from Other Services

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

February 15, 2008

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES 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 43,131 people assigned to 75 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

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 January 2008)

Madam Chairwoman and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. The Air Force Medical Service exists and operates within the Air Force culture of accountability wherein medics work directly for the line of the Air Force. Within this framework we support the expeditionary Air Force both at home and while deployed. We align with the Air Force's top priorities: Win Today's Fight, Take Care of our People, and Prepare for Tomorrow's Challenges. We are the Nation's Guardian—America's force of first and last resort. We get there quickly and we bring everyone home. That's our pledge to our military and their families.

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

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

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

A story that clearly illustrates the success of enroute care is that of Army SGT Dan Powers, a squad leader with the 118th Military Police Company. He was stabbed in the head with a knife by an insurgent on the streets of Baghdad on July 3, 2007. Within 30 minutes of the attack, he was flown via helicopter to the Air Force theater hospital at Balad Air Base. Army neurosurgeons at the Balad theater hospital and in Washington D.C. reviewed his condition and determined that SGT Powers, once stabilized, needed to be transported and treated at the National Naval Medical Center, Bethesda, MD as soon as possible. The aeromedical evacuation system was activated and the miracle flight began.

A C17 aircrew from Charleston Air Force Base, S.C., picked up SGT Powers with a seven-person Critical Care Air Transport Team and flew non-stop from Balad Air Base, Iraq, to Andrews Air Force Base, MD. After a 13-hour flight, they landed at Andrews AFB where SGT Powers was safely rushed to the National Naval Medical Center for lifesaving surgery.

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

We care for our families at home; we respond to our Nation's call supporting our warriors, and we provide humanitarian assistance to countries around the world. To execute these broad missions, the Services must work jointly, inter-operatively, and interdependently. Our success depends on our partnerships with other federal agencies, academic institutions, and industry. Our mission is vital. Everyday we must earn the trust of America's all-volunteer force-- Airmen, Soldiers, Sailors and Marines, and their families. We hold that trust very dear.

Take Care of our People

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

Wounded Warrior Initiatives

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

Care Management, Rehabilitation, Transition

When a service member is ill or injured, the AFMS responds rapidly through a seamless system from initial field response, to stabilization care at expeditionary surgical units and theater hospitals, to in-the-air critical care in the AE system, and ultimately home to a military or Department of Veterans Affairs (VA) medical treatment facility (MTF). Commanders, Family Liaison Officers, Airmen & Family Readiness Center representatives, Federal Recovery Coordinators, and medical case managers together ensure "eyes-on" for the service member and family throughout the care process. If possible, those wounded and ill war fighters requiring follow-up medical care, receive it at the MTF nearest to where they live. If no MTF is available, the TRICARE network expands options for our wounded. If transition to care within the VA is the right thing for our Airmen, we work to make that transition as smooth and effective as possible. If separated from active duty, care is provided through the TRICARE Transitional Health Care Program and the Veterans Affairs health system. The AF Wounded Warrior Program, formerly known as Palace Hart, maintains contact and provides assistance to those wounded airmen who are separated from the Air Force for a minimum of 5 years.

The AFMS provides timely medical evaluations for continued service and fair and equitable disability ratings for those members determined not to be fit. We will implement DoD policy guidance on these matters and all final recommendations from the pilot programs to improve the disability evaluation system. We have processes in place to ensure healthcare transitions are efficient and effective. Briefings are provided on VA benefits when individuals enter the Physical Evaluation Board (PEB) process. Discharged members, still under active treatment, receive provider referral and transfer of their records. A key component of seamless

transfer of care is a joint initiative by the VA and DoD, called the VA Benefits Delivery at Discharge (BDD) Program. AF MTFs provide the BDD advance notice of potential new service members and their health information through electronic transfer.

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

Psychological Health and Traumatic Brain Injury (TBI)

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

Post Traumatic Stress Disorder (PTSD)

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

Traumatic Brain Injury

We recognize that Traumatic Brain Injury (TBI) may be the "signature injury" of the Iraq war and is becoming more prevalent among service members. Research in TBI prevention, assessment, and treatment is ongoing and the AF is an active partner with the Defense and Veterans Brain Injury Center (DVBIC), the VA, the CDC, industry and universities. The AF has very low positive screening for TBI —approximately 1 percent from OPERATION IRAQI FREEDOM and OPERATION ENDURING FREEDOM.

Screening for TBI occurs locally in theater, before transport of wounded service members stateside, and again at stateside hospitals as indicated. The Military Acute Concussive Evaluation (MACE) tool is administered in accordance with the Joint Theater Trauma System (JTTS) TBI Clinical Practice Guideline. U.S. Transportation Command (USTRANSCOM)

policy dictates that all service members be screened for the signs and symptoms of TBI prior to transportation out of theater at either Landstuhl Regional Medical Center or at U.S. Air Forces Europe Aeromedical Staging Facilities. Follow up care for those with positive screens is conducted at US military treatment facilities and/or DVBIC's. The 59th Medical Group, Lackland AFB, Texas, is one of three DoD DVBIC Regional Centers that cares for TBI patients.

The AF is involved in several cutting edge research initiatives involving TBI. One in particular is the collaboration between the Air Force Research Laboratory and the University of Florida's Brain Institute. This research is focusing on the presence of biochemical markers in spinal fluid that is associated with TBI. In addition, the AF is utilizing a new mild TBI cognitive assessment tool, called HeadMinders. This internet-based tool is used to assist in determining which warfighter can safely return to duty following a concussion. Another is the Brain Acoustic Monitor, which detects mild TBI injuries and replaces invasive pressure monitors used to measure brain pressure for severe TBI cases.

Traumatic brain injury is an expanding area of study requiring close cooperation among the Services, the Department of Veterans Affairs, academic institutions and industry. It is vital that we better understand this disorder and clarify the long-term implications for our Airmen, Soldiers, Sailors, and Marines.

Suicide Prevention

The AF suicide prevention program is a commander's program. It has received a great deal of national acclaim and has achieved a remarkable 28 percent decrease in AF suicides since the program's inception in 1996. We continue to aggressively work our 11 suicide prevention

initiatives using a community approach, and this year released the Frontline Supervisor's Course. This course further educates those with the most contact and greatest opportunity to intervene when Airmen are under stress. The Air Force integrates these prevention services through the Integrated Delivery System (IDS). IDS is a multidisciplinary team that identifies and corrects gaps in the community safety net. Leaders from the chapel programs, mental health services, family support centers, child and youth programs, family advocacy and health and wellness center are involved at each installation.

Prevention

Several years ago the AFMS shifted from a program of head-to-toe periodic physical examinations for all active duty members and moved to an annual focused process, the Periodic Health Assessment (PHA). Through the use of the PHA, we identify and manage personnel readiness and overall health status, to include preventative health needs.

In addition, there is a separate pre and post deployment health assessment process. Before deployment, our Airmen are assessed to identify any health concerns and determine who is medically ready to deploy. The Post-Deployment Health Assessments are completed at the end of their deployment and at six months post-deployment. These are used to, once again, assess the Airmen's overall health and fitness. This allows commanders the ability to assess the overall fitness of the force. Recently, questions were added to the post deployment assessments to screen for Traumatic Brain Injury (TBI).

Prepare for Tomorrow's Challenges

Our Medics

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

Medical Treatment Facility Recapitalization

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

quality of patient care, patient safety, and the environment of care. All AF medical facilities have passed inspection and are currently fully accredited.

Electronic Health Records

As we prepare for tomorrow's challenges, it is essential to leverage the power of information and delivery it to our Airmen -- faster, easier, and cheaper. Information flow must be seamless between the services and the VA.

An important lesson learned from the care of our returning warriors is the need for a seamless electronic patient health record. After assuming operational control of the Bagram and Balad hospitals, the Air Force successfully deployed a joint electronic health record known as Theater Medical Information Program (TMIP) Block 1. This revolutionary in-theater patient record is now visible to medical providers not only within the battlefield. Additionally, clinicians can access these theater clinical data at every military and VA medical center worldwide using the joint Bidirectional Health Information Exchange (BHIE). This serves to improve the overall delivery of healthcare home and abroad for wounded and ill service members.

Telehealth

Telehealth applications are another important area of focus as we seek improvements and efficiencies in our delivery of healthcare. Telehealth moved into the forefront with the AF Radiology Network (RADNET) Project. This project provides Dynamic Workload Allocation (DWA) by linking military radiologists via a global enterprise system. RADNET will provide

access to studies across every radiology department throughout the AFMS on a continuous basis. It's goal is to maximize physician availability to address workload, regardless of location. We are aggressively targeting deployment of this capability in FY09 to all AF sites.

Also scheduled for FY09 deployment is the Tele-mental Health Project. This project will provide video teleconference (VTC) units at every Mental Health clinic for live patient consultation. This will allow increased access to, and use of, mental health treatment to our beneficiary population. Virtual Reality (VR) equipment will also be installed at six AF sites as a pilot project to help treat patients with post traumatic stress disorder. Using this equipment will facilitate desensitization therapy by recreating sight, sound and smell in a controlled environment. We are excited about these initiatives, not only for our returning deployers, but for all of our service members and their families.

Conclusion

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

DOCUMENTS SUBMITTED FOR THE RECORD

FEBRUARY 15, 2008

Statement of Mutual Support
February 12, 2008

The Army and VA are committed to assisting service members and their families transitioning through the military Disability Evaluation System (DES).

Wounded, ill, and injured service members in the DES process will be offered the following assistance from the Army and VA:

The Army will provide nurse case managers, legal assistance, physical evaluation board liaison officers (PEBLO counselors), chain of command, primary care managers, and other service specific support. Soldiers may also call the Wounded Soldier and Family Hotline at 1-800-984-8523, overseas DSN 312-328-0002, stateside DSN 328-0002, or e-mail, wsfsupport@conus.army.mil.

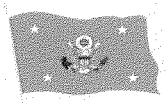
VA service representatives will provide information and advice regarding how medical evidence is used in the evaluation of disabilities under the Department of Veterans Affairs Schedule for Rating Disabilities. VA service representatives will assist and advise service members, but will not prepare documentation for other than VA benefit claims. VA benefit claims include the VA portion of joint claims processed through the Disability Evaluation System Pilot Program.

At military installations where the VA does not have permanent staff available, service members may contact VA service representatives via phone or e-mail. General information about VA benefits can be obtained at www.va.gov.

Veteran Service Organizations (VSOs) may also provide assistance with this process. A listing of the VSOs recognized by VA to assist claimants for VA benefits may be found on the VA website.

James B. Peake
Secretary of Veterans Affairs

Pete Geren
Secretary of the Army

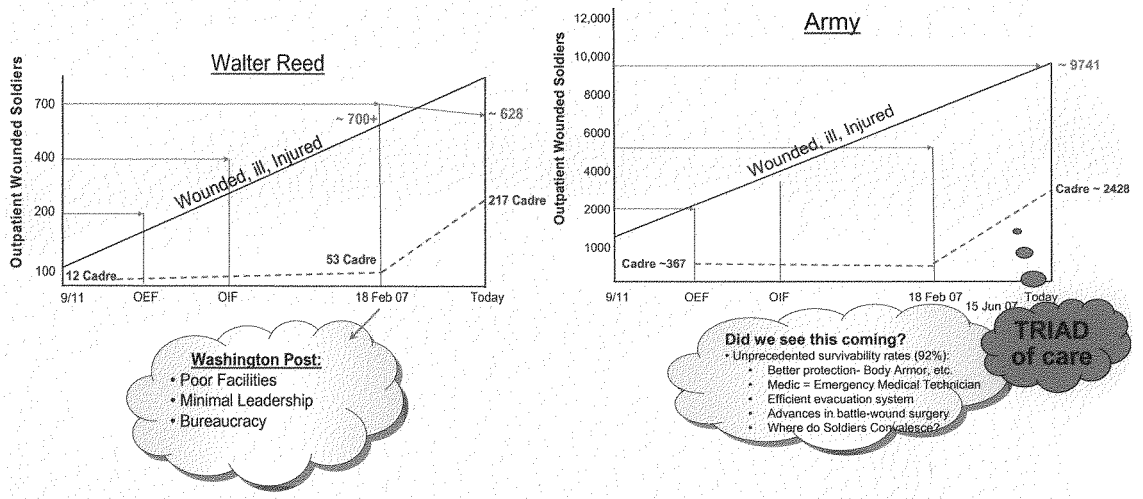


"Apart from the war itself, this department and I have no higher priority."

ARMY MEDICAL ACTION PLAN
Update

"A total transformation of the way we care for Soldiers and their Families"

Walter Reed; Representative of the rest of the Army



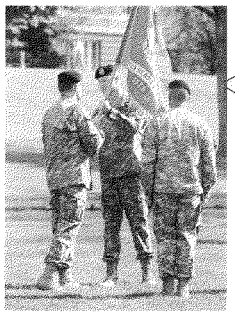
"Apart from the war itself, we have no higher priority!

So What Transformed?
…a snapshot:

18-Feb-07	Today
• Fragmented Sr leadership	• Established Assistant Surg General for Warrior Care and Transition
• Minimal trained leadership and staff (367)	• 2428 trained and certified cadre (WTUs at 35 locations)
• Poor facilities / Low priority	• Best facilities / Sr. GO ownership
• Maze of administrative bureaucracy	• Over 70 bureaucratic procedures eliminated or simplified
• Lack of integrated care: – Squad Leader = 1: >50 – Primary Care Manager (MD) 1: 1500 – Nurse Case Manager 1: >70	• Triad of care: – Squad Leader = 1:12 – Primary Care Manager (MD) 1: 200 – Nurse Case Manager 1:18
• Frustration; no advocates	• Ombudsman in every unit
• Forgotten Families	• Family escort / one-stop shop & services, sponsorship (SFAC)
• Complaints fell on deaf ears	• 1-800 Hotline (>7,000 calls)
• Poor unit organization	• Established official doctrinal organization – fully funded and staffed
• Poor feedback mechanisms	• Multiple methods to "see ourselves"

The Mission is Essential

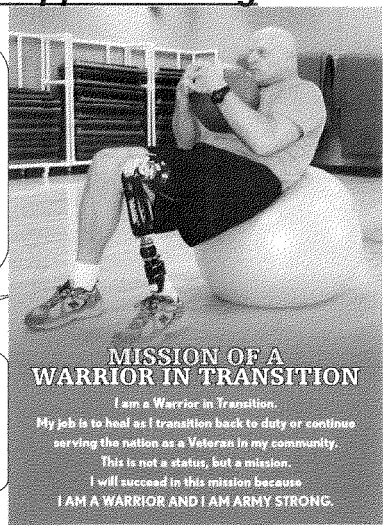
- All Units must have a ***Mission Statement***. A Mission Statement provides **Focus**, **Purpose** and **Essential Tasks**, which must be accomplished in order for the unit to be successful. The Mission of the WTU is to ***support healing***.



- Essential Tasks provide **metrics** that can be **measured**.
- Only then can you assess **unit performance – see yourself**.
- We **measure** this performance Monthly, Quarterly, and Semi-Annually.

The **Wounded Soldier** has a Mission: **To Heal**. This is his sole purpose. **Everything the Soldiers does must support healing:**

–Appointments, Rehab, Therapy, Medications are his job!
–**Nothing is more important than his mission to heal.**
–The Warrior Transition Unit sets the conditions for him to heal.

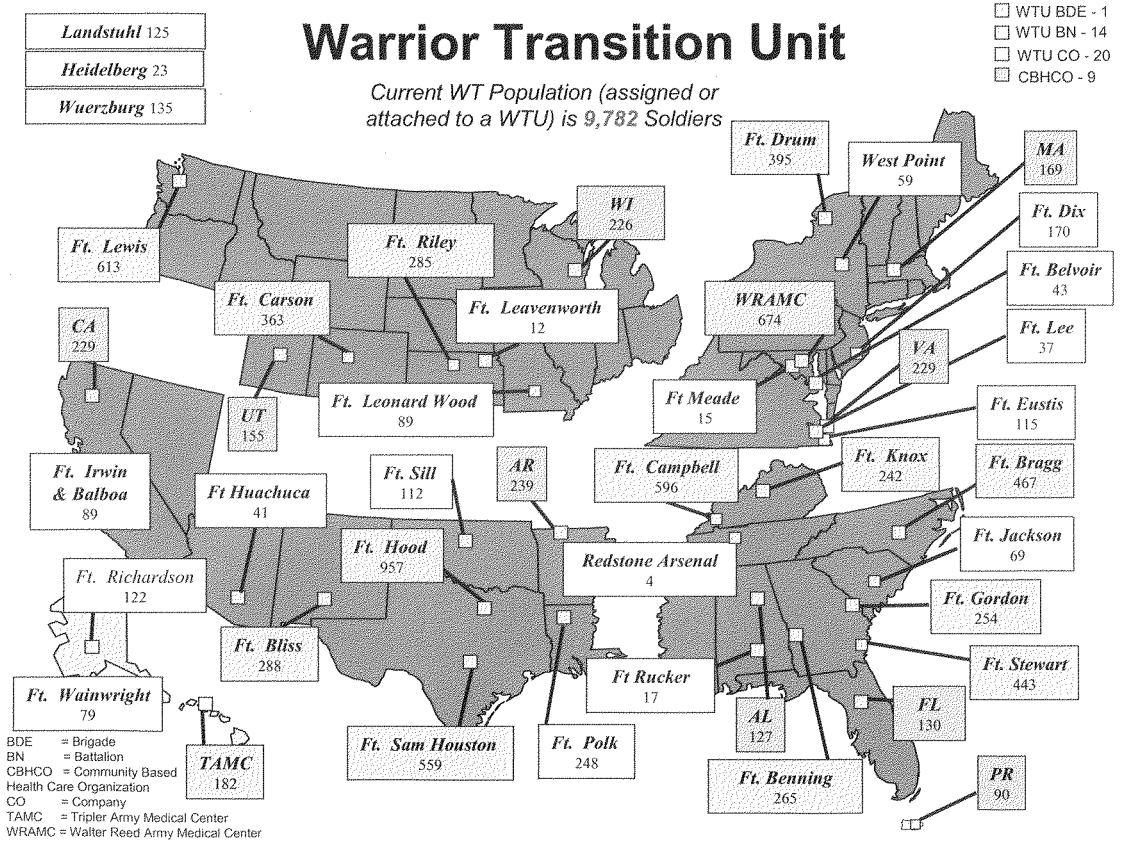


...a unit & Soldier without a mission is like a boat without a rudder!

"Apart from the war itself, we have no higher priority!

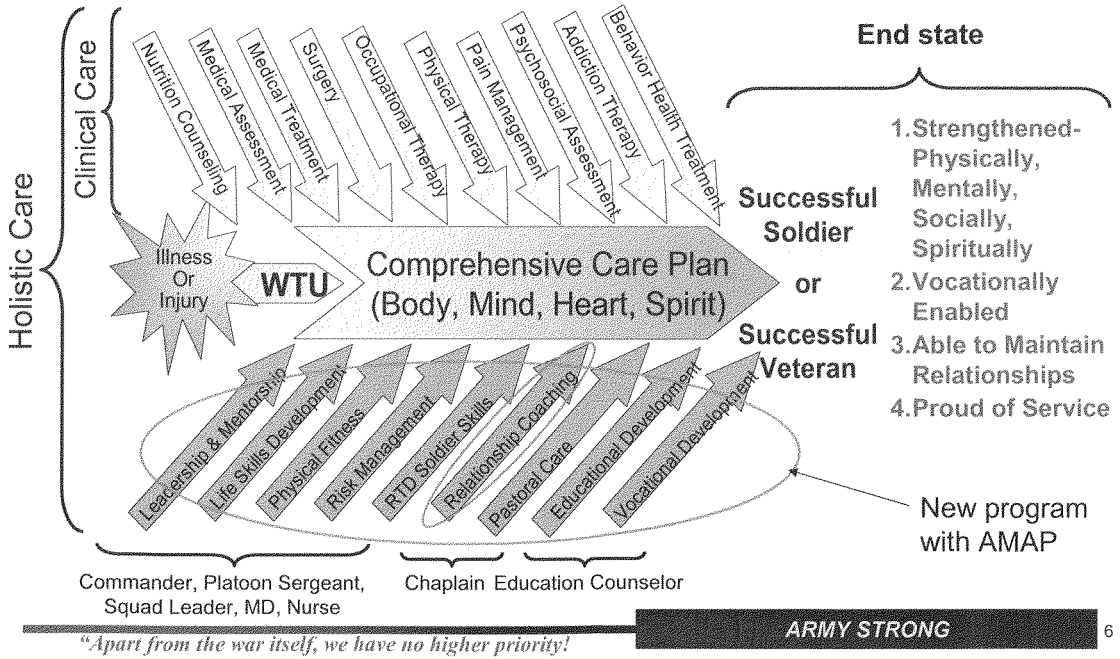
Warrior Transition Unit

Current WT Population (assigned or attached to a WTU) is 9,782 Soldiers



Comprehensive Care Plan

Healing the Total Person

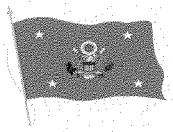


"Apart from the war itself, we have no higher priority!

Coordination with VA

What the Army Has Done…

- Added 16 VA advisors at major medical treatment facilities
- Provided VA unlimited access to DoD medical records / databases
- Federal Recovery Coordinator at WRAMC and BAMC (SOC Initiative)
- Senior Advisor Exchange w/ VA
- Statement of Mutual Support signed by Sec Army and Sec VA



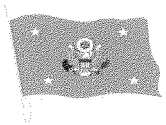
Mental Health

TBI / PTSD

What the Army Has Done…

- 800,000 Soldiers received training
- 129 of 272 new mental health hires;
  - **estimate a total of ~150 by 01 March**
- Battlemind Program
  helps Soldiers / Families understand
- Baseline – Cognitive testing
  - 40,000 completed
  - July 08' – Every Soldier
- Army One Source / confidential mental health counseling
- Helmet Pilot – 1,145 in theater
- WTU cadre undergo sensitivity training as part of their certification
- Completed PTSD / TBI training for social work personnel, nurse case managers, & psychiatric nurse practitioners
- Establishing mental health / counseling program to support children of wounded Soldiers

4- 6 Feb; SA / CSA directed Tiger Team to analyze and discover better methods to deter self-defeating behaviors (report due 12 Feb)



Physical Disability Evaluation System

What the Army has Done…

- Reduced paperwork by 58% (36 documents to 18 – Lean Six Sigma)
- Reduction in formal board requests by providing legal advice from trained SJAs
- Standardized training and certification for Physical Evaluation Board Liaisons (PEBLO)
- Provided Soldiers and their Families interactive access to their Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) eliminating appointments to review and provide input via AKO
- Increased MEB Staff from 1:80 ratio to 1:30
- Supporting DoD PDES pilot study at Walter Reed

Top 10 Bureaucracies Busted

1. Combat-Related Injury Pay allowed to continue while assigned to WTU/CBHCO, regardless of status.
2. Special Duty Pay created for Squad Ldrs and Platoon Sgts
3. Wounded given preference for location of care
4. Wounded Soldiers given top Housing Priority
5. Policy authorizing PCS of Warrior in Transition Families
6. Paper work reduced 58% for APDES processing
7. Ninety Day Window given for Transition to VA
8. Internet, Phone, Cable TV free to Wounded Soldiers
9. VA Advisors Co-located at Army Hospitals/Facilities
10. Med Records shared with VA

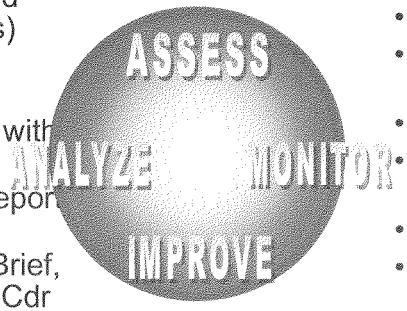
Dole-Shalala Report Implementation

Dole-Shalala	Army
• Develop integrated care teams	• Established Triad of a Squad Leader, Primary Care Manager (PCM), and Nurse Case Manager (NCM)
• Create Recovery Plan	• Developed Comprehensive Care Plan
• Develop corps of Recovery Coordinators	• Worked with LOA#3 to place FRC at WRAMC and BAMC
• Create a single, comprehensive medical exam	• Participating in DoD-VA PDES Pilot at WRAMC
• Address shortage in mental health professionals	• Contract to hire additional 272 (129 filled to date)
• Establish and expand networks of experts in PTSD and TBI	Army working with DOD Center of Excellence for PTSD/TBI
• Expand training regarding PTSD and TBI	Provided PTSD/TBI Awareness Tng to Army and to Families
• Develop or disseminate clinical practice guidelines	Clinical practice guidelines and training provided to PCMs, NCMs, and Behavior Health Providers.
• Expand caregiver training for families	• Nurse Case Manager and Primary Care Manager along with SFAC staff provides training to families
• Make patient information available to all personnel who need it, initially in readable form	• Made patient information available through read only files, access to AHLTA (DoD electronic health record).
• Continue efforts for fully interoperable information system	• Representatives on LOA#4 continue to work bidirectional interface between theater, MTF, and VA health facilities
• Develop a user-friendly single web portal for service members and veterans	• Army has developed myMEB/myPEB for Soldiers to access their board file and other information
• Assure adequate resources for WRAMC	• Army has ensured that WRAMC is fully funded
• Strengthen recruitment and retention of needed administrative and clinical staff at WRAMC	• Army M&RA is working with WRAMC and MEDCOM to ensure WRAMC remains fully staffed until after the new Walter Reed National Military Medical Center at Bethesda is open and fully operationally

Shining Light Into Darkness

How we see ourselves

- Weekly Dashboard (400 + data points)
- Monthly Status Reports (RMC)
- Monthly Cdr VTC with VCSA
- Monthly Status Report to Sec Army
- Quarterly Status Brief, MTF Cdr to RMC Cdr (COL – BG)
- Semi-Annual Status Brief, RMC Cdr – MEDCOM Cdr (BG – LTG)
- Annual Unit Certification
- Soldier Sensing sessions

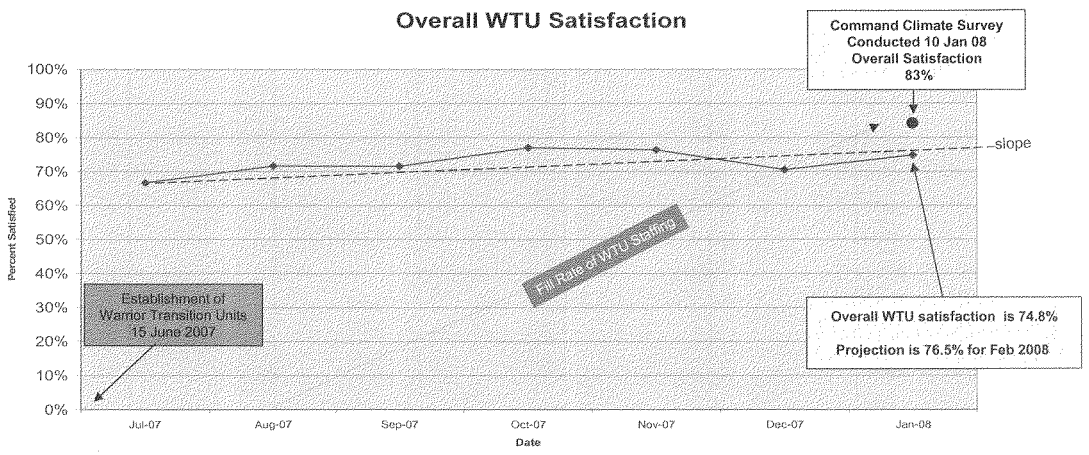


How others see us

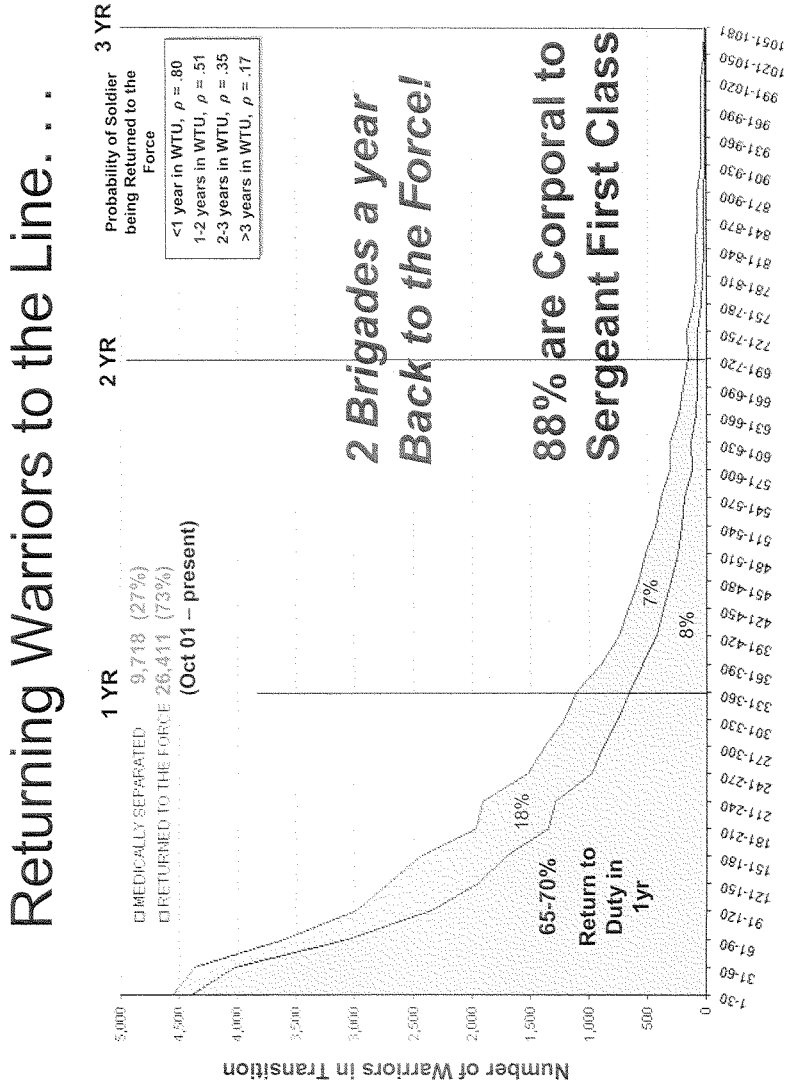
- Staff Assistance Visits
- Monthly Town Halls by Senior Cdr
- Unit Surveys
- OSD Health Affairs Surveys
- Ombudsman
- Wounded Soldier and Family Hotline 24/7
- Dole-Shalala Commission
- GAO
- DAIG
- Federal Recovery Coordinator

- Ensuring we don't drink our own bathwater !

Are our Warriors in the WTU Satisfied?



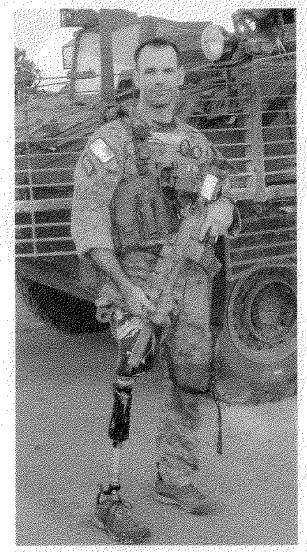
- Soldiers are becoming more satisfied as the WTU program matures (Statistically Significant $\rho < 0.05$, $r^2 = 0.32$)
- With the inclusion of the Active Component, we now have a comprehensive picture of the satisfaction of all Warriors in Transition
- Significant improvements have been observed in questions related to the PEBLO



Data source: MODS, October 2001—31 December 2007
POC: Dr. Michael J. Carino, OTSG

This is what we do . . .

- **I will Never Quit!**
- **I will Never Leave a Fallen Comrade!**



- **MSG Yerry (Delta Force) lost his leg to enemy machine gun fire in Sep '05.**
- **After 5 months at Walter Reed, he was returned to duty.**
- **He is currently deployed.**