Prepared Statement

of

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INTRODUCTION

SUPPORT AND CARE FOR OUR WOUNDED SOLDIERS

Mr. Chairman and distinguished members of this Subcommittee, thank you for this opportunity to discuss support and care for our wounded soldiers. As you know, we have just received the report of the Independent Review Group established by the Secretary of Defense. We very much appreciate their work and recommendations. We will be working on a fast track to coordinate the recommendations within the Department and develop aggressive action plans to implement those directed by the Secretary of Defense.

As you know, we also await the findings of the President's Commission on Care for America's Returning Wounded Warriors, which is taking a comprehensive look at the full life cycle of treatment for wounded veterans returning from the battlefield. The President also chartered the Department of Veterans Affairs Interagency Task Force on Returning Global War on Terror Heroes. The Department has been actively participating with the Department of Veterans Affairs and the many other agencies in developing the Task Force Action Plan which will be available within the next few days. In October, we look forward to the findings of the Veterans' Disability Commission, chaired by LTG (ret) Terry Scott and chartered by the National Defense Authorization Act of 2004. This Commission is studying veterans' benefits, and is scheduled to report out later this year.

Finally, we requested the Department of Defense Inspector General perform an independent review, evaluating our policies and processes for injured OIF/OEF Service members. The objective is to ensure they are provided effective, transparent, and

expeditious access to health care and other benefits when identified for separation or retirement due to their injuries. I expect to receive the Inspector General report by July 2007.

The intense work being done by all of these groups, as well as that underway within the Department itself, reflect a collective consensus that our existing systems for supporting the wounded need to be examined and improved. Some of them, notably the Disability Evaluation System, are based on laws and regulations that are decades old and don't reflect current operations and realities facing service members returning from battle today. We agree that fixes need to be made.

On April 12, appearing before the Senate Armed Services Committee and the Senate Veterans' Affairs Committee, Deputy Secretary of Defense England acknowledged the need for these changes and proposed three possible approaches:

- As a first step, focus on and seek innovative solutions for the wounded and severely wounded cases, and then turn to the general population of service members.
- Move beyond stove piped data storage systems to create a central data base of information to expedite full electronic information exchange.
- Make existing benefits more accessible through common terminologies and a fully integrated process.

He also proposed that we re-evaluate the entire national system for disability determination and compensation.

The Department of Defense (DOD) is determined to improve processes -- ours and those in which we collaborate or interface.

WE AREN'T WAITING

While awaiting the findings of the Independent Review Group and the other Commissions and Task Force, the Department has engaged in a number of actions to identify issues of concern and fix them. We have requested an adjustment to the Fiscal Year 2007 Emergency Supplemental request to provide $50 million to create a Medical Support Fund to implement any findings or recommendations in which the Department can take action before Fiscal Year 2008.

Walter Reed.

For example, the Department and the United States Army have moved quickly to improve conditions and enhance services at Walter Reed. We have taken steps to control security, improve access, and complete repairs at identified facilities that provide for the health and welfare of our nation's heroes. On March 23, the Army opened its Soldier and Family Assistance Center – a one-stop shop that brings together case managers, family coordinators, personnel and finance experts, and representatives from key support and advocacy organizations in one location. The Soldier and Family Assistance Center reduces in-processing locations from seven to two. In addition, the Army's new Warrior Transition Brigade will be fully operational at Walter Reed on June 7th to assist soldiers assigned to medical holdover. This brigade will reduce cadre-to-Soldier ratios from 1:55 to 1:12.

We can best address the changing nature of inpatient and outpatient healthcare requirements, specifically the unique health needs of our wounded Service members and the needs of our population through the planned consolidation of health services and

facilities in the National Capital Region. The BRAC decision preserves a precious national asset by sustaining a high-quality, world-class military medical center, co-located with robust graduate medical education program, and across the street from the Nation's premier health research organization in the Nation's Capital. The plan is to open this facility by 2011.

In the interim, we will not deprive Walter Reed of resources to function as the superb medical center it is. In fact, in 2005 we funded $10 million in capital improvements at Walter Reed's Amputee Center – responding to the immediate needs of our warrior population. We are proud of that investment in capacity and technology. We simply will not allow the plans for a new medical center to erode the quality of care delivered at the current hospital.

The Army has reported on the recent improvements to Walter Reed living conditions. There are no soldiers living in Building 18. The US Army Corps of Engineers has installed new IT upgrades, phone lines, internet access and cable television for all post lodging facilities. An Emergency Medical Technician is available 24/7 to the Mologne House. The establishment of the Warrior Transition Brigade establishes command responsibility for and oversight over a seamless continuum of care for the wounded or injured.

To provide for robust staffing at Walter Reed, the Office of Personnel Management provided Direct Hire Authority for over 100 patient care (medical and support) positions. The Army made 125 job offers at the recent Walter Reed "Caring for America's Heroes" Job Fair.

FEEDBACK FROM SERVICE MEMBERS AND FAMILIES

One of the most important things we can do to ensure that we are taking care of our wounded soldiers is to get feedback from them personally. To ensure we meet and exceed future expectations of Service members and their families, the Department of the Army set up a toll-free hotline to receive beneficiary input. TRICARE Management Activity and the Veterans Administration are integral components of the call center ensuring full-spectrum resolution of medical issues. In addition, we are conducting surveys of wounded warriors and their families, so we may assess what is going well and identify areas that need improvement. The first military health system survey is being fielded this month with initial results expected in June.

PROCESS OF DISABILITY DETERMINATIONS

With respect to disability determination, let me just say that Service members deserve fair, consistent and timely determinations. Complex procedures must be streamlined. The system must not be adversarial. We have several efforts underway – a fast track look at possible system changes for those injured or wounded in combat and a systemic look at the disability evaluation process for all. We have convened senior leaders of the Military Departments and the Office of the Secretary of Defense to begin the process of designing a system optimized for our wounded and severely wounded service members, speeding disability determinations and providing support for their transition to civilian life. Further, this afternoon, together with our partners in Veterans Affairs, we will begin a comprehensive re-design of our processes affecting the other 15 to 20,000 people annually who move through our disability evaluation and separation systems.

The Military Departments' Personnel Chiefs and Surgeons General recommended we charge the Disability Advisory Council with updating the set of directives and instructions that promulgate disability policies. We have done so. We have also tasked this group with strengthening oversight processes and making recommendations on program effectiveness measures. The Department has established working groups, under the Disability Advisory Council, consisting of senior human resource and medical subject matter experts from the Military Departments and the Office of the Secretary of Defense to address issues such as training, oversight and consistency of application. Additionally, we have invited representatives from the Department of Veterans Affairs (DVA) to sit on the Council to assist the process as we strive for a seamless transition for our servicemembers from the DoD Disability system to the VA system. We anticipate revised DoD instructions will be completed in May 2007.

In addition to our DoD-level initiatives, the Military Departments are also continually reviewing their processes to make them more effective. For example, Army leadership recently established a Physical Disability Evaluation System (DES) Transformation Initiative which integrates multiple major commands and the Department of Veterans Affairs. This combined effort targets improving process efficiency and timeliness in areas such as: Military Evaluation Board and Physical Evaluation Board processes, automation of disability data, counseling and training, and transition assistance. Additionally, in November 2006, the Army directed an internal Inspector General review of its DES process. I understand that the report is due out this fall.

PROCESS OF PROGRAM AND CARE COORDINATION

The quality of medical care we deliver to our Service members is exceptional, as evaluated by numerous independent reviews. Yet, we need to better attend to the coordination of services for members in long-term outpatient, residential rehabilitation and we must streamline the transition from DoD to VA. We are evaluating with VA a single case manager model. Additionally, we will assess and work towards the proper ratio of case-managers-to-wounded Service members. We will also assess the administrative and information systems in place to properly manage workload in support of the Service members and families.

We are committed to identifying and correcting the shortcomings that involve the joint responsibilities of the Departments of Defense and Veterans Affairs (VA). We have already begun working with our colleagues on corrective action. We are focused on facilitating a coordinated transition, enabling Service members, veterans, and their families to navigate a complex benefits systems with relative ease – a seamless transition. We have joined with the VA in a coordinated organizational structure. The VA/DoD Joint Executive Council, co-chaired by DVA Deputy Secretary Gordon Mansfield and Under Secretary of Defense David Chu provides guidance and policy for collaborative efforts. There are two subordinate counsels – one focused on health care issues, another on veterans' benefits. I will describe several of our ongoing efforts.

- One program under the purview of the Benefits Executive Council (BEC) resulted in agreements between DoD and VA officials at 130 different locations for both agencies to use the same, single separation physical. This program, called Benefits Delivery at Discharge (BDD), also brings claims specialists from the Veterans Benefits

Administration (VBA) into DoD facilities to assist Service members in filing disability claims as early as six months before they leave uniform.

- The Army Liaison/VA PolyTrauma Rehabilitation Center Collaboration program, a "Boots on the Ground" program, stood up in March 2005. The intent of this collaborative effort is to ensure that severely injured Service members who are transferred directly from an Medical Treatment Facility to one of the four VA PolyTrauma Centers (in Richmond, Tampa, Minneapolis, and Palo Alto), are met by a familiar face in a uniform.

DOD has a long-standing relationship with the VA, in which VA provides rehabilitative services for patients with traumatic brain injuries, amputations, and other serious injuries as soon after the incident as clinically possible. A staff officer or non-commissioned officer assigned to the Army Office of the Surgeon General is detailed to each of the four PolyTrauma Centers. The role of the Army liaison is primarily to provide support to the family on a broad array of issues, such as travel, housing, and military pay. The liaisons have also played a critical role in the rehabilitation process by promoting resiliency in Service members. The presence of a uniformed liaison reassures these Service members and their families that we appreciate their service and are committed to ensuring their needs are met by our sister agency.

The Joint Seamless Transition Program, established by VA, in coordination with the Military Services, assists severely injured Service members while they are still on active duty so that they can more timely resolve benefits. There are 12 VA social workers and counselors assigned at ten of DoDs Medical Treatment Facilities, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda.

They ensure the seamless transition of health care between DoD and VA by coordinating in advance the inpatient care and outpatient appointments at the VA medical center to which the patient will be moved. They follow-up with patients to verify success of the transfer plan, and to ensure continuity of therapy and medications. Case managers also refer patients to Veterans benefits counselors and vocational rehabilitation counselors. Veterans Benefit Administration counselors visit all severely injured service members and inform them of the full range of VA services, including readjustment programs, and educational and housing benefits. As of February 28, 2007, VA social worker liaisons had processed 7,082 new patient transfers to Veterans Health Administration (VHA) at the participating military hospitals.

• The Recovery and Employment Assistance Lifelines (REALifelines) initiative is a joint project of the U.S. Department of Labor, the Bethesda Naval Medical Center and the Walter Reed Army Medical Center. It creates a seamless, personalized assistance network to ensure that seriously wounded and injured service members who cannot return to active duty are trained for rewarding new careers in the private sector. Realifelines works closely with the VA's Vocational Rehabilitation program to ensure Service members have the skills, training, and education required to pursue their desired career field. The Department of Homeland Security's Transportation Security Administration has a transportation specialist assigned to the Center to facilitate travel of severely injured members and their families through our nation's airports. The Center's TSA liaison coordinates with local airport TSA officials to ensure that each member is assisted throughout the airport and given a facilitated (or private) security screening that takes into account the member's individual injuries. .

INFORMATION SHARING

The programs and benefits earned by Service members could not be delivered without complete cooperation between the DOD and the VA in the area of information sharing. Indeed, information sharing is critical to an effective and transparent transition process, and that is why so much attention is paid to information management and information technology in the JEC's Joint Strategic Plan.

- Electronic Health Records. The Federal Health Information Exchange (FHIE) is an electronic transfer of protected health information from DOD to VA at the time of the Service member's separation. The data contained in this transfer include: pharmacy and allergy data; laboratory and radiology results; consult reports; discharge summaries; admission, disposition and transfer information; and patient demographic information. Health care providers within VHA, and benefits counselors within VBA, access this information via the Computerized Patient Record System and Compensation and Pension Records Interchange, respectively. As of the end of March 2007, DOD has transmitted health data on more than 3.8 million patients.

Building on the success of FHIE, DOD now sends electronic pre- and post-deployment health assessment and post-deployment health reassessment information to the VA. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005, and the post-deployment health reassessment in December 2005. As of February 2007, VA had access to digital data comprising more than 1.6 million pre- and post-deployment health assessments and post-deployment health re-assessment forms on more than 681,000 separated Service members and demobilized National Guard and Reserve members who

had been deployed. In December 2006, we added weekly data pulls of post-deployment health reassessments for individuals referred to the VA for care or evaluation.

To support our most severely wounded and injured Service members transferring to VA PolyTrauma Centers for care in March 2007, DOD started sending radiology images from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC), Bethesda to the Tampa VA PolyTrauma Center. DOD plans to expand the capability to Brooke Army Medical Center (BAMC) and the other three VA PolyTrauma Centers in Minneapolis, Richmond, and Palo Alto. In addition, Walter Reed AMC also began scanning paper medical records and sending them electronically for the patients transferring to the Tampa VA PolyTrauma Center. DOD plans to expand this capability to encompass scanning records from NNMC and BAMC for patients transferring to any of the four VA PolyTrauma Centers.

Building from the FHIE, which is a one-way flow of information, DOD and VA have developed and begun deployment of the Bi-Directional Health Information Exchange (BHIE). This electronic exchange enables near real-time sharing of allergy, outpatient prescription, inpatient and outpatient laboratory and radiology results, and demographic data between DOD and VA for patients treated by both departments. BHIE is operational at all VA medical centers and at 14 DOD medical centers, 19 hospitals, and over 170 outlying clinics.

With an eye toward the future and to accelerate progress in sharing appropriate health information, the VA/DOD Health Information Technology Sharing Working Group established in FY 2006 an interface between BHIE and the DOD Clinical Health Data Repository. In the third quarter of this fiscal year, all DOD sites and all VA sites

will be able to view data from the other Department for shared patients. We are also focusing on increasing the amount of inpatient data exchanged. Most recently, BHIE began to exchange inpatient and emergency department discharge summaries. Other inpatient documentation, such as operative reports and inpatient consultations, are planned for the future.

DOD is aware of the concerns regarding the time it has taken to establish the desired level of interoperability. With the full deployment of DOD's electronic health record (EHR) – AHLTA – across the Military Health System accomplished, we are poised to continue building on our significant achievements in sharing critical health information across agency lines.

We are currently testing our ability to share inpatient information. In September 2006, DOD and VA began exchanging clinical information between clinical data repositories. Health information sharing of this magnitude has never been done before.

- The Clinical Data Repository/Health Data Repository (CHDR) is a DOD-VA interface. It exchanges standardized and computable pharmacy and medication allergy data. The pharmacy and allergy information supports drug-drug and drug-allergy order checking for shared patients, using data from both DOD and VA. DoD and VA have implemented this capability at eight sites. And, by July, DOD will allow all of its remaining locations to begin using this interface.

The ultimate desired end-state will be a completely electronic health care record that is accessible and useable to the provider regardless of which health care system they are operating within.

OTHER INFORMATION SHARING PROGRAMS

I want to discuss two additional information sharing programs that provide VA with essential data in order to expedite the benefits delivery process. First, DOD is providing contact information for Service members when they separate. In September 2003, DOD began routinely providing VA with rosters on recently separated OEF and OIF veterans – Active Duty and Reserve Components. VA uses these lists to distribute to veterans information on VA benefits related to service in a combat theater. Over 580,000 letters have been mailed.

Second, DOD is transmitting to VA's Office of Seamless Transition a monthly list of key demographic and contact information on Service members who have been referred to a Physical Evaluation Board. This list enables VA case managers to make contact with Service members at the earliest time possible, while they are still in uniform. DOD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates. We have provided information for more than 16,000 Service members while they were still on active duty, allowing the VA to better project future workload and resource needs.

DEPLOYMENT AND POST DEPLOYMENT HEALTH

For several years now, DOD has been performing health assessments on Service members prior to and just after deployment. These assessments serve as a screen to identify any potential health concerns that might warrant further medical evaluation. This includes screening the mental well-being of all Soldiers, Sailors, Airmen and Marines in both the Active and Reserve Components.

Every year, members are screened for mental health problems when they complete a preventative health assessment. Now, they are again screened before they

deploy. In addition, before returning home from deployment, members complete a post deployment health assessment, which contains questions aimed at identifying physical or mental health concerns; environmental exposure concerns; psychosocial concerns, such as acute post traumatic stress disorder, depression, anger, or inter-personal conflict; and potentially unexplained symptoms.

The Services are now implementing an additional health reassessment that is conducted 3-6 months after returning home – the Post Deployment Health Re-Assessment. Our experience has taught us that problems are not always apparent at the time Service members are immediately returning home, but they may surface a few weeks or months later. We want to assist in early identification of these concerns and facilitate ready access to care at the level most appropriate to the individual Service member.

Because of challenges faced by our forces, some Service members may develop chronic mental health symptoms. Mental health experts from the DOD and VA developed joint clinical practice guidelines for acute and post traumatic stress disorder, major depressive disorder, substance use disorders, medically unexplained symptoms, pain, and general post deployment health concerns. DOD uses all available resources, including local military or TRICARE providers (a benefit extended for up to 180 days post deactivation for Reservists); to provide treatment for affected Service members. VA is a partner in this process by providing health care and counseling services to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans who are no longer on active duty.

To supplement mental-health screening and education resources, we added the Mental Health Self-Assessment Program, or MHSAP, in 2006. This program provides military families, including National Guard and Reserve families, Web-based, phone-based and in-person screening for common mental-health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools. Spanish versions of these screening tools are available.

The Department is working on a number of measures to evaluate and treat Service members affected or possibly affected with traumatic brain injury (TBI). For example, in August 2006, we developed a clinical-practice guideline for management of mild TBI in theater for the Services. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to deal with TBI. The clinical-practice guideline included a standard Military Acute Concussion Evaluation (MACE) form to assess and document TBI for the medical record. We are also conducting research in the inpatient medical area. Furthermore, to enhance the Periodic Health Assessment, Post-Deployment Health Assessment and Post-Deployment Health Reassessment, we directed inclusion of questions on TBI to capture data that will contribute to a better understanding of TBI identification and treatment. In addition, these questions will help identify Service members possibly exposed to events that caused TBI that were not documented at the time of exposure. As of April 2007, the VA is screening all OIF/OEF veterans receiving medical care within the VA for possible TBI. This screening further provides a systematic approach to identify and treat individuals

that may have experienced a brain injury. Those veterans who screen positive for a possible symptomatic TBI are then referred for specialized follow up care within the VA.

We published a new DOD Instruction, "Deployment Health," in 2006. Among its many measures to enhance force health protection is a requirement for the Services to track and record daily locations of DOD personnel as they move about in-theater and report data weekly to the Defense Manpower Data Center. We can use the data collected to study long-term health effects of deployments and mitigate health effects in future conflicts.

HEALTH CARE FOR THE RESERVE COMPONENT

At the direction of Congress, we have implemented new health benefits that extend TRICARE coverage to members of the Guard and Reserve. We implemented the TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families as mandated in the NDAA for FY 2005, and then amended in the NDAA for FY 2006. We are now working on the new program mandated by the NDAA for FY 2007. Today, more than 34,000 reservists and their families are paying the premiums and getting TRS coverage. We have made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families.

The Department is committed to providing the assistance and support required to meet the challenges that confront our severely injured and wounded Service members, and their families.

The Department of Defense cares deeply about the well-being of its people. It has been painful to learn, as we have recently, that some of those recuperating from injury have not received the kind of care they deserve.

We have taken this sobering information as a call to action. Today we are making dramatic improvements in our system, discarding outdated assumptions, removing bureaucratic roadblocks, improving information sharing, and re-focusing our attention on the one thing that matters most: The health and well-being of our courageous Service men and women. We have done much, but there is more to do. We look forward to the results of every review effort in order to improve and continuously improve support to our warriors and their families.

Mr. Chairman, this concludes my statement. I look forward to working with the committee in this new Congress to uphold our traditional outstanding support of American heroes – our Nation's Servicemen and women, veterans, and their families.