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Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to discuss the Department's program on Psychological Health and Traumatic Brain Injury.

The Department of Defense is committed to providing excellence across the board in protection, prevention, diagnosis, treatment, recovery and care transition for our military members and their families who experience mental health conditions or traumatic brain injuries as a result of the Global War on Terror. In accomplishing those objectives, we are working hand-in-hand with our federal partners in the Department of Veterans Affairs (VA) as well as the Department of Health and Human Services (HHS). We sincerely and gratefully acknowledge the funding support from Congress to assist us in those efforts as we move forward in providing our military personnel and military families with the care and support they deserve.

To begin, this change required a vision for the future and a strategic plan to ensure that the system that we were creating met the needs of our military community during a time of prolonged conflict.

In establishing our plan of action, we relied on five guiding principles to define the progress of our work. They included:

1. Furnish strong, visible leadership and the resources necessary to provide for Service members who experience Traumatic Brain Injury or Psychological Health concerns and conditions;
2. Create, disseminate, and maintain excellent standards of care across the Department;
3. When best practices or evidence-based recommendations are not readily available, conduct pilot or demonstration projects to better inform quality standards;
4. Monitor and revise the access, quality, and fidelity of program implementation to ensure standards are executed and quality is consistent; and
5. With constant attention to the needs of our war-fighters and their families, construct a system in which each individual may expect and receive the same level of service and quality of service regardless of Service, Component, status, or geographic location;

Based on these principles, we have built a comprehensive plan on a foundation of seven initiatives. The seven initiatives will transform our system of care of psychological health (PH) and Traumatic Brain Injury (TBI) for our military members and the families of members in distress. We have assigned each program to one of the seven initiatives. Creating a continuum of care, however, often leads to program components that do not fit neatly into a two-dimensional descriptive diagram. For this reason, programs and their associated funding may shift over time as the program matures and takes shape. When components cut across initiative lines, we included them in the area for which the majority of the work fit best. The seven primary initiatives include:

(1) **Leadership and Advocacy** – The health of the force and the community is a leadership responsibility. We are working first and foremost to build a strong culture of leadership and advocacy.

(2) **Quality of care** – Quality care requires that we develop and ensure consistent standards and excellently trained clinicians both in our military treatment facilities (MTFs) and in the TRICARE provider network.

(3) **Access to care** – Ensuring easy, timely access to the full continuum of care, regardless of location, calls for an increase in healthcare providers and expanded telehealth services for hard-to-serve areas and populations. We have funded Service-specific telehealth initiatives and will coordinate standards and expand access through a centralized focus on telehealth and technology incorporated into the Defense Center of Excellence (DCoE).

(4) **Resilience promotion** – Our goal is to build strong minds and strong bodies. That requires solid prevention and protection, in addition to diagnosis and treatment. For this reason, we focus on psychological health, which includes the full continuum – removing or mitigating organizational risk factors, strengthening individual and family health and wellness, and traditional clinical diagnosis and treatment.

(5) **Screening and Surveillance** – In the area of screening and surveillance, our objective is to ensure early identification for individual conditions and concerns to afford the earliest possible intervention; identify trends as they emerge in the community so population-based changes may be made; and provide a solid structure for information management.

(6) **Transition and Coordination of Care** – We are partnering with federal agencies, including the VA and the HHS, as well as our TRICARE managed care support contactors, to ensure there are no gaps in care as patients transition through various systems of care or transition to different duty stations or geographic locations.

(7) **Research and Development** – We have expanded the research opportunities for PH and TBI to establish a strong foundation of medical and cross-functional research. We will continuously improve as researchers report findings and new information that shapes and reshapes our vision of the future.

In all these areas we strive to perpetuate a system of consistently excellent care across the Department and all the military Services. We have made significant accomplishments in each of these areas.

(1) CULTURE OF LEADERSHIP AND ADVOCACY

Leadership Vision. The Department's priority is to strengthen and maintain a culture of leadership and advocacy. Taking care of people is a leadership responsibility. We have taken this responsibility to heart at every level of leadership – from senior levels in the DoD down to the small unit level in military organizations and to the family units in our military community.

We formed a Senior Oversight Council, chaired by the Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs. Participants include senior leadership from each of the military Departments, as well as the medical leadership from the DoD and each of the Services. This council meets weekly to plan and monitor our work toward improving care and support for our wounded, ill and injured service members and families. We will continue to convene this council until we are assured our system of support and care is effectively meeting the needs of our community, as viewed through their eyes.

We have eight lines of action under the Senior Oversight Council. The Line of Action 2 (LOA2) group is looking at TBI and Post Traumatic Stress Disorder (PTSD) (under the umbrella of developing and maintaining positive psychological health). LOA2 compiled more than 400 recommendations from external and internal review groups to identify ways to improve the effectiveness of our system of care. Undaunted by the task ahead, we moved forward with an aggressive timeline to accomplish those goals.

Fiscal Responsibility. Leadership and advocacy requires effective financial planning and execution. In FY07, we received a generous addition of $900M to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system. We do not consider the funds as intended to supplant existing funding or programs. We take responsibility in using these funds to support change, and we will leverage change through optimal planning and execution of the special supplemental funding.

We allocated and distributed the funds based on an overall strategic plan created by representatives from DoD and the Services, including VA input. We then examined proposals from the Services and other DoD organizations to use the funds to accomplish the strategic plan.

To date, we have distributed funds in three phases to the Services for execution. Of the $600M O&M Funds, $566M or 94 percent has been distributed, including $315M for PH and $251M for TBI. The small amount remaining is reserved for expansion of promising demonstration programs and for additional costs that emerge as the plans are executed.

Spend plans generally call for a measured distribution of expenditures in accordance with specific program requirements. We do expect all funds to be expended at the beginning of the year, but rather expect that the execution of funds will flow throughout the year, in accordance with projected expenditures based on program objectives and activities. To track the planned expenditure rate, we established a spend plan monitoring program that seeks to examine the planned rate of expenditure against the actual rate to determine how timely the funds are being executed. This plan is reported monthly to the senior leadership of the MHS. This is a continuous evaluation to ensure best use of resources to achieve the desired outcomes.

Defense Center of Excellence for Psychological Health and TBI. Third in our efforts to develop a culture of leadership and advocacy is the creation of the DoD Center of Excellence for PH and TBI or DCoE. The MHS appointed the DCoE director in September 2007 and

opened the doors for operations in November 2007. The MHS designed this Center to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with mental health and TBI concerns. It also will provide a nexus for research planning and monitoring the research plans in this important area of knowledge.

While the DCoE will provide some intensive outpatient care for wounded warriors in the National Capital Area, an equally important function is to instill that same quality of care across the country and around the world through establishing clinical standards, conducting clinical training, developing education and outreach resources for leaders, families and communities, along with researching, refining and distributing lessons learned and best practices to our MTFs and to the TRICARE provider networks.

The DCoE staff incorporates a balanced mix of uniformed and civilian staff members who are charged with building and orchestrating a national network of research, training and clinical expertise. The DCoE is leveraging existing expertise by integrating functions currently housed within the Defense Veterans Brain Injury Center (DVBIC) and the Center for Deployment Psychology (CDP).

Functionally, the DCoE is engaged in several focus areas, including:

1) Mounting an anti-stigma campaign projected to begin this spring through a national collaborative network that includes partnering with the Uniformed Services University for the Health Sciences, the National Institutes of Health, the VA, the Substance Abuse and Mental Health Services Agency, our coalition partners, and others in the public and private sectors;
2) Establishing effective outreach and educational initiatives, including creating an Information Clearinghouse, public website, a wide-reaching newsletter, and a 24/7 call center that will allow any service member or family member who needs assistance in navigating the system of care to get help with a single phone call. The call center would equally serve clinicians across the Department with questions concerning clinical practices, training, or standards of care in the area of PH and TBI;
3) Promulgating a Telehealth Network for clinical care, monitoring, support and follow-up;
4) Coordinating an overarching program of research that is relevant to the needs of the field, in coordination with other DoD organizations, VA, National Institutes of Health and other partners;
5) Providing training programs aimed at providers, line leaders, families and community leaders; and
6) Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building funded by the Intrepid Fallen Heroes Fund to house the DCoE that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

More than $83M has been allocated toward DCoE-related functions. That total includes amounts allocated specifically to telehealth infrastructure and to DVBIC functions. An additional $45M was allocated to research and development projects.

(2) QUALITY OF CARE

One of the most critical functions of the DCoE lies with the Quality of Care initiative, which relies on developing and disseminating clinical guidance and standards, as well as training clinicians in clinical practice guidelines (CPGs) and in effective, evidence-based methods of care.

Because we urgently need these functions, we are not relying solely on the DCoE to attain full functional capacity to begin training. We funded each of the Services to initiate quality of care functions, including critical clinician training. In the area of mental health, we funded each Service to provide training to mental health providers in CPGs and evidence-based treatment for PTSD and formed a strong partnership with the VA to develop and deliver this training. We also funded each Service to provide training to primary care providers in mental health CPGs. Regarding TBI, we funded a TBI training course attended by more than 800 providers, including VA providers. We will repeat this training in 2008 to provide a basic level of understanding of mild TBI to as many healthcare providers as possible. Over the coming months, we will be consolidating and standardizing these training efforts under the DCoE umbrella.

Severe traumatic brain injury is easily observed. Similar to other severe trauma situations, severe TBI is treated using well-established procedures. Moderate TBI is also usually clearly recognizable with an event-related period of loss of consciousness and clearly observable neurocognitive, behavioral, or physical deficits. On the other hand, mild TBI, while more prevalent, is more difficult to identify and diagnose on the battlefield, just as it is in civilian scenarios. The index of suspicion must be high to ensure that those who have suffered mild TBI are appropriately evaluated, treated, and protected. We have established a strategy to improve the entire continuum of care for TBI, concentrating our efforts primarily on mild TBI, and we published a DoD policy on the definition and reporting of TBI. This policy guidance serves as a foundation for shaping a more mature TBI program across the continuum of care and sets the stage for the mild TBI CPG to follow.

While evidence-based CPGs have been published for severe and moderate TBI, as well as for in-theater care of mild TBI, we need a full-scale CPG for mild TBI in garrison. We funded the Army Quality Management Office, the DoD executive agent for Clinical Practice Guidelines, to create a formal CPG for mild TBI. Guidelines generally require 2 years to develop; however, we are expediting that process and will have the CPG completed in one year.

Having standard guidelines and a trained staff is only part of the quality equation. A similarly important factor is having the proper equipment for the provision of care. The Army and Marine Corps are the population at highest risk for potential brain trauma. Therefore, funds

were used to purchase or lease equipment to enhance screening, diagnosis and recovery support for soldiers and Marines.

(3) ACCESS TO CARE

Our ability to deliver the highest quality care depends, in part, on easy and timely access. Access, in turn, depends on the adequacy of staff, both military and civilian, to meet the demand in line with acceptable standards for appointment wait times while also providing the services in a location or manner in which the service or family member can interface with the provider or system without undue hardship or long travel times and distances.

In October 2007, we issued a new policy. It reiterated that patients should be scheduled for initial primary appointments within seven days of request.

In addition to increasing access for initial mental health appointments, we are moving behavioral health functions forward into primary care settings. We have funded all the Services to hire personnel in mental health clinics and behavioral health personnel to work in primary care clinics. In this setting, behavioral health providers can easily consult with primary care providers to help identify mental health conditions and make the appropriate referrals for treatment or manage the care in primary care when appropriate. It also enables us to provide care for behavioral aspects of more traditionally physical health problems, such as pain and sleep problems that cause patients to seek care. Primary care providers will be a big help in the area of TBI.

To ensure ready access to mental health and TBI care in our MTFs, we are increasing the number of staff, both military and civilian, using a number of approaches.

For TBI, we developed a standard capabilities model of multi-disciplinary staffing for TBI care and management that we are now assessing for full use across all the military Services. This model provides the basis for a site certification pilot the Army has undertaken to ensure that soldiers with TBI receive care only at those treatment facilities with established capability to care for them.

Deployment-related healthcare has proven to be most effective when integrated with total healthcare. The Institute of Medicine advocated this position, and it was codified in the DoD/VA Post-Deployment Health Evaluation and Management Clinical Practice Guideline (PDH-CPG) mandated for implementation and practice across the DoD. Telehealth technology will help bridge this gap. While the DCoE will coordinate and integrate telehealth activities and capabilities across the Department, the Services have begun demonstration projects to assess how best to leverage telehealth technology to increase care for TBI patients in remote or underserved locations.

For mental health, we developed a population-based, risk adjusted staffing model to more clearly inform us of the right number of mental health providers. We contracted with the Center for Naval Analysis (CNA) to validate the model and expect results from that contract

later this year. Using that validated model, we will be able to adjust the number of mental health providers in the next fiscal year.

Mental health providers are in short supply across the country. There are some hard-to-serve areas, such as remote rural locations. To increase providers in these areas, we are forming a partnership with the Public Health Service (PHS), which provides uniformed mental health providers to the DHHS. They have committed to providing us with 200 unformed PHS mental health providers of all disciplines. We asked the Military Services where those providers would be best positioned and are placing them in those locations.

In terms of civilian and contract providers, we are increasing our mental health staff by more than 750 mental health providers and about 95 support personnel across the Department. All funds for these providers have been distributed to the Services for their execution. They will be a mix of civil service and contract personnel. The MTF commanders have direct hire authority and will be increasing their staff through local means to meet any unique demands in their community.

Within the past few months, the managed care support contractors have added more than 3,000 new mental health providers to the TRICARE network across the three regions. In addition, they have reached out to thousands of non-network providers to identify clinicians who would be available to take on new patients if a network provider could not be identified within the established access standard timeframe.

In addition to civilian staff, it is increasingly important to recruit and retain military providers, as they serve critical missions as an integral part of our deploying force. We appreciate the continuing support of Congress in providing authority for incentive pays to all of our deserving military healthcare providers.

(4) RESILIENCE PROMOTION

We are pursuing a vision where building psychological fitness is equally important to building physical fitness. When health concerns do present, we are striving to break down the barriers to seeking care at the earliest possible time and in the least restrictive setting, including non-medical settings, such as chaplains and Military OneSource Counselors.

The DCoE is developing an anti-stigma campaign. An important part of reducing stigma is education. The DCoE also is pursuing a standardized curriculum for psychological health and TBI education for leaders, service members, and family members. In the interim, each Service has been funded to implement training across the leadership spectrum that adheres to our overarching principles yet is adapted to the culture of their particular Service.

For families, we have implemented and expanded several education and outreach initiatives. First, we are continuing and expanding the Mental Health Self-Assessment Program. This program is available in person at health fairs across the Department and in a web-based format. This program has been well-received and has been expanded to include our school-aged family members. The Signs of Suicide Program is an evidence-based prevention and

mental health education program in our DoD Educational Activity (DoDEA) schools. In addition, we are expanding this program to public middle and high schools in areas with high concentrations of deployed forces.

For our younger children, the Sesame Street Workshop has proven to be quite successful in helping young children understand and manage the emotions that go along with having a parent deployed. In fact, the program was nominated for an Emmy and has been distributed to more than 400,000 families. We are now funding expansion of this educational program to include the impact of having a deployed parent come back with an injury or illness. This program will be added to the original Workshop educational program and distributed widely across the Department. It is scheduled for completion and kick-off in April 2008 to coincide with the Month of the Military Child.

In pursuing resilience, we must not forget our healthcare and community support personnel who work tirelessly to support our deployed forces and their families. For this critically important group, compassion fatigue is a looming threat. Therefore, part of the mission of the DCoE is to develop a new curriculum of training or to validate existing training that will help to alleviate and mitigate compassion fatigue. Of course, compassion fatigue is intimately tied with each of the other aspects of PH and TBI. Without an adequate number of staff, the existing personnel are called upon to serve a high number of distressed personnel. As we increase our staff numbers, we hope to see the potential for fatigue and burn-out also decreased.

(5) SCREENING AND SURVEILLANCE

The primary objective of the screening and surveillance initiative is to promote the use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring, and management of PH and TBI conditions and concerns.

Screening and surveillance are ongoing initiatives being rolled out in an iterative fashion. We must incorporate these initiatives into the lifecycle of the service member as well as the deployment cycle.

We added questions to both the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) to facilitate TBI screening. We also are supporting initial identification teams at high-density deployment platforms to ensure screening is accomplished in a consistent manner and to further evaluate and treat those who screen positive.

We will move toward incorporating baseline neurocognitive assessments into our lifecycle health assessment procedures from access through retirement. As we progress in that objective, we are providing pre-deployment baseline assessments until we have finalized tests of various neurocognitive assessment tools to determine the best fit for full implementation.

The DCoE's DVBIC will play a pivotal role in collecting and analyzing screening data and making recommendations for future programs and tools. In addition, a critical element for

TBI surveillance is the TBI registry which is being built as a single repository for TBI case information across the DoD.

(6) TRANSITION AND COORDINATION OF CARE

More than in previous conflicts, the current conflict reminds us that we must effectively establish a patient- and family-centered system that manages care and ensures a seamless transition between healthcare systems and phases of care. Transition and coordination of care programs help wounded war-fighters and their families make the transition between clinical and other support resources in a single location, across different medical systems, across geographic locations, and across functional support systems, which often can include non-medical systems.

In terms of transition, we are pursuing better methods to ensure provider-to-provider referrals when patients move from one location to another or one healthcare system to another, such as between DoD and VA or the TRICARE network. This is relevant most especially for our reserve component members.

While resilience promotion is considered more relevant to PH domains, care coordination is more critical to TBI patients who may have multiple health concerns being treated by multiple health professionals and supported by other service providers. An important part of this coordination function includes accurate and timely information on benefits and resources available. The DCoE Outreach and Clearinghouse function will assist in this effort. While we develop this capability, the Army and Marine Corps, who have the highest number of personnel affected by multiple injuries and illnesses, have been funded to establish enhanced care coordination functions.

In conjunction and coordination with parallel efforts going on throughout the DoD and VA, we are endeavoring to build an effective system of care that engages users, develops a plan of care and links the healthcare users to health and other services that address the full range of patient needs and concerns. The principles of care transition and coordination include assessment, identification, and prioritization of concerns, strengths and needs.

Several key programs are supporting and improving transition activities by hiring care managers. The Marine Corps created a robust call center within its Wounded Warrior Regiment to follow up on Marines diagnosed with TBI and PH concerns to ensure they are successfully maneuvering the healthcare system until their full recovery or transition to the VA. The Navy is hiring PH coordinators to work with their returning Reservists, and the National Guard is hiring Directors of PH to put at each State headquarters to help coordinate the care of Guardsman who have TBI/PH injuries or illness related to their mobilization. The other Reserve Components are looking closely at these programs to obtain lessons learned as they set up their own programs.

Information sharing is a critical part of care coordination. The Information Management offices of both the DoD and VA are working to ensure that information can be passed smoothly and quickly to facilitate effective transition and coordination of care. The DCoE is

also tasked with implementing telehealth and technology systems that will assist in documentation and in sharing of information, as well as tracking and coordinating care for war-fighters and their families as they transition back to their hometowns.

(7) RESEARCH AND DEVELOPMENT

Research and development provide a foundation upon which other programs are built. Our intent has been to shape our investment strategy to rely on evidence-based programs. Yet a quick assessment of the field reveals that we need a systematic program of research, not isolated research projects, in order to establish the broad and deep foundation of research we need in the areas of PH and mild TBI. To that end, we have established integrated individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis, and treatment of combat-related PH issues and TBI.

The US Army Medical Research and Materiel Command's Office of the Congressionally Directed Medical Research Programs (CDMRP) administers the Post Traumatic Stress Disorder/Traumatic Brain Injury (PTSD/TBI) Research Program. FY07 Congressional appropriations for this program total $301M: $151M and $150M for peer-reviewed PTSD and TBI research, respectively.

The goal of the PTSD/TBI Research Program is to fund scientifically meritorious research to prevent, mitigate, and treat the effects of traumatic stress and traumatic brain injury on function, wellness, and overall quality of life for service members and their caregivers and families. The program strives to establish, fund, and integrate both individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis, and treatment of combat related PH and TBI.

In June 2007, we assembled a Stakeholders' Meeting to identify and prioritize research gaps related to the prevention, detection, diagnosis, and treatment of PTSD and/or TBI. A group of expert scientists and clinicians from academia, industry, the military, and other federal government agencies assembled for the purpose of identifying and discussing possible ways to address the highest priority gaps. We used the information gathered at this stakeholders' meeting to determine the programmatic goals and objectives at the PTSD/TBI Research Program vision-setting meeting, held June 13, 2007. The prioritized PTSD research gaps include:

(1) treatment and intervention;
(2) prevention;
(3) measures of screening, detection, and diagnosis;
(4) epidemiological studies;
(5) families/caregivers projects; and
(6) neurobiology/genetics.

The prioritized TBI gaps include:

(1) treatment and clinical management;
(2) neuroprotection and repair strategy;
(3) rehabilitation/reintegration strategies;

(4) field epidemiology; and
(5) physics of blast as it relates to brain injury.

The PTSD/TBI Research Program challenged the scientific community to design innovative research that will foster new directions for, address neglected issues in, and bring new investigators into the fields of PTSD- and TBI-focused research. Program announcements for 12 extramural and four intramural (DoD and VA) award mechanisms were released in July 2007. The deadlines for proposal submission ranged from August 16, 2007 to November 26, 2007.

We are reviewing proposals according to the two-tier review model recommended by the National Academy of Sciences Institute of Medicine. The first tier is a scientific peer review of proposals against established criteria for determining scientific merit. The second tier is a programmatic review that compares submissions to each other and recommends proposals for funding based on scientific merit and overall program goals. A "Joint Program Integration Panel" is conducting a programmatic review of the proposals. Panel members include representatives from the Armed Services Biomedical Research Evaluation and Management Secretariat (Army, Navy, Air Force, the Office of the Assistant Secretary of Defense/Health Affairs); Uniformed Services University of the Health Sciences; Director of Defense Research and Engineering; the VA; the NIH; and clinical consultants from each of the Services.

We recently completed scientific peer review of all submitted proposals and programmatic review for several awards, including a recommended priority list for funding. The Department is pleased that the response to this solicitation for research was very robust, as shown by the number of proposals received/funded: Intramural 248/42; Concept Award 667/41; New Investigator Award 312/(TBD January 31); and Investigator Initiated Research Award 364/(TBD January 31).

The final programmatic review for the Clinical Consortium, Advanced Technology-Therapeutic Development and Multidisciplinary Research Consortium Award mechanisms will occur in early March 2008. This timeline for execution is on schedule with the timeline briefed to Congress in September 2007.

The PTSD/TBI research program is designed to facilitate translational science to quickly bring forth cutting-edge preclinical research to the clinic for evaluation in clinical trials. These efforts make possible a dynamic continuum of scientific knowledge between clinical observation and basic research.

The Multidisciplinary Research Consortium is intended to optimize research and accelerate the solution of a major overarching problem in PTSD or TBI research within an integrated consortium of the best scientists and clinicians as members of a synergistic, multidisciplinary team.

The overarching goal of the PTSD/TBI Clinical Consortium is to combine the efforts of the nations' leading investigators to bring to market novel treatments or interventions that will ultimately decrease the impact of PTSD and TBI and improve the function, wellness, and

overall quality of life of Service members as well as their families, caregivers, and the American Public. The Clinical Consortium will consist of a coordinating center plus multiple clinical research sites. Investigators from the Clinical Consortium will integrate with the DoD Center of Excellence.

Academic and industry applicants were highly encouraged to collaborate with military and VA scientists and clinicians. A positive outcome of the execution of the research program will be the establishment of many new collaborations among DoD, VA, academia, and industry that will ultimately make an impact on the care of our active duty Service members and their families affected by PTSD and TBI.

REMAINING CHALLENGES

Pursuing change in a system as large as the MHS, which serves 9.2 million beneficiaries around the world, while also coordinating with our federal partners in the VA and DHHS, comes with many challenges.

EXECUTING QUALITY CHANGE TAKES TIME. Effecting quality change takes time and effective change requires considerable thought, planning and deliberate action. Funds assist in motivating change for the better, even when that change is uncomfortable or inconvenient. However, ensuring that funds drive needed, quality change in a large system takes time. As our ability to effectively use these funds becomes clearer, we look forward to working closely with this committee on this years' and future years' plans.

CROSS-FUNCTIONAL PLANNING. As we attempt to build a true continuum of care, it has become ever more apparent that cross-functional planning is required. Healthcare dollars have limits to their expenditure. Planning in a cross-functional environment creates the need for innovative solutions and problem solving that affects more than the healthcare community. While time is required to work through these issues, a better continuum of care will surely result. We will work with this committee to identify the non-healthcare initiatives needed to support the full continuum.

IN CONCLUSION, the Department of Defense is moving aggressively to transform prevention, protection, identification, management, and transition of care for our war-fighters and their families in the critical combat health areas of PH and TBI. We appreciate the support Congress provides to our military community, members of which have earned our respect and support through their service to our national security strategy.

Mr. Chairman, thank you for the opportunity to provide you and the members of the Subcommittee an overview of our Psychological Health and TBI Program.

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