Prepared Statement

of

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INTRODUCTION

Mr. Chairman and members of this distinguished Subcommittee, thank you for inviting me to be here today to present an overview of health programs within the Department of Defense.

A crucial part of my portfolio as the Under Secretary of Defense for Personnel and Readiness is the health of our Service members. Recent attention on deficiencies of services at Walter Reed highlighted systemic flaws related especially to the Disability Evaluation System that we are reviewing and fixing. I am pleased to have an opportunity today to discuss with you the efforts we are taking to repair the trust in the military healthcare system, as well as to highlight the successful programs already in place.

THE MILITARY HEALTH SYSTEM

Sustaining the Military Health Benefit. The Department is firmly committed to protecting the health of our Service members and to providing world-class healthcare to its more than nine million beneficiaries.

The FY 2008 Defense Health Program (DHP) funding request is $20.7 billion for Operation and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the Military Health System (MHS) mission. The total military health program is $38.7 billion for FY 2008. This includes payment of $10.9 billion to the Department of Defense Medicare Eligible Retiree Healthcare Fund.

As you know, the Department is challenged by the growing costs of the MHS. We need important changes in our well-regarded health benefit program, TRICARE, to sustain a superior

benefit for the long term. We need the help and support of Congress to achieve this goal. Our FY 2008 budget request assumes savings of $2.2 billion from sustaining reform (as projected last year for FY 2008); we await the interim report of the Department of Defense Task Force on the Future of Military Healthcare as a basis for dialogue with the Congress on how these should be shaped.

As the civil and military leaders of the Department have testified, we must place the health benefit program on a sound fiscal foundation or face adverse consequences. Costs have more than doubled in six years—from $19 billion in FY 2001 to $39 billion in FY 2007—despite MHS management actions to make the system more efficient. Our analysts project this program will cost taxpayers at least $64 billion by 2015. Healthcare costs will continue to consume a growing slice of the Department's budget, reaching 12% of the budget by 2015 (versus 6% from 2001).

Over the last 13 years, the TRICARE benefit was enhanced through reductions in co-pays, expansions in covered services (particularly for Medicare-eligible beneficiaries), new benefits for the Reserve component, and other additions, but the premiums paid by beneficiaries have not changed. The benefit enhancements have come at a time when private-sector employers are shifting substantially more costs to employees for their healthcare.

The twin effect of greater benefits for DoD beneficiaries at no change in premiums, coupled with reduced benefits for military retirees employed in second careers in the private sector, has led to a significant increase in military retirees electing to drop their private health insurance and rely entirely on TRICARE for their health benefit. Some employers actively encourage this shift through incentives to their employees.

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 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.

Budgeting for the Defense Health Program. The MHS utilizes a collaborative, disciplined process to develop the DHP budget. Requirements identified for funding by the three Service Medical Departments, and the TRICARE Management Activity (TMA) are analyzed and validated throughout the process. Resource priorities are balanced to achieve an integrated, effective budget that reflects senior leader guidance, and allocates required resources to sustain operational readiness while continuing to provide high quality, accessible healthcare. The following MHS committees review and make recommendations on issues pertaining to the development and execution of the DHP budget:

- The Resource Management Steering Committee includes the senior resource managers for the Service Surgeons General and the TMA Private Sector Care Program.
- The Chief Financial Officer Integration Council includes the Service Deputy Surgeons General and the TMA Deputy Director.
- The Senior Military Medical Advisory Council includes the Service Surgeons General and the Assistant Secretary of Defense (Health Affairs), Deputy Assistant Secretaries of Defense within Health Affairs and the TMA Deputy Director.

Issues that can not be resolved within the MHS are addressed in the Department-wide Budget Review. A medical issue team is established and includes representation from DoD staff as well as representatives from the Military Departments (medical and Line), the Under Secretaries of Defense, and the Joint Staff. The team thoroughly evaluates all outstanding issues, develops alternatives, and provides recommendations for coordination within the Department. Final decisions are made by the Secretary of Defense and incorporated into the President's Budget request.

The DHP budget enacted by Congress is distributed to the Army, Navy, Air Force medical components and TMA. The Service Surgeons General approve the allocation of funding provided to the military treatment facilities and oversee the execution of the funds utilized during the fiscal year. In addition to the funding included in the President's Budget, unbudgeted requirements such as the Global War on Terror, and emergencies such as Hurricane Relief, are included in the DoD's request for supplemental funding for validated, essential requirements. During the execution of the budget, resources that may become available are utilized to fund emerging, priority requirements, primarily in the in-house care system. Budgeting for healthcare benefits is an imprecise science – the 2% carryover authority authorized by Congress for the DHP has served as an invaluable tool to appropriately manage DHP resources within the President's Budget request.

Management. The Department has initiated several management actions to use resources more effectively and help control the increasing costs of healthcare delivery. The MHS continues to implement a prospective-payment system in a phased, manageable way which provides incentive for local commanders to focus on outputs, rather than on historical budgeting.

We are confident this budgeting approach will ensure our hospitals and clinics remain high-quality, highly efficient medical institutions in service to our patients.

In addition, the MHS has recently composed a new strategic plan for the future. Through this plan, the MHS is strengthening its commitment to military medical forces, to our war fighters, and to our nation's security. The MHS strategic plan takes important steps toward consolidating administrative and management functions across the MHS, and it will strengthen joint decision-making authorities.

With implementation of the BRAC recommendations, the major medical centers in San Antonio and the national capital area will be consolidated. These BRAC actions provide us the opportunity to provide world-class medical facilities for the future while streamlining our healthcare system and creating a culture of best practices across the Services.

Under the BRAC recommendations, we are also developing a medical education and training campus (METC) that will co-locate medical basic and specialty enlisted training at Fort Sam Houston, Texas. By bringing most medical enlisted training programs to Fort Sam Houston, we will reduce the overall technical-training infrastructure while strengthening the consistency and quality of training across the Services.

In the meantime, we are doing everything possible to control our cost growth. We are executing our new TRICARE regional contracts more efficiently, and we are demanding greater efficiency within our own medical facilities. However, one area—pharmacy—is particularly noteworthy. Nearly 6.7 million beneficiaries use our pharmacy benefit, and in FY 2006, our total pharmacy cost was more than $6 billion. If we did nothing to control our pharmacy cost growth, we project pharmacy costs alone would reach $15 billion by 2015.

To address this issue we are taking every action for which we have authority: promoting our mandatory generic substitution policy; joint contracting with Veterans Affairs; launching a home-delivery promotion campaign; and making voluntary agreements with pharmaceutical manufacturers to lower costs.

These efforts are working. But recent legislation passed by Congress and other regulations limit our ability to control costs in the fastest growing area of pharmacy—the retail sector. The acquisition price of brand-name drugs, which represent the bulk of pharmaceutical expenditures in DoD, average 25% to 40% less at military treatment facilities and mail-order when compared to retail. Congress can help us by allowing the Department to make appropriate changes in the structure of our pharmacy benefit. These changes will accelerate use of our new home-delivery program, enhance the use of generics, and give us greater leverage when negotiating with pharmaceutical manufacturers.

Another area in which we need your assistance is restoring the flexibility to manage Defense Health Program resources across budget activity groups. Our new healthcare contracts use best-practice principles to improve beneficiary satisfaction, support our military treatment facilities, strengthen relationships with network providers, and control private-sector costs.

Our civilian partners must manage their enrollee healthcare and may control their and the system's costs by referring more care to our military treatment facilities in the direct-care system. As noted earlier, we have implemented a prospective-payment system that creates the financial incentive for our military treatment facilities to increase productivity and reduce overall costs to the Department.

Funds must flow freely between the military treatment facilities and the private sector, based on where care is actually delivered. Capping Defense Health Program private-sector-care

funds inhibits the Department's ability to provide the TRICARE benefit in the most accessible, cost-effective setting.

AHLTA—DoD's comprehensive, global electronic health record and clinical data repository—significantly enhances MHS efforts to build healthy communities. AHLTA constructs a life-long, computer-based patient record for each and every military health beneficiary, regardless of their location, and provides seamless visibility of health information across the entire continuum of medical care. This gives providers unprecedented access to critical health information whenever and wherever care is provided to our Service members and beneficiaries. In addition, AHLTA offers clinical reminders for preventive care and clinical-practice guidelines for those with chronic conditions.

In November 2006, the MHS successfully completed worldwide deployment of AHLTA, which began in January 2004, at all 138 DoD military treatment facilities. Additional components to AHLTA are yet to be unveiled, including a new inpatient module. To enhance continuity of care and save the taxpayers money, DoD and the VA will collaborate and plan to develop a joint inpatient electronic health record system for Active duty military personnel and veterans. A requirements study is presently under way.

We are working with industry experts to design and develop the government requirements for TRICARE's third generation of contracts (T-3). The Managed Care Support Contracts are TRICARE's largest and most complex purchased-care contracts. Others include the TRICARE Pharmacy Program (TPharm), the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), the Active Duty Dental Contract, the National Quality Monitoring Contract, and the TRICARE Retiree Dental Contract.

The Balanced Scorecard has guided the MHS through the strategic planning process over

the last five years and helps the MHS manage strategy at all levels of the organization. Military treatment facilities remain at the core of the MHS, and the TRICARE structure promotes increased involvement of the military commanders in determining the optimum approach to healthcare delivery within each region. Military commanders' accountability and responsibility for patient care in their communities is centered on sound business planning and resourcing to meet their planned production.

The three TRICARE Regional Directors are actively engaged in managing and monitoring regional healthcare with a dedicated staff of both military and civilian personnel. They are strengthening existing partnerships between the Active duty components and the civilian provider community to help fulfill our mission responsibilities.

Force Health Protection. Force Health Protection embraces a broad compilation of programs and systems designed to protect and preserve the health and fitness of our Service members—from their entrance into the military, throughout their military service to their separation or retirement, and follow-on care by the VA. Our integrated partnership for health between Service members, their leaders and healthcare providers ensures a fit and healthy force and that the continuum of world-class healthcare is available anytime, anywhere.

In 2006, we recorded remarkable war-wounded survival rates, the lowest death-to-wounded ratio in the history of American military operations, and the lowest disease non-battle injury rate. Our military medical personnel have performed extraordinarily on the battlefield and in our medical facilities in the United States. Our investments in people, training, technology and equipment have paid major and historic dividends. We have established new standards in virtually every major category of wartime medicine:

- Lowest Disease, Non-Battle Injury Rate. As a testament to our medical readiness and preparedness, with our preventive-medicine approaches and our occupational-health

capabilities, we are successfully addressing the single largest contributor to loss of forces – disease.

- Lowest Death-to-Wounded Ratio. Our agility in reaching wounded Service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the *golden hour* to the *platinum fifteen minutes*. We are saving Service members with grievous wounds that were likely not survivable even 10 years ago.

- Reduced time to evacuation and definitive tertiary care. We now expedite the evacuation of Service members following forward-deployed surgery to stateside definitive care. We changed our evacuation paradigm to employ airborne intensive-care units. Wounded Service members often arrive back in the United States within 3–4 days of initial injury.

Our successful efforts to prevent loss of life from battle injuries have consequences. Many of our wounded Service members have worked heroically to regain their skills to the greatest extent possible. Of particular note, among the approximately 612 individuals who have had major limb amputations, approximately 7% have returned to duty.

Our most important preventive health measures in place for Service members today—immunization programs—offer protection from diseases endemic to certain areas of the world and from diseases that can be used as weapons. These vaccines are highly effective, and we base our programs on sound scientific information that independent experts have verified. Insect-repellant-impregnated uniforms and prophylactic medications also protect our Service members from endemic diseases during deployments.

Since January 2003, environmental health professionals have analyzed more than 5,000 theater air, water, and soil samples to ensure that forces are not unduly exposed to harmful substances during deployments.

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.

We continue to monitor the health affects of our Service members exposed to depleted uranium (DU) munitions. DoD policy requires urine uranium testing for those wounded by DU munitions. We also test those in, on, or near a vehicle hit by a DU round, as well as those conducting damage assessments or repairs in or around a vehicle hit by a DU round. Additionally, the policy directs testing for any Service members who requests it. Each Service member returning from a deployment is asked about possible DU exposure. More than 2,161 Service member veterans of Operation Iraqi Freedom have been tested for DU exposures. Of this group, only nine had positive tests, and these were due to fragment exposures.

Testing continues for veterans exposed to DU munitions from the 1990–1991 Persian Gulf War. Of the 74 victims of that war in a VA medical follow-up study, only a quarter of them have retained DU fragments in their bodies. To date, none have developed any uranium-related health problems. This DU follow-up program is in place today for all Service members with similar exposures.

Among the many performance measures the MHS tracks is the medical readiness status of individual members, both Active and Reserve. The MHS tracks individual dental health, immunizations, required laboratory tests, deployment-limiting conditions, Service-specific health assessments, and availability of required individual medical equipment. We are committed to deploying healthy and fit Service members and to providing consistent, careful post-deployment health evaluations with appropriate, expeditious follow-up care when needed.

Medical technology on the battlefield includes expanded implementation of the Theater Medical Information Program and Joint Medical Work Station in support of OIF. These

capabilities provide a means for medical units to capture and disseminate electronically near-real-time information to commanders. Information provided includes in theater medical data, environmental hazards, detected exposures, and such critical logistics data as blood supply, beds, and equipment availability.

With the expanded use of the web-based Joint Patient Tracking Application, our medical providers should have total visibility into the continuum of care across the battlefield, and from theater to sustaining base. New medical devices introduced to OIF provide field medics with blood-clotting capability; light, modular diagnostic equipment improves the mobility of our medical forces; and individual protective armor serves to prevent injuries and save lives.

DoD has been performing health assessments on Service members prior to and just after deployment for several years now. 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 the Active Force, Reserves and National Guard.

Service members receive pre-deployment health assessments to ensure they are fit to deploy and post-deployment health assessments to identify any health issues when they return. The DoD maintains deployment health records in the individual's permanent health record and centrally archives electronic copies of the health assessment for easy retrieval. We have an aggressive quality-assurance program to monitor the conduct of these assessments.

Beginning in 2005, we added an additional health assessment, the post-deployment health reassessment, or PDHRA, which we conduct three to six months after deployment. The PDHRA is designed to identify health and adjustment concerns that Service members may not notice or mention immediately upon the return from deployment. For the period of June 1, 2005, to

February 12, 2007, 244,933 Service members have completed a post-deployment health reassessment, with 27% of these individuals receiving at least one referral for additional evaluation.

Mental health services are available for all Service members and their families before, during, and after deployment. Service members are trained to recognize sources of stress and the symptoms of depression, including thoughts of suicide, in themselves and others, that might occur because of deployment. Combat-stress control and mental healthcare are available in theater. In addition, before returning home, we brief Service members on how to manage their reintegration into their families, including managing expectations, the importance of communication, and the need to control alcohol use.

During redeployment, we educate Service members and assess them for signs of mental health issues, including depression and Post Traumatic Stress Disorder (PTSD), and physical health issues. During the post-deployment reassessment, we include additional education and assessment for signs of mental and physical health issues. The Services began initial implementation of this program in June 2005, and we are working toward Department-wide implementation.

After returning home, Service members may seek help for any mental health issues that may arise, including depression and PTSD, through the MHS for Active duty and retired Service members, or through the VA for non-retired veterans. TRICARE is also available for six months post-return for Reserve and Guard members. To facilitate access for all Service members and family members, especially Reserve component personnel, the Military OneSource Program—a 24/7 referral and assistance service—is available by telephone and on the Internet. In addition, we provide face-to-face counseling in the local community for all Service members and family

members. We provide this non-medical counseling at no charge to the member, and it is completely confidential.

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 also includes parental screening instruments to assess depression and risk for self-injurious behavior in their children, along with suicide-prevention programs in DoD schools. Spanish versions of the screening tools are available, as well.

Pandemic influenza represents a new threat to national security. With our global footprint and far-reaching capabilities, we are actively engaged in the Federal interagency effort to help prevent, detect and respond to the threat of avian influenza, domestically and internationally. The President's National Strategy for Pandemic Influenza includes the DoD as an integral component in our nation's response to this threat. One example of this integrated response is DoD's medical Watchboard website, established in 2006, to provide ready access to pandemic influenza information for DoD Service members, civilians, and their families; DoD leaders; and DoD healthcare planners and providers. The DoD Watchboard is linked to PandemicFlu.gov for one-stop access to U.S. Government avian and pandemic influenza information.

Defense Mishap Reduction Initiative. As a world class military, we do not tolerate preventable mishaps and injuries. The direct cost of mishaps is over $3 billion per year, with estimates of total costs up to $12 billion.

We have rededicated ourselves to achieve our 75% accident reduction goal and are aggressively working toward it. For example, the Marine Corps has reduced its civilian lost day rate by 62% and last fiscal year the Air Force achieved the best aviation class "A" mishap rate in its history.

To get to the next level in military and civilian injury reductions, safety is now a performance element under the new National Security Personnel System and in military evaluations. The Department is implementing Occupational Safety and Health Administration's Voluntary Protection Program (VPP) at over 80 installations and sites. This program brings together management, unions, and employees to ensure safe working conditions. VPP and our other accountability programs have the highest visibility and support within the Department.

We also believe that the use of technologies to address many safety issues has a demonstrated cost benefit. Safety technologies include systems and processes. For example, we are pursuing the Military Flight Operations Quality Assurance (MFOQA) process to reduce aircraft flight mishaps. We are exploring the use of data recorders and roll-over warning systems as tools to help drivers avoid wheeled vehicle accidents. Our plan is for DoD components to include these and other appropriate safety technologies as a standard requirement in all future acquisition programs.

TAKING PROPER CARE OF THE WOUNDED

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 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.

Each Service has programs to serve severely wounded from the war: the Army Wounded Warrior Program (AW2), the Navy SAFE HARBOR program, the Air Force Helping Airmen Recover Together (Palace HART) program, and the Marine4Life (M4L) Injured Support Program. DoD's Military Severely Injured Center augments the support provided by the Services. It reaches beyond the DoD to other agencies, to the nonprofit world and to corporate America. It serves as a fusion point for four Federal agencies – DoD, the VA, the Department of

Homeland Security's Transportation Security Administration (TSA), and the Department of Labor.

The Military Severely Injured Center unites Federal agencies through a common mission: to assist the severely injured and their families. The VA Office of Seamless Transition has a full-time liaison assigned to the Center to address VA benefits issues ranging from expediting claims, facilitating VA ratings, connecting Service members to local VA offices, and coordinating the transition between the Military and the VA systems. The Department of Labor has assigned three liaisons from their REALifelines program which offers personalized employment assistance to injured Service members to find careers in the field and geographic area of their choice. 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.

The Military Severely Injured Center has coordinated with over 40 non-profit organizations, all of which have a mission is to assist injured Service members and their families. These non-profits offer assistance in a number of areas from financial to employment to transportation to goods and services. Many are national organizations, but some are local, serving Service men and women in a specific region or at a specific military treatment facility. Some of the many organizations that are providing assistance are the Wounded Warrior Project,

the Injured Marine Semper Fi Fund, the VFW, the American Legion, Disabled American Veterans, the Coalition to Salute America's Heroes, and, of course, the Service Relief Societies. There are hundreds of other non-profits who offer assistance to military families in general that are part of the America Supports You network (www.americasupportsyou.mil).

The Department continues to sponsor Operation Warfighter (OWF), a temporary assignment or internship program for Service members who are convalescing at military treatment facilities in the National Capital Region. This program is designed to provide recuperating Service members with meaningful activity outside of the hospital environment that assists in their wellness and offers a formal means of transition back to the military or civilian workforce. The program's goal is to match Service members with opportunities that consider their interests and utilize both their military and non-military skills, thereby creating productive assignments that are beneficial to the recuperation of the Service member and their views of the future. Service members must be medically cleared to participate in OWF, and work schedules need to be flexible and considerate of the candidate's medical appointments. Under no circumstance will any OWF assignment interfere with a Service member's medical treatment or adversely affect the well-being and recuperation of OWF participants.

In 2006, 140 participants were successfully placed in OWF. Through this program, these Service members were able to build their resumes, explore employment interests, develop job skills, and gain valuable Federal government work experience to help prepare them for the future. The 80 Federal agencies and sub-components acting as employers in the program were able to benefit from the considerable talent and dedication of these recuperating Service members. Approximately 20 permanent job placements resulted from OWF assignments upon the Service member's medical retirement and separation from military service.

The American public's strong support for our troops shows especially in their willingness to help Service members who are severely injured in the war and their families, as they transition from the hospital environment and return to civilian life. Heroes to Hometowns' focus is on reintegration back home, with networks established at the national and State levels to better identify the extraordinary needs of returning families before they return home. They work with local communities to coordinate government and non-government resources necessary for long-term success.

The Department has partnered with the National Guard Bureau and the American Legion, and most recently the National Association of State Directors of Veterans Affairs, to tap into their national, State, and local support systems to provide essential links to government, corporate, and non-profit resources at all levels and to garner community support. Support has included help with paying the bills, adapting homes, finding jobs, arranging welcome home celebrations, help working through bureaucracy, holiday dinners, entertainment options, mentoring, and very importantly, hometown support.

The ability of injured Service members to engage in recreational activities is a very important component of recovery. We continue to work with the United States Paralympics Committee and other organizations so that our severely injured have opportunities to participate in adaptive sports programs, whether those are skiing, running, hiking, horseback riding, rafting, or kayaking. We are also mindful of the need to ensure installation Morale Welfare and Recreation (MWR) fitness and sports programs can accommodate the recreational needs of our severely injured Service members. At Congressional request, we are studying the current capabilities of MWR programs to provide access and accommodate eligible disabled personnel.

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.

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 healthcare 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 under way 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. DoD is determined to improve processes -- ours and those in which we collaborate or interface.

We Are Not Waiting. While the various commissions and task forces continue their reviews, 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.

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.

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 under way – 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. Together with our partners in Veterans Affairs, we will begin a comprehensive re-design of our processes affecting the other 15,000 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 Service members from the DoD Disability system to the VA system. I have signed the first set of revised DoD instructions that is the product of this effort.

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.

DoD-DVA Sharing. DoD works closely with the VA at many organizational levels to maintain and foster a collaborative Federal partnership. We have shared healthcare resources

successfully with the VA for 20 years, but many opportunities for improvement remain. Early in this Administration we formed the DoD-VA Joint Executive Council, which meets quarterly to coordinate health and benefit actions of the two cabinet departments.

The recently updated VA/DoD Joint Strategic Plan supports the common goals from both the VA Strategic Plan and the MHS Strategic Plan and incorporates them into the goals and objectives of the councils and their associated work groups.

Healthcare resource sharing incorporates everything from general and specialized patient care, to education and training, research and development, and healthcare administrative support. At the end of FY 2006, DoD military treatment facilities and Reserve units were involved in sharing agreements with 157 VA Medical Centers.

The FY 2003 NDAA required VA and DoD to undertake significant collaborative initiatives. Section 721 of that Act required that the departments establish, and fund on an annual basis, an account in the Treasury, referred to as the Joint Incentive Fund (JIF). The JIF is intended to eliminate budgetary constraints as a possible deterrent to sharing initiatives, by providing earmarked funding to cover the start-up costs associated with innovative and unique sharing agreements. The 2006 projects cover such diverse areas of medical care as mental health counseling, web-based training for pharmacy technicians, cardio-thoracic surgery, neurosurgery and increased physical therapy services for both DoD and VA beneficiaries.

Section 722 of the same Act mandated the departments execute no fewer than three healthcare coordination demonstration projects over a five-year period. There are seven sites currently testing initiatives, such as the Bi-Directional Health Information Exchange, Laboratory Data Sharing Initiative and Joint Market workload data analysis. The demonstration projects

will generate valuable lessons learned for future DoD and VA sharing initiatives across the country.

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 DoD and 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, that I co-chair with DVA Deputy Secretary Gordon Mansfield, provides guidance and policy for collaborative efforts. There are two subordinate counsels – one focused on healthcare 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 healthcare 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 15 DoD medical centers, 18 hospitals, and over 190 outlying clinics. Approximately 2.1 million DoD patients from these facilities have correlated with the VA's Master Person Index (MPI) and would therefore have their data available to view (bidirectionally) via BHIE.

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 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 healthcare record that is accessible and useable to the provider regardless of which healthcare system they are operating within.

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.

CONCLUSION

In conclusion, I would like to reiterate that ours is a shared responsibility to look after our Service members. Their health status today is good, a reflection of the many programs implemented under the authority and funding provided by the Congress. As part of the Long War in which we are engaged, we are committed to maintaining the existence of the Military Health System. That will require placing it on a sustainable financial path to the future. I look forward to working with you to achieve our common objectives.