THE MILITARY HEALTH SYSTEM

OVERVIEW STATEMENT

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Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). The MHS serves more than 2.2 million members of the Active, Reserve, and Guard components with more than 251,000 service members deployed overseas.

The Department is committed to protecting the health of our service members and to providing the best healthcare to more than 9 million eligible beneficiaries. The Fiscal Year (FY) 2008 Defense Health Program funding request is $20.7 billion for Operation and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the MHS mission. Total military health program expenditures, including personnel expenses, is $38.7 billion for FY 2008. This includes payment of $10.9 billion to the Department of Defense Medicare Eligible Retiree Health Care Fund.

The MHS Strategic Plan – Keeping Warfighters Ready. For Life.

In the past year, the MHS took several additional important steps in the multi-year transformation that will prepare our military forces and our military medical forces for the future. Our focus has been to develop greater joint capabilities and joint operations. I will outline a number of these initiatives today.

We guide all of our efforts through a vision of jointness, interoperability, greater efficiency, improved outcomes, and world-class education, research, and medical care. We have refined our MHS Strategic Plan, itself a superb road map, to provide a long-term perspective on the critical imperatives that will determine our success for the years ahead. We shaped our strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), and the Base Realignment and Closure Commission (BRAC) reports.

This plan – developed in concert with the Surgeons General, the Joint Staff and our line leaders – recognizes that our stakeholders, including this congressional body representing the American people, expect the following outcomes from the resources invested in military medicine:

- A fit, healthy and protected force;
- The lowest possible death, injuries and diseases during military operations, and superior follow-up care and seamless transition with the Department of Veterans Affairs (VA);
- Satisfied beneficiaries;
- Creation of healthy communities; and
- Effective management of healthcare costs.

Our internal measures and those of independent, external organizations show we are excelling in our mission. Yet, we are hardly complacent. We recognize that we must build upon our successes to sustain this global, unique military medical system.

A Fit, Healthy and Protected Force

Our primary objective is ensuring that every service member is medically protected and fit for duty. Together with the military commanders, we use a variety of tools to achieve this outcome.

Based on outcomes data, process measures, and independent assessments by healthcare organizations around the country, our military medical personnel have performed extraordinarily on the battlefield and in our medical facilities in the United States. We are proud of these accomplishments -- improving virtually every major category of wartime medicine, and many areas of peacetime medicine:

- Lowest Disease, Non Battle Injury (DNBI) Rate. As a testament to training, medical readiness and preparedness, preventive medicine approach and occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease. The present DNBI rates for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are the lowest ever reported, 5% and 4% respectively. By comparison, the DNBI rates in Desert Shield/Desert Storm were 6.5% per week, Operation Joint Endeavor (Bosnia) were 7.1% per week, and Operation Joint Guardian (Kosovo) were 8.1% per week.

- 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 lives of wounded troops who would not have survived even 10 years ago. For example, almost 88% of those wounded in Afghanistan and Iraq survive, compared with 75% in World War II and 81% in Vietnam.

- Reduced time to evacuation. We now expedite the evacuation of service members following forward-deployed surgery to stateside definitive care. Using airborne intensive care units and the latest technology, we have been able to move wounded service members from the battlefield to the highest quality of definitive care in the United States in as little as 48 hours.

- Our medical professionals provide high-quality medical care, and our quality indicators compare very favorably with national benchmarks. The DoD Patient Safety Program is a national model. TeamSTEPPS, which is a part of our Patient Safety Program, is a national model for improving communication and teamwork skills. We have achieved significant results through our efforts to reduce medical errors.

Our commanders expect the MHS to ensure that service members are physically fit and that we promote healthy behaviors. We instituted an Individual Medical Readiness (IMR) metric to assess each service member's preparedness for deployment.

The IMR provides commanders with a picture of the medical readiness of their soldier, sailor, airman and marine down to the individual level. Current health assessments and dental examinations and up-to-date medical vaccination records comprise some of the measures we use to calculate the IMR of U.S. military forces.

The Department has programs to protect our service members against a variety of illnesses. The Department continues to view smallpox and anthrax as real threats that may be used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines. To date, with vaccines we have protected almost 1.6 million service members against anthrax spores and more than 1.1 million against the smallpox virus. These vaccination programs have an unparalleled safety record and are setting the standard for the civilian sector. Since the FDA published the Final Order confirming that the anthrax vaccine absorbed (AVA) is safe and effective for its labeled indication to protect individuals at high risk for anthrax disease, we are restarting the mandatory anthrax vaccination program.

The DoD has also been a leader in planning for a possible global epidemic of avian influenza. The lessons of the 1918 pandemic, which killed more American solders in WWI than the enemy did, has not been lost on the military. We recognize that as a globally deployed force we are uniquely vulnerable, and also responsible for contributing to the global efforts in surveillance, education (i.e. hygiene), and rapid eradication.

We are also ensuring our service members are medically evaluated before deployments (through the Periodic Health Assessment), upon return (through the Post-Deployment Health Assessment) and then again 90–180 days after deployment (through the Post-Deployment Health Reassessment). These health assessments provide a comprehensive picture of the fitness of our forces and highlight areas where we need to intervene. For example, we have learned that service members do not always recognize or voice health concerns at the time they return from deployment.

For the period of June 1, 2005 to April 2, 2007, 258,996 service members have completed a post-deployment health reassessment, with 27 percent of these individuals receiving at least one referral for additional evaluation. By reaching out to service members three to six months post-deployment, we have found that that the most prevalent concerns are physical concerns, such as back or joint pain and mental-health concerns. This additional evaluation gives medical staff an opportunity to provide education, reassurance, or additional clinical evaluation and treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions.

The MHS has also included questions screening for symptoms of Traumatic Brain Injury (TBI) on the Periodic Health Assessment, Post-Deployment Health Assessment and Post Deployment Health Reassessment. These questions will capture data and help us better understand TBI, including its identification and treatment.

The Department is working on a number of additional measures to evaluate and treat service members affected or possibly affected by TBI. In August 2006, we

developed a clinical-practice guideline for the Services for management of mild TBI in-theater. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to look for signs and treat TBI. This clinical-practice guideline included a standard Military Acute Concussion Evaluation (MACE) form for field personnel to assess and document TBI for the medical record. They are just starting to use the system, so data on its' impact should be available in a few months. We are also conducting research in the inpatient medical area.

To supplement mental-health screening and education resources, we added the Mental Health Self-Assessment Program (MHSAP) in 2006. This program provides military families, including National Guard and Reserve families, web-based, phone-based and in-person screening for common mental-health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools. Spanish versions of these screening tools are also available. This voluntary and anonymous program is designed to provide increased awareness education in the area of mental health conditions and concerns. It supplements the more formal assessment programs and extends the educational process to families. A robust outreach program provides increased awareness to the military and family members around the globe, leading to a growing use of more than 2000 participants a month for the web-based education and over 160,000 participants each year in the in-person educational events. These events aim to reduce the sigma of suffering from mental health conditions, and foster an environment that encourages self-referral and/or colleagues and battle buddies looking out for one another, reinforcing the credo "no Soldier or Marine left behind."

In 2006, we published a new DoD Deployment Health Instruction. 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 those health effects in future conflicts. An example might be to determine where an outbreak of dysentery or Tuberculosis began in order to identify and treat those who were exposed or to learn more about some mystery illness by studying what geographic location was visited by those who came down with it.

At the direction of Congress, we executed new health benefits which extend TRICARE coverage to members of the National Guard and Reserve. We implemented the TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families. We are now working on the expanded program mandated by the NDAA for FY 2007. Today, more than 34,000 reservists and their families are paying premiums to receive TRS coverage. In addition, we 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. Our FY 2008 budget request includes $381 million to cover the costs of this expanded benefit.

Internationally, our medical forces deploy with great speed, skill and compassion. Their accomplishments in responding to international disasters further our national security objectives; allow us to constructively engage with a number of foreign nations; and save civilian lives throughout the world.

Operating on the global stage, our medics – from the youngest technicians to the most experience neurosurgeons – perform in an exemplary manner in service to this country. We make necessary changes to our policies and processes, while remaining mindful of the skills, dedication, and courage of our medical forces.

Satisfied Beneficiaries

Here in the U.S., our beneficiaries continue to give the TRICARE program high marks in satisfaction. MHS beneficiaries' overall satisfaction with medical care in the outpatient and inpatient settings compares very favorably against national civilian benchmarks. The quality of our medical care is further attested to by the fact that all DoD fixed military treatment facilities (MTFs) are accredited and in good standing by one of these two nationally recognized accrediting organizations (the Joint Commission and the Accreditation Association for Ambulatory Health Care), with the exception of a single new Air Force clinic in San Antonio that is in its pre-accreditation process with AAAHC site visit and final accreditation planned for this summer.

Overall satisfaction with the TRICARE health plan has risen significantly and consistently each year since 2001. Given the stresses of war during this time period, this is a remarkable achievement. The annual Outpatient Satisfaction Survey of military health system beneficiaries provides feedback that permits us to benchmark the satisfaction of beneficiaries with their outpatient experience at military treatment facilities against civilian health maintenance organizations. For the period of October 2005 through September 2006, MHS beneficiaries' overall satisfaction with medical care in the outpatient setting was 6.11 compared with the national civilian benchmark of 6.18 (on a seven-point scale where *7* is *completely satisfied*). For the same time period, MHS beneficiaries' overall satisfaction with the clinics at which outpatient services were provided was 6.02 compared with the national civilian benchmark of 6.13.

The MHS also administers the TRICARE Inpatient Satisfaction Survey to assess beneficiary satisfaction with inpatient care (MTF and civilian network). For the period of July 1, 2005, to September 30, 2005, 79 percent of beneficiaries who received care from MTFs were very satisfied with their care as compared with the civilian benchmark of 81 percent. Eighty-one percent of TRICARE beneficiaries who received care from network facilities were very satisfied with their care.

Moreover, we added financial incentives to our managed care support contracts to improve beneficiary satisfaction from our contract partners and to ensure our contractors are financially rewarded for care delivered in the private sector. Through our new MHS governance and strategic plan, we are focusing on the effectiveness and efficiencies of military treatment facilities and adding performance-based management and patient-centered care initiatives to transform our patients' experiences.

Finally, we enhanced our beneficiaries' online capabilities. In November 2006, we unveiled a new TRICARE Online Web portal. This online service allows beneficiaries to more easily enroll, make appointments, obtain pharmacy refills, check the status of their TRICARE claims, and perform online health assessment for specific disease risk and more. There is no medical system in the world that arranges for a greater number, or percentage, of its appointments via the Internet than ours.

Creation of Healthy Communities

We have the internal ability to expand upon two major initiatives in the coming years: increasing the use of evidence-based medicine, and increasing the patient-provider partnership in sustaining health.

We need to do more to enlist patients as partners in their healthcare. We are increasing the services available to specific populations – seeking to stem the adverse effects of alcohol abuse, tobacco usage, and obesity. The DoD has developed and implemented a series of demonstration and pilot projects to address the key health behaviors associated with premature and preventable death identified in the 2002 Health Related Behavior Survey.

Known as the "Healthy Lifestyles Initiatives," these projects address the increase in tobacco use, obesity, and alcohol misuse and abuse among beneficiaries, both active and non-active duty identified in the survey. We are primarily focusing these health-promotion activities on disease prevention and the adoption of healthy behaviors while testing the effectiveness of comprehensive benefits not currently covered by TRICARE.

The tobacco-cessation and weight-management demonstration projects are comprehensive behavioral interventions. The tobacco-cessation demonstration provides pharmacotherapy in addition to a telephone hotline, a web-based educational tool, and individualized quit kits. The weight-management demonstration provides health/weight loss coaching, as well as telephone and web-based educational and motivational information.

The alcohol-abuse pilot project employs web-based tools to educate and assess participants' knowledge of alcohol abuse, attitudes towards alcohol use and abuse, and current alcohol use. Preliminary results of the pilot study show that participants had a significant reduction in binge and heavy drinking, as well as real reductions in the number of drinks per occasion. We will conduct the more important, longer-term follow-up of these results in year two of the project.

The 2002 DoD Survey of Health Related Behaviors Among Military Personnel indicated that rates of cigarette use, heavy alcohol use, and overweight had all risen since 1998, and that these three health threats occur in our young enlisted population. To respond to these threats, TRICARE began counter-marketing campaigns to encourage quitting tobacco and reduction in binge drinking among the young enlisted population.

Good medical care is comprehensive compassionate, coordinated, confidential, clear, and controlled by the patient. This is the job of most doctors and nurses in the

office or hospital. But we also have a responsibility to prevent disease by educational campaigns that promote a healthy diet, exercise, vaccines, use of seatbelts, responsible consumption of alcohol, cigarette cessation, etc. We are actively seeking innovative ways to incentivize beneficiaries and caregivers to reach these goals.

Both counter-marketing campaigns use themes developed from focus-group research among our young enlisted population. Since humor and emphasis on everyday negative consequences appealed to the target audience, we selected a popular icon that is out of control, "That Guy," as an effective mechanism and a campaign theme to reduce binge drinking. The alcohol counter-marketing campaign is currently being tested at four military installations (Fort Bragg, Pope AFB, Camp Lejeune, and Naval Air Station Pensacola). Traffic on the highly innovative ThatGuy.com website is noteworthy, not only because of the rapid growth in volume of user sessions but also because the user sessions are unusually long (over 5 minutes). We chose the second campaign theme, "Quit Tobacco. Make Everyone Proud," because target-audience members had a favorable response to appeals that use their position as role models, particularly to children, as a motivation to quit using tobacco. The initial test rollout of the anti-tobacco campaign began on February 20, 2007.

Recently, we announced the results of the 2005 DoD Health Related Behaviors Survey. We added questions that addressed deployment issues and were pleased to find that the self-reported information indicated our military personnel are coping with the rigors of conflict and separation from family and home. Although we found that most personnel use such positive coping mechanisms as talking to friends or exercising to cope with stress, we want to focus on those who report using unhealthy behaviors to help cope with their stress. We are quite concerned that of personnel who were deployed last year 13.6 percent began using or increased their use of alcohol since being deployed. However, we are pleased that 17 percent stopped or decreased their alcohol use since deployment. We are also concerned that 10.3 percent began smoking or increased their cigarette smoking, 6.1 percent began using or used more smokeless tobacco, and 6.3 percent began or increased their cigar smoking.

However, 66.8 percent of the military personnel who were "smokers" in the past year made an attempt to quit during the last year. We are also pleased that 66.2 percent of military personnel indicated they were either "satisfied" or "very satisfied" overall with their current work assignment. Military personnel were notably and significantly less likely than civilians to use any illicit drugs in the past 30 days (4.6 percent versus 12.8 percent).

We will also be introducing targeted disease-management programs to engage our patients by offering tools and technologies that can reduce hospital admissions, decrease visits to the emergency room, and improve quality of life. Our approach to disease management is twofold: 1) keep the well healthy, with a focus on healthy lifestyles, disease prevention, and health promotion and 2) maintain an active disease-management program for high- risk beneficiaries with specific chronic disease conditions. We are using evidence-based clinical-practice guidelines and educational resources developed

jointly by the Departments of Defense and Veterans Affairs in both the MTF and managed care support contractor disease-management programs.

On September 1, 2006, the MHS implemented a new disease-management initiative based on a consistent approach across all three managed care regions, focusing on asthma and congestive heart failure. Diabetes will be added in June 2007. The NDAA for FY 2007 requires the MHS to develop a plan that would address: diabetes, cancer, heart disease, asthma, chronic obstructive pulmonary disorder, and depression and anxiety disorders. A formal evaluation of the first three programs will be used in order to effectively and efficiently expand our disease-management efforts to the three other chronic diseases mentioned above.

High-quality care is safe care, and part of building healthy communities includes taking steps to minimize preventable harm as patients receive healthcare services. Both healthcare professionals and informed, prepared patients have roles to play in creating a safe patient experience. In a joint endeavor with the HHS Agency for Healthcare Research and Quality (AHRQ), the MHS has introduced TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) to improve quality and patient safety. TeamSTEPPS represents more than 20 years of research and evidence on teams and team performance in such diverse areas as aviation, nuclear power, business and healthcare. Ineffective, inadequate communication is a major contributing factor for medical errors. TeamSTEPPS provides the tools to counter this problem area. Our goal is to share this important tool with every healthcare facility in America to help them create and continue team training systems. Facilities that have implemented the program are already observing improvements in patient safety.

Electronic Medical Record

AHLTA – DoD's comprehensive, global electronic health record and clinical data repository – significantly enhances our effort to create healthy communities and increase patients' personal engagement in their own healthcare. AHLTA creates 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 our entire continuum of medical care. This gives our providers unprecedented access to critical health information whenever and wherever care is provided to our service members and beneficiaries.

The system is secure, standards based, and patient centric for use in our garrison-based medical facilities and forward-deployed medical units. AHLTA provides our physicians with decision support and builds a single encounter document out of a team effort, linking diagnoses, procedures and orders into one record. In addition, AHLTA offers clinical reminders for preventive care and clinical-practice guidelines for those with chronic conditions.

In November 2006, we successfully completed worldwide deployment of AHLTA Block 1 at all DoD Medical Treatment Facilities (MTFs). We began the implementation

in January 2004. Our implementation-support activities spanned 11 time zones and included training for 55,242 users, including 18,065 healthcare providers. DoD's Clinical Data Repository is operational and contains electronic clinical records for more than 8.9 million beneficiaries. AHLTA use continues to grow at a significant pace. As of March 16, 2007, our providers had used AHLTA to process 42,585,868 outpatient encounters, and they currently process more than 99,006 patient visits per workday.

Additional components to AHLTA are yet to be unveiled, including a new inpatient module. At the American Health Information Community (AHIC) meeting in January, VA Secretary Nicholson and my predecessor, Dr. William Winkenwerder, announced that DoD and VA will collaborate to study and develop a joint inpatient electronic health record system for active duty military personnel and veterans. The Secretary Gates' Independent Review Group and the Task Force on Returning Global War on Terror Heroes have also recommended that DoD and VA develop more compatible IT Systems. With our sharing of clinical data, we are already decreasing redundant tests and procedures for our patients, and reducing errors that are inherent to a paper records system.

AHLTA contains the largest computable and structured medical data repository in the world. As you know, we are leading the nation in standards adoption and interoperability. Before the end of this decade we will be using AHLTA as a central research and planning tool, leveraging its computable health data to improve patient outcomes through prevention, early detection, and proper intervention. Our accomplishments associated with the successful implementation of AHLTA are truly remarkable. It stands today as one of the most comprehensive, sophisticated, and promising electronic medical record systems in the world. But we are determined to make further improvements to make the system faster and easier, more private and secure, so that doctors, nurses and patients all begin to use it to promote safe and cost-effective health care.

We are also using our DoD and VA information sharing experience to advance the President's health information technology goals. We are working closely in a leadership role with other federal agencies, the AHIC, and the Health Information Technology Policy Council and the Healthcare Information Technology Standards Panel (HITSP) to lead the nation toward the adoption of electronic health records. In particular, our DoD and VA collaboration work has helped HITSP to accelerate the establishment of national standards. We foresee significant benefits in advancing health informatics and standards through better quality and greater efficiency in health care delivery.

Identifying the Way Forward for Rehabilitative Care and Transition

A few months ago, the *Washington Post* addressed important issues that deserved and received our immediate and focused attention. The Army and the Department have taken swift action to improve existing conditions and enhance services provided at Walter Reed Army Medical Center (WRAMC). We are also identifying areas that merit further study and improvement. Army leadership initiated immediate steps to control security, improve access, and complete repairs at identified facilities to provide for the health and

welfare of our nation's heroes. They also held accountable those personnel responsible for the failures.

Secretary Gates commissioned an independent review group (IRG) on March 1, 2007, to evaluate and make recommendations on this matter. On April 11, the IRG deliberated its draft findings and recommendations at a public meeting held at WRAMC. The IRG reported its final findings to the Secretary of the Army, the Secretary of the Navy, and me on April 16.

- An underlying theme within their report was the recognition of the moral, human, and budgetary costs of war/national security, and that the Department, the government, and the nation must be prepared to execute on those obligations.

- The twenty-five specific findings and over sixty recommendations provided in the IRG's final report address two main areas of concern, continuum of care and leadership, policy and oversight. Key among the findings was the cumbersome and adversarial nature of the current disability evaluation system.

- Among findings and recommendations related to health care delivery, the IRG concluded that while first class trauma and inpatient care are provided to the service members at the medical centers, there is a breakdown in health services and care management during transition to outpatient status.

- The IRG also found room for improvement in comprehensive care, treatment and administrative services, with a need for a more interdisciplinary collaborative approach. The need for sufficient and properly trained case managers to help wounded service members navigate the health system was paramount in the IRG's conclusions.

- Traumatic brain injury and post traumatic stress disorder and shortage in mental health staff were pointed as issues requiring particular attention.

- Specific to WRAMC, the IRG outlined a "Perfect Storm" of events impacted by BRAC, A-76, staffing and training limitations and funding constraints.

- The IRG also advocated for accelerating construction of the Walter Reed National Military Medical Center and implied that modifications to the TRICARE benefit may be needed to address the needs of medically retired wounded veterans living outside TRICARE Prime catchment areas.

The Department takes the IRG's findings very seriously and will be relentless in its actions – engaged, action-oriented and focused on making measurable improvements. For the recommendations that deal specifically with healthcare delivery, the MHS has developed clear goals and milestones. Efforts are already underway to address some of the findings, particularly the need for more trained case managers (ombudsmen) and traumatic brain injury treatment and research. While many of the recommendations can

be acted upon immediately, others require careful consideration. To this end I have made four visits to WRAMC in my first week as the Assistant Secretary of Defense for Health Affairs and have spoken privately with dozens of medical personnel, patients, family members, facilities personnel, and the command. These visits have been an opportunity to thank caregivers and families, and to invite suggestions for improvement. In all cases, however, we will regularly inform the people we serve – the service members, the families, military leaders, the Congress, the Secretary and the President – on our progress. We will share our progress with the public.

An Assessment of the Issues

There are a number of disturbing elements to the conditions at WRAMC, yet I am confident that each of these items is fixable with sustained leadership and oversight. The Department, with the assistance of the Secretary's independent review group (IRG), is revising approaches to address the complex personnel and medical issues. We will also work closely with the other Commissions, and Task Forces to implement their recommendations. The Department categorizes the problems as follows:

Physical Facility Issues. In the case of substandard housing, the Army quickly implemented a corrective action plan for facility repair and improvements. Clearly, other facility improvements may require more comprehensive repairs that may take longer. I am confident the Army at WRAMC and the Navy at Bethesda to a lesser extent are taking steps to ensure that any needed improvements will be made.

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 in this community through the planned consolidation of health services and facilities in the National Capital Region. The BRAC decision preserves a precious national asset, Walter Reed, by sustaining a high-quality, world-class military medical center with a robust graduate medical education program in the Nation's Capital. The plan is to open this facility by 2011. In the interim, we will not deprive the current WRAMC of resources to function as the premier medical center it is. In fact, in 2005 we funded $ 10 million in capital improvements at WRAMC's Amputee Center – recognizing 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 interfere with the ongoing facility improvements needed in the current hospital.

Process of Disability Determinations. We believe resources and processes need to be better aligned. Our first step in assessing processes will be to identify the desired outcome. We must redraw our processes with the outcomes we have in mind, with as much simplicity and timeliness as possible. We know that both the service member and the Department expect:

- Full rehabilitation of the service member to the greatest degree medically possible;

- A fair and consistent adjudication of disability; and

- A timely adjudication of disability requests – neither hurried nor slowed due to bureaucratic processes.

Process of Care Coordination. Again, the quality of medical care we deliver to our service members is exceptional. Independent review supports this assertion. Yet, we need to better attend to the process of coordinating delivery of services to members in long-term outpatient, residential rehabilitation. The Army has assessed, and our office is reviewing, the proper ratio of case managers to wounded service members. We are also reviewing the administrative and information systems in place to properly manage workload in support of service members and their families.

The Army's new Warrior Transition Brigade became operational at WRAMC, on April 26, 2007 to assist soldiers assigned to medical holdover. This brigade will be fully operational when two more companies will be added in June 2007 and will reduce cadre-to-Soldier ratios from 1:55 to 1:12. In addition, on March 23, 2007, 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 and reduces in-processing locations from seven to two. To ensure we meet and exceed future expectations of service members and their families, the MHS and the Army set up a toll-free hotline to receive beneficiary input. In addition, the MHS and the Army are conducting surveys of wounded warriors and their families, so we may assess what is going well and areas that need improvement.

The bottom line – we will continue to serve our warriors and other beneficiaries until we move to the new campus.

Effective Management of Healthcare Costs

Our primary mission is sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat. Yet, our resources are not unlimited. Military commanders, defense leaders and our elected officials rightly expect us to simultaneously manage healthcare costs and provide outstanding healthcare to our beneficiaries. We are working hard to manage all the MHS more efficiently and effectively with the resources we have. Let me highlight what we are doing.

We are bringing about the most comprehensive changes to our system in a generation through the Base Realignment and Closure decisions. The BRAC recommendations will improve use and distribution of our facilities nationwide, and affect healthcare delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area and San Antonio will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust platforms to support Graduate Medical Education. In some areas, we expect to significantly enhance care by providing services closer to where our beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities

will cease to provide inpatient services and instead focus on the delivery of high-quality ambulatory care. The BRAC recommendations will bring most medical enlisted training programs to Fort Sam Houston. As a result, the MHS will reduce its overall technical-training infrastructure while strengthening the consistency and quality of training across the Services.

We have important activities underway at all facilities affected by BRAC. The key to our success in BRAC is a sound planning principle that is shaping these new structures in ways that are joint, interoperable, non-redundant, and effective. In short, we will build the platforms necessary to "train like we fight." In November 2006, following many months of work led by my office and the Joint Staff, the Deputy Secretary of Defense issued a policy that establishes new joint authority structures for a governance model that will serve our system well in aligning responsibility and authority throughout the MHS. We will consolidate and operate more jointly our large medical-delivery markets, education and training, medical research and development, and critical common-shared-service functions that support the entire MHS.

We will also replace the aging and overcrowded facilities at the United States Army Medical Research Institute for Infectious Diseases (USAMRIID) with a cutting-edge, modern research facility that will continue to produce medical countermeasures to the world's deadliest diseases. The new USAMRIID will serve as the cornerstone of the emerging National Biodefense Campus at Fort Detrick, Maryland, which is currently under development with the Department of Homeland Security and the National Institute of Allergy and Infectious Diseases. We are also planning a replacement facility to support the U.S. Army Institute of Chemical Defense (USAICD) at Aberdeen, Maryland, the nation's premier center of excellence to identify and develop medical countermeasures for chemical warfare agents. The transformation of our physical infrastructure helps us meet the demands of the evolving war on terrorism and the potential threats we face today.

Despite efficiently managing healthcare costs and utilizing a variety of initiatives, we have much work to do. We continue to use a number of proven means to reduce healthcare costs in our system. These include:

- Obtaining significant savings for pharmaceuticals at our MTFs and mail-order venue when compared to the retail point of service. The acquisition price of brand-name drugs, which represent the bulk of pharmaceutical expenditures in DoD, average 25 percent to 40 percent less at MTFs and mail-order when compared to retail.

- Implementing the new TRICARE pharmacy Uniform formulary. We estimate savings of more than $500 million in just the past two years due to key formulary-management changes and decisions.

- Contract strategies. Effective TRICARE contracting strategies have reduced administrative costs, and our effort to further enhance the next generation of the TRICARE contract is well underway. Once again, our Chief Financial

Officer estimates several hundreds of millions of dollars in savings due to these new contracts.

- Further increases in VA and DoD sharing of facilities, capabilities, and joint procurements.

- The introduction of new prime vendor agreements to lower costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricings with medical-supply vendors across the country, and we project cost avoidance of $28.3 million.

Since 2005, we have embarked on a thorough analysis of our medical force structure. The Medical Readiness Review was a Secretary of Defense (SECDEF) level approach to analyzing our force composition and defining an optimal balance of uniformed personnel and civilians. As a result of this analytical process, we are now using military-to-civilian conversions as an effective tool to reduce costs and sustain operational readiness while continuing to provide high-quality, accessible healthcare.

We are evaluating proposed conversions for potential impact. We are implementing only the opportunities that will not increase costs and will not degrade quality of or access to care. Since the beginning of this initiative, the Congress has required that the Service Secretaries certify that conversions will not negatively impact their mission. This certification process has been delayed by successive FY 2007 Continuing Resolutions, in which funding for planned conversions has not been provided. Delayed funding impedes our ability to certify and execute the conversions and puts projected savings at risk. It also has the potential to impact access to care if funds are not available to hire qualified staff to replace the departing service member.

We continue to implement a prospective payment system in a phased, manageable way, and we incentivize 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.

Using our strategic planning tool – The Balanced Scorecard – we are identifying the most critical mission activities, and then applying Lean Six Sigma methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing the fruits of this commitment to building better processes. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In the fall 2006, we began the Innovations Investment Program, to identify the best practices in place at select MTFs or best practices utilized by private-sector healthcare firms and introduce them to DoD on a global scale. Our intent is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better healthcare delivery.

The evaluation phase is already underway, and we plan to begin substantive program changes in the coming year.

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 reform proposals (as projected last year for FY 2008); we await the interim report of the Department of Defense Task Force on the Future of Military Health Care 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 percent of the budget by 2015 (versus 4.5 percent in 1990).

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 become entirely reliant on TRICARE for their health benefit. Some employers actively encourage this shift through incentives to their employees.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit to better manage the long-term cost structure of our program. Failure to do so will harm military healthcare and the overall capabilities of the Department of Defense – outcomes we cannot afford.

Sharing Initiatives with VA

The Department of Defense cares deeply about the well-being of its people. We have fallen short in several areas relating to those recuperating from injury and those seeking to move forward with their lives. We are committed to identifying and correcting the shortcomings that involve the joint responsibilities of the Departments of Defense and Veterans Affairs. We have already begun working with our colleagues on corrective action.

DoD and VA are currently working on five major areas: Facilities, including housing for soldiers; case-worker and family-support personnel; improved disability determination processes; special care for traumatic brain injury and the severely injured; and emphasis on care for those diagnosed with mental-health conditions and post-traumatic stress disorder. Together, the DoD and our colleagues at VA will not rest until we can provide that same level of healthcare when the wounded come home to begin their rehabilitation and recovery.

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. As a formal way to express the continued commitment, Dr. Chu and Mr. Gordon Mansfield signed a memorandum outlining the areas identified by both Departments as further opportunities to leverage resources and improve care.

As we continue to seek ways to improve the healthcare for our beneficiaries, we constantly explore new avenues of partnership with the VA. We have established 504 sharing agreements covering 2,090 health services with the VA, and in FY 2006, 98 VA Medical Centers reported reimbursable earnings during the year as TRICARE Network providers. Every day we collaborate to further improve the healthcare system for our service members. We have substantially increased joint procurement, and we are working to publish jointly used evidence-based clinical-practice guidelines for disease management to improve patient outcomes.

We are committed to working with the VA on appropriate electronic health information exchanges to support our veterans. The Federal Health Information Exchange enables the transfer of protected electronic health information from DoD to the VA at the time of a service member's separation. We have transmitted messages to the FHIE data repository on more than 3.7 million retired or separated service members.

Building on the success of FHIE, we are now sending 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 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. DoD and the VA are also in the process of assessing our requirements for the joint development of an inpatient module for our electronic medical record.

To support our most severely wounded and injured Service members transferring to VA Polytrauma Centers for care, DoD started sending radiology images from WRAMC and National Naval Medical Center, Bethesda to the Tampa VA Polytrauma

Center in March 2007. 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, WRAMC 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 by December to encompass scanning records from NNMC and BAMC for patients transferring to any of the four VA Polytrauma Centers. We are also measuring interim methods of facilitating transfer of records, yet keeping them secure; electronic copy of the record, in the patients' hands, is one such means being studied.

We have worked closely with our partners in the VA, in our shared commitment to provide our service members a seamless transition from the MHS to the Department of Veterans Affairs. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance for collecting and transmitting critical data elements for service members involved in a medical or physical evaluation board. DoD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates, allowing the VA to better project future workload and resource needs.

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. When the VA receives these data directly from DoD before service members separate, it helps to reduce potential delays in developing a benefits claim. This process ensures that the VA has all the relevant information to decide claims for benefits and services in a timely manner.

The Legacy of Military Medicine

American military medicine has led the world in epidemic surveillance, response, trauma care, disaster medicine, health information technology, fitness and prevention.

U.S. military medicine and our medical personnel are national assets, representing a readiness capability that does not exist anywhere else, and – if allowed to dwindle – could not be easily reconstituted. We must preserve these assets.

As we address the problems that lie at the intersection of personnel issues and healthcare delivery, it is our shared responsibility to focus on the specific problems, and not the people who have done so much to improve the health of our military service members. We are blessed with a rich cadre of dedicated, hard-working, skilled professionals. I have complete confidence that they will rise to the occasion again, as they have done in the past, learn from what went wrong, and build an even stronger, more responsive system for all.

Conclusion

Our military engagements in Iraq, Afghanistan and other locations, combined with our medical humanitarian missions and our peacetime health-delivery mission have simultaneously tested the MHS. Our medics, corpsmen, and our nurses and surgeons

operating in tents and on ships and in planes, continue to exceed the expectations of all our stakeholders.

Yet, the critical concept that MHS leaders share is simple – we can never be satisfied with our accomplishments. The people we serve – our line commanders and civilian leadership; our service members and military families; and the representatives of the American people in the Congress – expect us to accomplish even more, and to build upon our successes.

And there is more work to do: We must invest in medical technologies to protect and defend our military community against future threats; provide wise stewardship of limited taxpayer dollars to sustain a quality health system serving more than 9 million Americans; and commit to continued military and professional development of medical professionals of all types – physicians, dentists, nurses, enlisted specialists, and administrators.

Many people in many places have very high expectations for this country's military health system. Our responsibility in the coming years is to continue to exceed these expectations. Our obligations are to those who follow us – today's sergeants and corporals, lieutenants and captains, and civilians now rising through the system.

With the assured support of the DoD leadership and of the Congress, the MHS remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future. On behalf of the MHS, I am grateful for the resources and encouragement you provide to all who serve, and look forward to working with you in the coming year(s).

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