

WRITTEN TESTIMONY OF

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Chairman Inouye, Vice Chairman Cochran and distinguished members of the committee. Thank you for providing me this opportunity to share with you today my thoughts on the future of the U.S. Army Medical Department (AMEDD) and highlight some of the incredible work being performed by the dedicated men and women with whom I am honored to serve alongside. We are America's most trusted premier medical team, and our successful mission accomplishment over these past ten years is testimony to the phenomenal resilience, dedication, and innovative spirit of Soldier Medics, Civilians, and Military Families throughout the world.

Since 1775, Army Medicine has been there. In every conflict the US Army has fought, Army Medicine stood shoulder to shoulder with our fighting forces in the deployed environment and received them here at home when they returned. The past ten years have presented the AMEDD with a myriad of challenges, encompassing support of a two-front war while simultaneously delivering healthcare to beneficiaries across the continuum. Our experiences in Iraq and Afghanistan have strengthened our capacity and our resolve as a healthcare organization. Army Medicine, both deployed and at home, civilian and military, has worked countless hours to ensure the wellness of our fighting force and its Families. Army Medicine continues to support in an era of persistent conflicts, and it is our top priority to provide comprehensive healthcare to support War-fighters and their Families. The Soldier is America's most sacred determinant of the Nation's force projection and the Army's most important resource; it is our duty to provide full spectrum healthcare for our Nation's best. Committed to the health, wellness, and resilience of our force and its Families, we will stand alongside and inspire confidence in our Warriors when our Nation calls. Through the development of adaptive, innovative, and decisive leaders, we stand poised to support the foundation of our Nation's strength.

Over the past decade, Army Medicine has led the joint healthcare effort in the most austere environments. As part of the most decisive and capable land force in the world, we stand ready to adapt to the Army's reframing effort. Ten years of contingency operations have provided numerous lessons learned. We will use these as the

foundations from which we deliver the Army's vision. The following focus areas are the pillars upon which we deliver on that effort.

Support the Force

I was privileged to serve as the International Security Assistance Force Joint Command (COMIJC) Special Assistant for Health Affairs (SA-HA) from July – October 2011. My multi-disciplinary team of 14 military health professionals conducted an extensive evaluation of Theater Health Services Support (HSS) to critically assess how well we were providing healthcare from point of injury to evacuation from theater. It cannot be overstated that the best trauma care in the world resides with the US military in Afghanistan and Iraq. From the most forward combat outposts to the modern Role 3 facilities on the mature forward operating bases, the performance and effectiveness of the US military health system is remarkable. The medical community holds the trust of the American Service Member sacred. The fact that Service Members are willing to go out day to day and place themselves in harm's way in support of our freedom is strongly dependent on the notion that, if they become injured, we will be there providing the best medical care in the world. This has been proven time and time again with MEDEVAC remaining an enduring marker of excellence in the CJOA-A. The average mission time of 44 minutes is substantially below the 60 minute mission standard established by the Secretary of Defense in 2009. The survival rate for the conflict in Afghanistan is 90.1 %. This ability to rapidly transport our wounded Service Members coupled with the world-class trauma care delivered on the battlefield has resulted in achievement of the highest survival rate of all previous conflicts. The survival rate in WWII was about 70%; in Korea and Vietnam it rose to slightly more than 75%. In WWII only 7 of 10 wounded troops survived, today more than 9 out of 10 do. Not only do 9 in 10 survive, but most are able to continue serving in the Army.

Enhanced combat medic training has without question contributed to the increased survival rates on the battlefield by putting the best possible care far forward. The need for aerial evacuation of critical, often post-surgical patients, presented itself in Afghanistan based on the terrain, wide area dispersment of groundbased forces, as

well as increased use of forward surgical teams. En route management of these patients required critical care experience not found organic to MEDEVAC. In response to these needs, our flight medic program (AD, NG, AR) is raising the standard to the EMT-Paramedic level to include Critical Care nursing once Paramedic certified for all Components. This will enhance our capabilities to match the civilian sector and make our flight medics even more combat ready for emergencies while on mission. We've just begun the first course that will pave the way with 28 flight medics coming from all components. By 2017, we will have all flight medics paramedic certified. In the area of standardization of enlisted medical competencies, we are ensuring that our medics are being utilized as force multipliers to ensure world-class health care in our facilities. We are working with our sister services to ensure that all medics, corpsmen, and medical technicians are working side-by-side in our joint facilities and training to the highest joint standard.

We have an enduring responsibility, alongside our Sister Services and the Department of Veterans Affairs (VA), to provide care and rehabilitation of wounded, ill and injured service members for many years to come. We will stand alongside the Soldier from point of injury through rehabilitation and recovery, fostering a spirit of resiliency. The Warrior Care and Transition Program is the Army's enduring commitment to providing all Wounded, Ill and Injured Soldiers and their Families a patient-centered approach to care. Its goal is to empower them with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. Since the inception of Warrior Transition Units in June 2007, more than 51,000 wounded, ill, or injured Soldiers and their Families have either progressed through or are being cared for by these dedicated caregivers and support personnel. Twenty-one thousand of these Soldiers, the equivalent of two Divisions, have been returned to the force, while another 20,000 have received the support, planning, and preparation necessary to successfully and confidently transition to civilian status. Today, we have 29 Warrior Transition Units (WTU) and 9 Community Based Warrior Transition Units (CBWTU). More than 9,600 Soldiers are currently recovering in Warrior Transition Units (WTUs) and Community-Based Warrior Transition Units with more than

4,300 professional Cadre supporting them. Standing behind these Soldiers each stage of their recovery and transition is the Triad of care (Primary care manager, Nurse Case Manager and Squad Leader) and the interdisciplinary team of medical and non-medical professionals who work with soldiers and their families to ensure that they receive the support they deserve.

The Army remains committed to supporting Wounded, Ill, or Injured Soldiers in their efforts to either return to the force or transition to Veteran status. To help Soldiers set their personal goals for the future, the Army created a systematic approach called the Comprehensive Transition Plan, a multidisciplinary and automated process which enables every Warrior in Transition to develop an individualized plan, which will enable them to reach their personal goals. These end goals shape the Warrior in Transition's day-to-day work plan while healing.

For those Soldiers who decide to transition to Veteran status the Warrior Transition Command's (WTC) mission is to assist them to successfully reintegrate back into the community with dignity, respect and self-determination. One example of how the WTC is working to better assist this group of Soldiers is the WTC sponsored, joint service Wounded Warrior Employment Conference (WWEC) held in February. This is the second year the WWEC has brought together key stakeholders in the federal government and private industry. The goal is improved alliance and collaboration between military, civilian, federal entities and employers to encourage them to cooperatively support employment related objectives and share best practices in hiring, retaining, and promoting Wounded Warriors, recently separated Disabled Veterans, their Spouses and Caregivers.

The Care Experience

The Warfighter does not stand alone. Army Medicine has a responsibility to all those who serve, to include Family members and our Retirees who have already answered the call to our Nation. We continue to fully engage our patients in all aspects of their

healthcare experience. At each touch point, starting with the initial contact, each team member plays an important role in enhancing patient care. We will make the right care available at the right time, while demonstrating compassion to those we serve and value to our stakeholders. Beneficiaries will choose hospitals who give them not only outstanding outcomes but the best possible experience. And we aim to elevate the patient care experience across the enterprise to make the direct care system the preferred location to receive care. I am proud to share today that our patient satisfaction rate is currently above 92% and we are in the top 10 percent of health plans in the United States according to Healthcare Effectiveness and Data Information Set (HEDIS®), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care. This said, my challenge --and my personal belief is that we can get better--we must be better. I'd like to outline a few areas where we continue to better ourselves in order to better the care experience for our patients.

Army Medicine is committed to accountable care - where our clinical processes facilitate best practice patterns and support our health care team in delivering competent, compassionate care. In everything we do, there is a need for accountability — to our patients, our team members, and ourselves. Accountability is not just providing competent delivery of health care; our Warfighters deserve more than that. Accountability is about taking ownership of the product we create and how it is delivered, considering it a reflection of ourselves and the organization. At the end of the workday, accountability is not measured by Relative Value Units, but by impact on patients. It is not about the final outcome, but about the process and upholding our commitment to Soldiers and their Families. Soldier well-being and health are absolutely our top priorities. The Army Medicine Team will continue advocating for patients and their well-being. As an Army at war for over a decade, we stand shoulder-to-shoulder with the Warfighter, both on the battlefield and at home. This means never losing sight of the importance of caring for our Nation's heroes and their Families. Realizing that this Army Medicine team is working around the clock and around the world to ensure Soldiers and their Families are cared for with compassion and dignity, I have asked our leaders to focus on caring for those who are giving care. The Army Medicine Team is

not immune to the stress of deployments, workload demands, and challenging circumstances. We provide the best care for our patients when we take care of each other. By doing that, we give our best to all those entrusted to our care.

Army Medicine has consciously committed to building a “Culture of Trust.” Trust in patient care, trust within Army Medicine and the Army Family. In healthcare, trust plays a critical and important role. This strategic initiative is focused on an organizational culture change within Army Medicine and creating a lifestyle of trust. A culture of trust in Army Medicine is a shared set of relationship skills, beliefs and behaviors that distinguish our commitment to our beneficiaries to provide the highest quality and access to health services. Every initiative aimed at reducing variance and standardizing and improving patients’ healthcare experiences, outcomes and readiness will be founded on a Culture of Trust. Last fall the Culture of Trust task force began piloting the initial Culture of Trust training. This foundational training provides information on trust behaviors, tenets and fundamentals creating a baseline upon which we will grow and expand.

We constantly seek to establish stronger more positive relationships with all that we serve in Army Medicine, to produce the very best possible individual care experience. To that end, Army Medicine has implemented a training program titled, “Begin with the Basics.” The central theme of this training is individual personalized engagement practiced by each and every member of Army Medicine. Through these relationships we increase understanding and in understanding our patients better, we are able to provide better solutions. The goal is full deployment of the basics of this model across Army Medicine in the next eighteen months. We are using this model for care and service training as we deploy our medical home care model across Army Medicine.

In February 2011, Army Nursing began implementing a patient-centered outcomes focused care delivery system encompassing all care delivery environments; inpatient, outpatient, and deployed. The Patient Caring Touch System (PCTS) was designed to reduce clinical quality variance by adopting a set of internally and externally validated best practices. PCTS swept across Army Medicine, and the last facility completed implementation in January 2012. PCTS is a key enabler of Army Medicine’s

Culture of Trust and nests in all of Army Medicine's initiatives. PCTS is enhancing the quality of care delivery for America's Sons and Daughters. PCTS has improved communication and multi-disciplinary collaboration and has created an increased demand and expanded use of multi-disciplinary rounds. Several facilities have reported that bedside report, hourly rounding, and multi-disciplinary rounding are so much a part of the routine that they cannot recall a time when it was not part of their communication process.

The collective healthcare experience is driven by a team of professionals, partnering with the patient, focused on health promotion and disease prevention to enhance wellness. Essential to integrated health care delivery is a high-performing primary care provider/team that can effectively manage the delivery of seamless, well-coordinated care and serve as the patient's medical home. Much of the future of military medicine will be practiced at the Patient-Centered Medical Home (PCMH). We have made Patient Centered Medical Homes and Community Based Medical Homes a priority. The Army's 2011 investment in patient centered care is \$50M. Patient Centered Medical Home (PCMH) is a primary care model that is being adopted throughout the Military Health System (MHS) and in many civilian practices throughout the nation. Army PCMH is the foundation for the Army's transition from a "health care system to a system for health" that improves Soldier Readiness, Family wellness and overall patient satisfaction through a collaborative team based system of comprehensive care that is ultimately more efficient and cost effective. The PCMH will strengthen the provider-patient relationship by replacing episodic care with readily available care with one's personal clinician and care team emphasizing the continuous relationship while providing proactive, fully integrated and coordinated care focusing on the patient, his or her Family, and their long term health needs. The Army is transforming all of its 157 primary care practices to PCMH practices. A key component of transformation to the Army Patient Centered Medical Home requires each practice to meet the rigorous standards established by the National Committee for Quality Assurance (NCQA). In December of 2011, 17 Army practices received NCQA recognition as PCMHs and I anticipate we will have 50 additional practices that will obtain NCQA recognition by the end of this calendar year. It is expected that all Army

primary care clinics will be transformed to Army Medical Homes by FY15.

Transformation to the PCMH model should result in an increased capacity within Army military treatment facilities of over 200,000 beneficiaries by FY16. The Army has established Community Based Medical Homes to bring Army Medicine closer to our patients. These Army operated clinics in leased facilities are in off-post communities closer to our beneficiaries and aim to improve access to healthcare services, including behavioral health, for active duty family members by expanding capacity and extending the military treatment facility services off post. Currently we are approved to open 21 clinics and are actively enrolling beneficiaries at 13 facilities.

Unity of Effort

The ability to form mixed organizations at home and on the battlefield with all Service and coalition partners contributing to a single mission of preserving life is proof of the flexibility and adaptability of America's medical Warfighters. It is our collective effort – Army, Air Force and Navy - that saves lives on the battlefield. It is an Army MEDEVAC crew who moves a wounded service member from the point of injury to a jointly staffed Role III field hospital. It's the Air Force provided aeromedical evacuation to Landstuhl Regional Medical Center where a triservice medical care team provides further definitive care. And then finally it's a joint team's capabilities at locations such as Walter Reed National Military Medical Center and the San Antonio Military Medical Center that provide the critical care and rehabilitative medicine for this Service member, regardless if they are a Soldier, Sailor, Airman, or Marine. The AMEDD is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team, anywhere, anytime.

We are at our best when we operate as part of a Joint Team, and we need to proactively develop synergy with our partners as military medicine moves toward a joint operating environment. The wars in Afghanistan and Iraq have led to increased collaboration and interoperability with allied medical services, and have highlighted differences and gaps in our respective combat health service support systems. While the Combatant Commands have a responsibility to harvest and publicize lessons

learned and implement new best practices operationally, the MHS has the opportunity to address and apply, at the strategic, operational and tactical levels, the lessons learned regarding combat casualty care and medical coalition operations.

MHS governance changes will change the way we currently operate for everyone. These recommended changes will strengthen our system. In the delivery of military medicine, the Military Departments have more activities in common than not – together we will drive toward greater common approaches in all areas, except where legitimate uniqueness requires a service-specific approach. Our commitment is to achieve greater unity of effort, improve service to our members and beneficiaries, and achieve greater efficiency through a more rapid implementation of common services and joint purchasing, as well as other opportunities for more streamlined service delivery.

Our MHS is not simply a health plan for the military it is a military health system. A system that has proven itself in war and peace time. Our focus continues to be on supporting Soldiers, other Warriors and their Families--past, present and future--and on the most effective and efficient health improvement and healthcare organization to add value in the defense of the Nation. The best way to do that is through a unified and collaborative approach to care, both on the battlefield and in garrison. We must have outcome and economic metrics to measure and accountability assigned. And we must develop standard and unified performance measures across a wide range of health and care indicators e.g., population health, clinical outcomes, access, continuity, administrative efficiency, agile operational support, Warrior care and transition programs, patient satisfaction, cost, and others, to ensure we are effective, efficient and timely.

Innovate Army Medicine and Health Service Support

Many innovations in healthcare have their origins on the battlefield. Army Medicine's medical innovations borne from lessons learned in combat have become the worldclass standard of care for Soldiers on the battlefield and civilians around the world. As our presence in the current war begins to change, we must remain vigilant in developing and assessing strategies to protect, enhance, and optimize Soldier wellness,

prevention and collective health. Through leverage of information technology and militarily relevant research strategies, we will continue to develop new doctrine and education programs to reflect best practice healthcare on and off the battlefield, while ensuring that Army Medicine remains responsive and ready. Our speed of execution, combined with the ability to leverage knowledge and actionable ideas quickly, is paramount to optimize the constancy of improvement. Our biggest competitive edge is our knowledge and our people.

In 2004 the Assistant Secretary of Defense for Health Affairs directed to the formation of the the Joint Theater Trauma System (JTTS) and the Joint Theater Trauma Registry (JTTR). The Joint Theater Trauma System coordinates trauma care for our wounded warriors. Since that time the Services, working together, have created a systematic and integrated approach to battlefield care which has minimized morbidity and mortality and optimized the ability to provide essential care required for the battle injuries our Soldiers are facing. The vision of the JTTS is for every Soldier, Marine, Sailor or Airman wounded or injured in the theater of operations to have the optimal chance for survival and maximal potential for functional recovery and they are. Our 8,000 mile operating room stretches from Kandahar to Landstuhl to Walter Reed National Military Medical Center at Bethesda, to San Antonio Military Medical Center to the Veteran's Administration and other facilities throughout the United States. It's collaborative, it's integrated, and it knows no boundaries. JTTS changed how the world infuses blood products for trauma patients. In fact we just had a patient receive 400 units of blood. He coded three times on the battle field. And today he is recovering in Walter Reed National Medical Center at Bethesda. The JTTS also led to materiel changes in helmets, body armor and vehicle design. This is not a success of technology or policy. This is a success of a trauma community that expects and values active collaboration across its 8,000 mile operating room.

The JTTR, is the largest combat injury data repository and is an integral and integrated part of the JTTS. It provides the information necessary to advance the improvement of battlefield and military trauma care and drive joint doctrine and policy, while enabling process improvement and quality assurance. Additionally it enables more efficient and effective medical research in a resource-constrained environment.

The improvements in trauma care driven by both the JTTS and JTTR are increasing the survival rate on today's battlefield and saving lives in our Nations civilian trauma centers through shared lessons learned. We must maintain this critical capability to ensure that we continue to drive innovation and are able to respond to our next threat.

An area in which the Army and our Sister Services have innovated to address a growing problem is in concussion care. The establishment of a mild Traumatic Brain Injury (TBI)/concussive system of care and implementation of treatment protocols has transformed our management of all battlefield head trauma. Traumatic Brain Injury (TBI) is one of the invisible injuries resulting from not only the signature weapons of this war, improvised explosive devices and rocket propelled grenades, but also from blows to the head during training activities or contact sports. Since 2000, 220,430 Service Members have been diagnosed with TBI worldwide (Armed Forces Health Surveillance Center, 2011). In 2010, Military Medicine implemented a new mild traumatic brain injury management strategy to disseminate information that our healthcare workers needed and outlined the unit's responsibilities, creating a partnership between the medical community and the line units. This policy directed that any Soldier who sustained a mandatory reportable event must undergo a medical evaluation including a mandatory 24 hour down time followed by medical clearance before returning to duty. The mandatory events are a command-directed evaluation for any Soldier who sustains a direct blow to the head or is in a vehicle or building associated with a blast event, collision or rollover, or is within 50 meters of a blast. Since the DoD implemented Policy Guidance for Management of Concussion/mTBI in the Deployed Setting in June 2010, deployed Commanders screened over 10,000 Service Members for concussion/mild TBI, temporarily removed them from the battlefield to facilitate recovery, and ensured that each of them received a mandatory medical evaluation. Codification of this concussive care system into AMEDD doctrine is ongoing. To further support the TBI care strategy over the past 21 months the Services have stood up 11 facilities devoted to concussive care far forward on the battlefield, staffed with concussion care physicians and other medical providers, in order to care for those with TBI at the point of

injury. The Army has medical staff at 9 of these facilities. These centers provide around-the-clock medical oversight, foster concussion recovery, and administer appropriate testing to ensure a safe return to duty. The current return to duty rate for Soldiers who have received care at Theater concussion centers is over 90%.

To further the science of brain injury recovery, the Army relies on the US Army Medical Research and Materiel Command's TBI Research Program. The overwhelming generosity of Congress and the DoD's commitment to brain injury research has significantly improved our knowledge of TBI in a rigorous scientific fashion. Currently, there are almost 350 studies funded by DoD to look at all aspects of TBI. The purpose of this program is to coordinate and manage relevant DoD research efforts and programs for the prevention, detection, mitigation and treatment of TBI. In the absence of objective diagnostic tools, MRMC is expediting research on diagnostic biomarkers and other definitive assessment tools that will advance both military and civilian TBI care. By identifying and managing these injuries on the battlefield, we have eliminated many unnecessary medical evacuation flights and facilitated unprecedented return to duty rates. The Army realizes that there is much to gain from collaboration with external partners and key organizations. We have partnered with the Department of Veterans Affairs, the Defense and Veterans Brain Injury Center, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, academia, civilian hospitals and the National Football League, to improve our ability to diagnose, treat, and care for those affected by TBI.

There are significant health related consequences of over ten years of war, including behavioral health needs, post-traumatic stress, burn or disfiguring injuries, chronic pain or loss of limb. Our Soldiers and their Families need to trust we will be there to partner with them in their healing journey, a journey focused on ability vice disability.

A decade of war in Afghanistan and Iraq has led to tremendous advances in the knowledge and care of combat-related physical and psychological problems. Ongoing research has guided health policy, and multiple programs have been implemented in theater and post-deployment to enhance resiliency, address combat operational stress

reactions and behavioral health concerns. Similar to our approach to concussive injuries, Army Medicine harvested the lessons of almost a decade of war and has approached the strengthening of our Soldiers and Families' behavioral health and emotional resiliency through a campaign plan to align the various Behavioral Health programs with the human dimension of the ARFORGEN cycle, a process we call the Comprehensive Behavioral Health System of Care (CBHSOC). This program is based on outcome studies that demonstrate the profound value of using the system of multiple touch points in assessing and coordinating health and behavioral health for a Soldier and Family. The CBHSOC creates an integrated, coordinated, and synchronized behavioral health service delivery system that will support the total force through all ARFORGEN phases by providing full spectrum behavioral health care. We leveraged experiences and outcome studies on deploying, caring for Soldiers in combat, and redeploying these Soldiers in large unit movements to build the CBHSOC. The CBHSOC is a system of systems built around the need to support an Army engaged in repeated deployments - often into intense combat – which then returns to home station to restore, reset the formation, and re-establish family and community bonds. The intent is to optimize care and maximize limited behavioral health resources to ensure the highest quality of care to Soldiers and Families, through a multi-year campaign plan.

The CBHSOC campaign plan has five lines of effort: Standardize Behavioral Health Support Requirements; Synchronize Behavioral Health Programs; Standardize & Resource AMEDD Behavioral Health Support; Access the Effectiveness of the CBHSOC; and Strategic Communications. The CBHSOC campaign plan was published in September 2010, marking the official beginning of incremental expansion across Army installations and the Medical Command. Expansion will be phased, based on the redeployment of Army units, evaluation of programs, and determining the most appropriate programs for our Soldiers and their Families.

Near-term goals of the CBHSOC are implementation of routine behavioral health screening points across ARFORGEN and standardization of screening instruments. Goals also include increased coordination with both internal Army programs like Comprehensive Soldier Fitness, Army Substance Abuse Program, and Military Family

Life Consultants. External resources include VA, local and state agencies, and the Defense Centers of Excellence for Psychological Health.

Long-term goals of the CBHSOC are the protection and restoration of the psychological health of our Soldiers and Families and the prevention of adverse psychological and social outcomes like Family violence, driving under intoxication violations, drug and alcohol addiction, and suicide. This is through the development of a common behavioral health data system; development and implementation of surveillance and data tracking capabilities to coordinate behavioral health clinical efforts; full synchronization of Tele-behavioral health activities; complete integration of the Reserve Components; and the inclusion of other Army Medicine efforts including TBI, patient centered medical home, and pain management. We are leveraging predictive modeling tools to improve our insight into data, research advances, and electronic medical record systems in order to provide "genius case management" for our patients with BH disease, that is, care that is tailored for each patient, and a care plan aimed at better understanding the patient, and not just their disease. Integral to the success of the CBHSOC is the continuous evaluation of programs, to be conducted by the Public Health Command.

For those who do suffer from PTSD, Army Medicine has made significant gains in the treatment and management of PTSD as well. The DoD and VA jointly developed the three evidenced based Clinical Practice Guidelines for the treatment of PTSD, on which nearly 2,000 behavioral health providers have received training. This training is synchronized with the re-deployment cycles of US Army Brigade Combat Teams, ensuring that providers operating from MTFs that support the Brigade Combat Teams are trained and certified to deliver quality behavioral healthcare to Soldiers exposed to the most intense combat levels. In addition, the US Army Medical Department Center & School collaborates closely with civilian experts in PTSD treatment to validate the content of these training products to ensure the information incorporates emerging scientific discoveries about PTSD and the most effective treatments.

Work by the Army Medical Department and the Military Health System over the past 8 years has taught us to link information gathering and care coordination for any

one Soldier or Family across the continuum of this cycle. Our Behavioral Health specialists tell us that the best predictor of future behavior is past behavior, and through the CBHSOC we strive to link the management of issues which Soldiers carry into their deployment with care providers and a plan down-range and the same in reverse. We have embedded behavioral health personnel within operational units circulate across the battlefield to facilitate this ongoing assessment.

The management of combat trauma pain with medications and the introduction of battlefield anesthesia was a tremendous medical breakthrough for military medicine. The first American use of battlefield anesthesia is thought to have been in 1847 during the Mexican-American War, and the use of opioid medication during the Civil War was not uncommon. Military Medicine has worked very hard to manage our Service Members' pain from the point of injury through the evacuation process and continuum of care. The management of pain- both acute and chronic or long-standing pain – remains a major challenge for military health care providers and for the Nation at large. We have launched a major initiative through a multi-disciplinary, multi-service and DOD-VA Pain Management Task Force to improve our care of pain. The use of medications is appropriate, if required, and often an effective way to treat pain. However, the possible overreliance on medication-only pain treatment has other unintended consequences, such as prescription medication use. The goal is to achieve a comprehensive pain management strategy that is holistic, multi-disciplinary and multi-modal in its approach, uses state of the art modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain. The military is developing regional pain consortiums that combine the pain expertise from DoD with local Veterans Health Administration and civilian academic medical centers. The first of many of these relationships has been established in Washington State between Madigan Army Medical Center, VA Puget Sound Health Care System, and University of Washington Center for Pain Relief. Some of the largest research projects dealing with wounded-warrior pain have been facilitated through partnerships with VHA research leaders. Collaborations of this type will ensure the latest, evidence-based pain-care techniques and protocols are available to patients. Pain research in direct support of military requirements will also be facilitated by these federal and civilian partnerships. Other

partnerships include working with organizations such as the Bravewell Collaborative and the Samuelli Institute, both of whom provide DoD with expertise in building mature integrative medicine capabilities to compliment and improve our existing pain medicine resources.

Another concerning area of emphasis for military medicine that has emerged from the current wars is “Dismounted Complex Blast Injury” (DCBI), an explosion-induced battle injury (BI) sustained by a warfighter on foot patrol that produces a specific pattern of wounds. In particular, it involves traumatic amputation of at least one leg, a minimum of severe injury to another extremity, and pelvic, abdominal, or urogenital wounding. The incidence of dismounted complex blast injuries has increased during the last 15 months of combat in the Afghanistan Theater of Operations (ATO). The number of Service Members with triple limb amputation has nearly doubled this past year from the sum of all those seen over the last eight years of combat. The number of genital injuries increased significantly from previous OIF rates. The severity of these injuries presents new challenges to the medical and military communities to prevent, protect, mitigate and treat. Army Medicine has spearheaded a Task Force comprised of clinical and operational medical experts from the Departments of Defense (DoD) and Veterans Affairs (VA) and solicited input from subject matter experts in both Federal and civilian sectors to determine the way forward for healing these complex injuries.

Evidence-based science makes strong Soldiers and for this we rely heavily on the US Army Medical Research and Materiel Command (MRMC). MRMC manages and executes a robust, ongoing medical research program for the MEDCOM to support the development of new health care strategies. I would like to highlight a few research programs that are impacting health and care of our Soldiers today.

The Combat Casualty Care Research Program (CCCRP) reduces the mortality and morbidity resulting from injuries on the battlefield through the development of new life-saving strategies, new surgical techniques, biological and mechanical products, and the timely use of remote physiological monitoring. The CCCRP focuses on leveraging cutting-edge research and knowledge from government and civilian research programs to fill existing and emerging gaps in combat casualty care. This focus provides

requirements-driven combat casualty care medical solutions and products for injured Soldiers from self-aid through definitive care, across the full spectrum of military operations.

The mission of the Military Operational Medicine Research Program (MOMRP) is to develop effective countermeasures against stressors and to maximize health, performance, and fitness, protecting the Soldier at home and on the battlefield. MOMRP research helps prevent physical injuries through development of injury prediction models, equipment design specifications and guidelines, health hazard assessment criteria, and strategies to reduce musculoskeletal injuries.

MOMRP researchers develop strategies and advise policy makers to enhance and sustain mental fitness throughout a service member's career. Psychological health problems are the second leading cause of evacuation during prolonged or repeated deployments. MOMRP psychological health and resilience research focuses on prevention, treatment, and recovery of Soldiers and Families behavioral health problems, which are critical to force health and readiness. Current psychological health research topic areas include behavioral health, resiliency building, substance use and related problems, and risk-taking behaviors.

The Clinical and Rehabilitative Medicine Research Program (CRM RP) focuses on definitive and rehabilitative care innovations required to reset our wounded warriors, both in terms of duty performance and quality of life. The Armed Forces Institute of Regenerative Medicine (AFIRM) is an integral part of this program. The AFIRM was designed to speed the delivery of regenerative medicine therapies to treat the most severely injured US service members from around the world but in particular those coming from the theaters of operation in Iraq and Afghanistan. The AFIRM is expected to make major advances in the ability to understand and control cellular responses in wound repair and organ/tissue regeneration and has major research programs in Limb Repair and Salvage, Craniofacial Reconstruction, Burn Repair, Scarless Wound Healing, and Compartment Syndrome.

The AFIRM's success to date is at least in part the result of the program's emphasis on establishing partnerships and collaborations. The AFIRM is a partnership

among the US Army, Navy, and Air Force, the Department of Defense, the VA, and the National Institutes of Health. The AFIRM is composed of two independent research consortia working with the US Army Institute of Surgical Research. One consortium is led by the Wake Forest Institute for Regenerative Medicine and the McGowan Institute for Regenerative Medicine in Pittsburgh while the other is led by Rutgers – the State University of New Jersey and the Cleveland Clinic. Each consortium contains approximately 15 member organizations, which are mostly academic institutions.

The health of the total Army is essential for readiness, and prevention is the best way to health. Protecting Soldiers, retirees, Family members and Department of Army civilians from conditions that threaten their health is operationally sound, cost effective and better for individual well-being. Though primary care of our sick and injured will always be necessary, the demands will be reduced. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is crucial to military success. Army Medicine is on the pathway to realizing this proactive, preventive vision.

The newest addition to the Army Medicine team is the Public Health Command, having reached initial operational capability in October 2010 with full operational capability is targeted for October 2011. As part of the overall US Army Medical Command reorganization initiative, all major public health functions within the Army, especially those of the former Veterinary Command and the Center for Health Promotion and Preventive Medicine have been combined into a new PHC, located at Aberdeen Proving Ground in Maryland. The consolidation has already resulted in an increased focus on health promotion and has created a single accountable agent for public health and veterinary issues that is proactive and focused on prevention, health promotion and wellness. Army public health protects and improves the health of Army communities through education, promotion of healthy lifestyles, and disease and injury prevention. Public health efforts include controlling infectious diseases, reducing injury rates, identifying risk factors and interventions for behavioral health issues, and ensuring safe food and drinking water on Army installations and in deployed environments. The long-term value of public health efforts cannot be overstated: public health advances in the past century have been largely responsible for increasing human

life spans by 25 years, and the PHC will play a central role in the health of our Soldiers, deployed or at home. A significant initiative driven by the Public Health Command which will be instrumental to achieving public health is our partnering with Army installations to standardize existing Army Wellness Centers to preserve or improve health in our beneficiary population. The centers focus on health assessment, physical fitness, healthy nutrition, stress management, general wellness education and tobacco education. They partner with providers in our Military Treatment Facilities (MTFs) through a referral system. I hold each MTF Commander responsible for the health of the extended military community as the installation Director of Health Services (DHS).

Army Medicine has put a closer lens on women's health through a recently established Women's Health Task Force to evaluate issues faced by female Soldiers both, in Theater and CONUS. Women make up approximately 14 percent of the Army Active Duty fighting force. As of August 2011, almost 275,000 women have deployed in support of OIF/OND/OEF. The health of female Soldiers plays a vital role in overall Army readiness. Army medicine recognizes the magnitude and impact of women's health and appreciates the unique challenges of being a woman in the Army. In order for women to be fully integrated and effective members of the team, we must ensure their unique health needs are being considered and met. The Task Force combines talent from different disciplines: civilian and military, officer and enlisted, as well as collaborates with our private industry partners. We will assess the unique health needs and concerns of female Soldiers, conducting a thorough review of the care currently provided, identifies best practices and gaps, and revises, adapts and initiates practices so that we may continue to provide first class care to our female Warriors. The Women's Health Campaign Plan will focus on standardized education and training on women's health, logistical support for women's health items, emphasis on the fit and functionality of the Army uniform and protective gear for females; and research and development into the psychosocial effects of combat on women. While Sexual Assault is not a gender specific issue, the Women's Health Task Force is working with HQDA G1 to evaluate Theater policy with regards to distribution of Sexual Assault Forensic Examiners and professionalizing the role of the Victim Advocate. The Task Force is

collaborating with Tri-Service experts to investigate the integration of Service policies and make recommendations.

While proudly acknowledging our many healthcare accomplishments at home and in theater, I want to turn to the future. It is time we further posture Army Medicine in the best possible manner that aligns with the MHS strategic vision that moves us from healthcare to health. We must ask, where does “health” happen, and I have charged Army Medicine leadership to spearhead the conversion to health and to fully integrate the concept into readiness and the overall strategy of health in the Force. Improved readiness, better health, better care, and responsibly managed costs are the pillars on which the MHS Quadruple Aim stands, but between those pillars, or in that “White Space”, is where we can create our successful outcomes. Sir William Osler, considered to be the Father of Modern Medicine, said “One of the first duties of the physician is to educate the masses not to take medicine”. A snapshot of the average year with the average patient shows that healthcare provider spend approximately 100 minutes with their patient during that year. How much health happens in those 100 minutes? There are approximately 525,600 minutes in that year, yet we focus so much of our time, effort, and spending on those 100 minutes; the small fraction of a spot on the page. But what happens in the remaining 525,600 minutes of that year? What happens in the “White Space?” I will tell you what I think happens – that is where health is built, that is where people live. The “White Space” is when our Soldiers are doing physical fitness training, choosing whether to take a cigarette break, or deciding whether they will have the cheeseburger or the salad for lunch. It’s when Family Members are grocery shopping or cooking a meal. The “White Space” is when Soldiers spend time with their family, or get a restful night of sleep, or search the internet to self-diagnose their symptoms to avoid adding to those 100 minutes in the clinician’s office. We want to lead the conversation with Army leadership to influence the other 525,600 minutes of the year with our Soldiers...the “White Space”. In order for us to get to health, we must empower patients, move beyond the 100 minutes, and influence behaviors in the white space. The way ahead is connected, collaborative, and patient centered.

I have discussed but a few of the important medical issues and programs that are relevant to the current wars and vital to the future of Military Medicine require solutions

and funding that will go years beyond the end of the current wars. Our Nation, our Army and Army Medicine have a duty and responsibility to our Soldiers, Families, and retirees. There will be considerable ongoing health care costs for many years to support for our wounded, ill, or injured Soldiers. The programs we have established to care for our Soldiers and Families cannot falter as our deployed footprint diminishes. The level of care required does not end when the deployed Soldier returns home.

Optimize Resources

One of Army Medicine's greatest challenges over the next 3-5 years is managing the escalating cost of providing world-class healthcare in a fiscally constrained environment. People are our most valuable resource. We will employ everyone to their greatest capacity and ensure we are good stewards of our Nation's resources. To capitalize on the overall cost savings of procurement and training, we will standardize equipment, supplies, and procedures. And we will leverage our information technology solutions to optimize efficiencies.

Despite the cost containment challenges we face, we must accomplish our mission with an eye on reducing variance, focusing on quality, and expecting and adapting to change. These are our imperatives. Army Medicine will focus on collaborative international, interagency, and joint partnerships and collective health, including prevention and wellness, to ensure the enduring capabilities required to support the current contemporary operating environment and those of the future are retained.

We will be methodical and thoughtful in our preparation for budget restraints to ensure that the high quality care our Warriors and Military Family demand is sustained. With the anticipated downsizing of forces, there will be a need to critically look at where medical services could be consolidated. However, we will use this as an opportunity to evaluate workloads to maximize efficiencies while maintaining effectiveness and focus on what services are best for our beneficiary population and dedicate resources to those.

The rising cost of healthcare combined with the increasingly constrained defense budget poses a challenge to all within the MHS. The Department of Defense offers the

most comprehensive health benefit, at lower cost, to those it serves than the vast majority of other health plans in the nation - and deservedly so. The proposed changes in TRICARE fees do not change this fact - the TRICARE benefit remains one of the best values for medical benefits in the United States with lower out-of-pocket costs compared to other health care plans. Adjustment to existing fees, and introduction of new fees are proposed. Importantly, these benefit changes exempt Soldiers, and their Families, who are medically retired from active service, and Families of Soldiers who died on active duty from any changes in cost-sharing. I support these modest fee changes when coupled by the MHS's shift in focus from healthcare to health, maintaining health and wellness, identifying internal efficiencies to capitalize on, and instituting provider payment reform.

A major initiative within Army Medicine to optimize talent management and move towards a Culture of Trust, discussed earlier in this testimony, is the Human Systems Transformation, led by a newly established Human Systems Transformation Directorate. Army Medicine's ability to efficiently transform our culture requires a roadmap for achieving planned systemic change. The plan focuses on enhanced investment in four human system tiers (lines of effort) to: Improve senior leader development (new command teams/designated key staff positions), increase investment in the development of Army Medicine workforce members, establish a cadre of internal Organizational Development professionals, leverage partnering and collaboration opportunities with internal and external stakeholders. In order to change the culture of our organization, we must invest in our people.

Develop Leaders

At the core of our medical readiness posture is our people. The Army calls each of us to be a leader, and Army Medicine requires no less. We will capitalize on our leadership experiences in full spectrum operations while continuing to invest in relevant training and education to build confident and competent leaders. Within this focus area, we will examine our leader development strategy to ensure that we have clearly identified the knowledge, skills, and talent required for leaders of Army Medicine. We

will continue to develop adaptive, innovative, and decisive leaders who ensure delivery of highly-reliable, quality care that is both patient-centered and inherently trustworthy. Being good stewards of our Nation's most treasured resources, through agile, decisive, and accountable leadership, we will continue to build on the successes of those who have gone before us. Our recruitment, development and retention of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses.

Support the Army Profession

Army Medicine has a rich history of sustaining the fighting force, and we need to tell our story of unprecedented successes across the continuum of care – from the heroic efforts of our medics at the point of injury to the comprehensive rehabilitation of our Wounded Warriors in overcoming exceptional challenges. After more than ten years of persistent conflict, it is time to renew our collective commitment to the Army, its ideals, traditions, and ethos. As we have stood alongside our warfighters on the battlefield we have earned the trust of our combat tested Warfighters, and it is critical that we continue to demonstrate integrity and excellence in all that we do.

Worldwide Influence

Army Medicine reaches around the world; from those supporting two theaters of war and humanitarian relief efforts to those conducting militarily relevant research and providing care to our military Families overseas, Army Medical Department Soldiers and civilians answer our Nation's call. The time that two oceans protected our freedom-loving nation is long gone, and replaced with ever-present risks to our way of life. The Nation relies on its Army to prepare for and conduct full spectrum operations from humanitarian and civil support to counterinsurgency and general war throughout the world. Army Medicine stands committed to sustain the Warfighter and accomplish the mission, supporting the world's most decisive land force and the strength of the Nation.

In the MHS, one of our biggest challenges lies in integrating the shared electronic health record information available in our systems with the information that is provided through our civilian network providers and VA partners. Without that seamless integration of data, health care cannot be coordinated properly for the patient's across all providers and settings. To support DoD and VA collaboration on treating PTSD, pain, and other health care issues, the Electronic Health Record (EHR) should seamlessly transfer patient data between and among partners to improve efficiencies and continuity of care. The DoD and the VA share a significant amount of health information today and no two health organizations in the nation share more non-billable health information than the DoD and VA. The Departments continue to standardize sharing activities and are delivering information technology solutions that significantly improve the secure sharing of appropriate electronic health information. We need to include electronic health information exchange with our civilian partners as well – a health information systems which brings together three intersecting domains – DoD, VA, civilian – for optimal sharing of beneficiary health information and to provide a common operating picture of health care delivery. These initiatives enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country. Previously, the burden was on service members to facilitate information sharing; today, we are making the transition between DOD and VA easier for our service members. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will deliverable a fully integrated electronic health record that will enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country.

At the core of our Army is the Warfighter. A focus on wellness and prevention will ensure that our Warriors are ready to heed the Nation's call. Yet in the Army today we have more than a Division of Army soldiers who are medically not ready. This represents a readiness problem. We created a Soldier Medical Readiness Campaign to ensure we maintain a health and resilient force. The deployment of healthy, resilient and fit Soldiers and increasing the medical readiness of the Army is the desire end state of this campaign. The campaign's key tasks are to provide Commanders the tools to manage their Soldiers' medical requirements; coordinate, synchronize and integrate

wellness, injury prevention and human performance optimization programs across the Army; identify the medically not ready population; implement medical management programs to reduce the MNR population; assess the performance of the campaign; and educate the force.

Those Soldiers who no longer meet retention standards must navigate the Physical Disability Evaluation System (PDES). The present disability system dates back to the Career Compensation Act of 1949. Since its creation problems have been identified include long delays, duplication in DOD and VA processes, confusion among Service members, and distrust of systems regarded as overly complex and adversarial. In response to these concerns, DOD and VA jointly designed a new disability evaluation system to streamline DOD processes, with the goal of also expediting the delivery of VA benefits to service members following discharge from service. The Army began pilot testing the Disability Evaluation System (DES) in November 2007 at Walter Reed Army Medical Center and has since expanded the program, now known as the Integrated Disability Evaluation System (IDES), to 16 military treatment facilities. DOD has replaced the military's legacy disability evaluation system with the IDES.

The key features of the of the IDES are a single physical disability examination conducted according to VA examination protocols, a single disability rating evaluation prepared by the VA for use by both Departments for their respective decisions, and delivery of compensation and benefits upon transition to veteran status for members of the Armed Forces being separated for medical reasons. The DoD and VA continue to move towards reform of this process by identifying steps that can be reduced or eliminated, ensuring the service members receive all benefits and entitlements throughout the process. Within the Army, I recently appointed a task force focused on examining the Integrated Disability Evaluation Process in parallel with ongoing MHS efforts. The AMEDD is committed to working collaboratively with our partners across the MHS to seek solutions that will best serve those who have selflessly served our country.

I would like to close today by discussing the Army Medicine Promise. The Promise, a written covenant that will be in the hands of everyone entrusted to our care over the next year, tells those we care for what we, the Army Medicine Team, believe

they deserve from us. It articulates what we believe about the respect and dignity surrounding the patient care experience. The Promise speaks to what we believe about the value of the care we deliver, about the compassion contained in the care we deliver and how we want to morally and ethically provide care for those we serve. I'll share two items from the Promise with you---

"We believe our patients deserve a voice in how army medicine cares for them and all those entrusted to our care." Our patients want to harness innovation to improve or change their health and we are empowering their efforts via our wellness centers. At our premier wellness clinics, we collaborate with patients to not only give them the tools they need to change their health, but also a lifespace partner to help them change their life. Our wellness clinics are new and still evolving but I am committed to increasing their numbers and expanding their capabilities in order to dramatically impact those over 500,000 minutes out of the year when our patients are living life outside the walls of our hospitals. The wellness clinics allow us to reach out to those we care for rather than them having to reach in.

"We believe our patients deserve an enhanced care experience that includes our belief in their desire to heal, be well, and have an optimal life." The warrior transition care comprehensive transition plan supports this promise by providing countless wounded warriors with a dynamic plan for living that focuses on the soldier's future across six domains of strength---career, physical, emotional, social, family and spiritual strength. The plan empowers soldiers to take control of their lives."

In conclusion, the AMEDD has served side-by-side with our sister services in Iraq and Afghanistan, and at home we will continue to strengthen those collaborative partnerships to provide responsive, reliable, and relevant healthcare that ensures a healthy fighting force and healthy Families. To succeed, we must remain ready and relevant in both our medical proficiencies as well as our Soldier skills. We will continue to serve as a collaborative partner with community resources, seek innovative treatments, and conduct militarily relevant research to protect, enhance, and optimize Soldier and military Family well-being. Soldiers, Airmen, Sailors, Marines, their Families and our Retirees will know they are receiving care from highly competent and compassionate professionals.

I am incredibly honored and proud to serve as the 43rd Surgeon General of the Army and Commander, US Army Medical Command. There are miracles happening at our command outposts, forward operating bases, posts, camps and stations every day because of the dedicated Soldiers and civilians that made up the Army Medical Department. With continued support of Congress we will lead the Nation in healthcare, and our men and women in uniform will be ready when the Nation calls them to action. Army Medicine stands ready to accomplish any task in support of our Warfighters and Military Family.