

LIEUTENANT GENERAL ERIC B. SCHOOMAKER  
THE SURGEON GENERAL OF THE UNITED STATES ARMY  
AND COMMANDER, US ARMY MEDICAL COMMAND

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Chairman Inouye, Vice Chairman Cochran and distinguished members of the committee. Thank you for providing me this opportunity to talk with you today about some of the very important work being performed by the dedicated men and women—military and civilian—of the U.S. Army Medical Department (AMEDD) who bring value and inspire trust in Army Medicine.

Now in my last Congressional hearing cycle as the Army Surgeon General and Commanding General, US Army Medical Command (MEDCOM), I would like to thank the committee for the opportunities provided over the past four years that have allowed me to share what Army Medicine is, to highlight the accomplishments we have made, to detail the challenges we have faced, and to hear your collective perspectives regarding the health of our extended Military Family and the military healthcare we provide. On behalf of the over 70,000 dedicated Soldiers, civilians, and contractors that make up Army Medicine, I also thank Congress for your continued support of Army Medicine and the Military Health System, providing the resources we need to deliver leading edge health services to our Warriors, Families and Retirees.

Despite over nine years of continuous armed conflict for which Army Medicine bears a heavy load, every day our Soldiers and their Families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in state-of-the-art fashion when prevention fails; and are supported by an extraordinarily talented medical force including those who serve at the side of the Warrior on the battlefield.

Army Medicine is a dedicated member of the Military Health System and is equally committed to partnering with our Soldiers, their Families, and our Veterans to achieve the highest level of fitness and health for each of our beneficiaries. Army Medicine historically is a leader in developing innovations for trauma care and preventive medicine that save lives and improve well-being for our uniformed personnel, improvements which have also favorably influenced civilian care. We are focused on delivering the best care at the right time and place. Army Medicine operates using the following strategic aims—The Five E's: Enduring, Early, Effective, Efficient, and Enterprise to reflect our commitment to selfless service.

- To provide **Enduring care** through initiatives such as the Warrior Care and Transition Program and the Soldier Medical Readiness Campaign Plan
- To reduce the need for subsequent care through **Early prevention**; for example, Army Medicine identifies medical issues early with its concussive protocols and behavioral health practices, and promotes healthy lifestyles with the patient-centered medical home model of primary care delivery.
- To use evidence-based practices which provide the most **Effective treatment** for medical issues such as pain management and post-traumatic stress (PTS).
- To **optimize Efficiencies** through leading edge business processes and partnerships with other services and veterans organizations.
- To be an integral part of the Army **Enterprise approach** through re-engineering Army Medicine such as the provisional Public Health Command (PHC) to keep the Army strong and with other Army commands and agencies to optimally serve the Soldier and Family.

We must continue to provide the very best ongoing care for wounded, ill, or injured Soldiers. We have an enduring responsibility – alongside our sister services and the Department of Veterans Affairs (VA) – to provide care and rehabilitation of our wounded, ill, and injured for many years to come. The US Army Warrior Transition Command (WTC) is a Major Subordinate Command under the MEDCOM and a key part of the enduring provision of care. The WTC Commander, Brigadier General Darryl Williams is also the Assistant Surgeon General for Warrior Care and Transition. The WTC's mission is to provide centralized oversight of the Army's Warrior Care and Transition Program. This includes providing the necessary guidance and advocacy to empower wounded, ill, and injured Soldiers and Families with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. The WTC supports Army Force Generation (ARFORGEN) by supporting those who have returned from combat and require coordinated, complex care management to help them cope with and overcome the cumulative effects of war and multiple deployments.

At the heart of the Warrior Care and Transition Program are 29 Warrior Transition Units (WTUs) located at major Army installations worldwide, and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the United States and Puerto Rico. Today, 4,280 highly trained cadre and staff oversee a current population of 10,011 wounded, ill and injured Soldiers. Since their inception in June 2007, more than 40,000 wounded, ill, or injured Soldiers and their Families have either progressed through or are being currently cared for by these dedicated caregivers and support personnel. Over 16,000 of those Soldiers have been returned to the force.

The Army, with great support of Congress, has spent or obligated more than \$1.2 billion in military construction projects to improve the accessibility and quality of Wounded Warrior barracks, including the development of Warrior Transition complexes that will serve both Warriors in Transition and their Families. Construction of complexes continues through FY12 at which time 20 state-of-the-art complexes will be in operation.

Since 2004, the Army Wounded Warrior Program (AW2) has supported the most severely wounded, ill, and injured Soldiers. Soldiers are assigned an AW2 Advocate who provides personalized assistance with day-to-day issues that confront healing Warriors and their Families, including benefits counseling, educational opportunities, and financial and career counseling. AW2 Advocates serve as life coaches to help these wounded Warriors and their Families regain their independence. Since its inception, AW2 has provided support to nearly 8,000 Soldiers and Veterans.

The WTC is refining a policy change to enhance the Army's ability to ensure Reserve Component Soldiers recovering at home from wounds, illnesses, or injuries incurred while on Active Duty benefit from the same system of care management and command and control experienced by Soldiers who are recovering in WTUs. The revised policy makes it easier for Reserve Component Soldiers who do not require complex medical care management to heal and transition closer to home.

To support each wounded, ill, or injured Soldier in their efforts to either return to the force or transition to Veteran status, the Army has created a systematic approach called the Comprehensive Transition Plan (CTP). The CTP is a six-part multidisciplinary and automated process which enables every Warrior in Transition to develop an individualized plan that will enable them to set and reach their personal

goals. These end goals shape the Warrior in Transition's day-to-day work plan while healing.

Additionally to help Warriors in Transition achieve their physical fitness goals, WTUs offer several adaptive sports options to supplement the Warrior in Transition's therapy, often in coordination with the U.S. Olympic Committee's Paralympic Military Program. The WTC is also coordinating the Army's participation in the 2011 Warrior Games to be held at the U.S. Olympic Training Center in Colorado Springs, Colorado 16-21 May 2011.

We created a Soldier Medical Readiness Campaign to ensure we maintain a healthy and resilient force. Major General Richard Stone, Deputy Surgeon General, Mobilization, Readiness, and Reserve Affairs, is the campaign lead. The deployment of healthy, resilient, and fit Soldiers and increasing the medical readiness of the Army is the desired 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 (MNR) Soldier population; implement medical management programs to reduce the MNR Soldier 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). Assigning disability has long been a contentious issue. 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 is now planning on replacing 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 PDES working group continues to reform this process by identifying steps that can be reduced or eliminated, ensuring the service members receive all benefits and entitlements throughout the process.

The WTC is also working with U.S. Army Medical Command staff to develop the concept of "Medical Management Centers." Medical Management Centers utilize the case management approaches developed for the WTUs to assist Soldiers who remain in their units but require a PDES determination. The WTC is also working closely with Army Reserve and Army National Guard leadership to develop and provide necessary support to the Reserve Component Soldier Medical Support Center (RCSMSC) being established in Pinellas Park, Florida. The RCSMSC is intended to ensure the PDES process also runs smoothly and efficiently for Reserve Component Soldiers not on Active Duty or in WTUs.

Army Medicine strives to reduce the need for subsequent care through **early prevention** and the emphasis on health promotion. Over the past year Army medicine has initiated multiple programs in support of this aim and I would like to highlight a few of those starting with the new US Army Public Health Command (Provisional) (PHC).

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, under the command of Brigadier General Timothy K. Adams. 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. The PHC reached initial operational capability in October 2010 and full operational capability is targeted for October 2011.

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.

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.

While the PHC itself is relatively new, a number of significant public health accomplishments already have been achieved. Some examples:

- 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).
- Hiring installation Health Promotion Coordinators (HPCs) to assist the MTF Commander/DHS and to facilitate health promotion efforts on Army installations. HPCs are the “air traffic controllers” or coordinators of services and identifiers of

service needs; they work with senior mission commanders and installation Community Health Promotion Councils to synchronize all of the installation health and wellness resources.

- Providing behavioral health epidemiological consultations to advise Army leaders and program developers on the factors that contribute to behavioral health issues including high-risk behaviors, domestic violence and suicide.
- Identifying Soldier physical training programs that optimize fitness while minimizing injuries and resultant lost-duty days and improve Soldier medical readiness.
- Decreasing the rate of overweight and obese Family members and retirees by adopting the Healthy Population 2010 goals for weight and obesity and implementing a standardized weight-management program developed by the VA.
- Integrating human and animal disease surveillance to better assess health risks.

The Army recognizes that traumatic brain injury or TBI is a serious concern, and we will continue to dedicate resources to research, diagnose, treat and prevent mild, moderate, severe, and penetrating TBI. The Army is leading the way in early recognition and treatment of mild TBI or concussive injuries with our “Educate, Train, Treat, and Track” strategy. Under the personal leadership of the Vice Chief of Staff of the Army, General Peter Chiarelli and refined by Brigadier General Richard Thomas, Assistant Surgeon General for Force Projection, we are fielding a program which some have called “CPR for the brain”. Our education and training efforts have led to increased awareness and screening for TBI and have contributed to decreasing the stigma associated with seeking diagnosis or treatment for TBI. TBI training has been integrated into education and training initiatives of all deploying units to increase awareness and education regarding recognition of symptoms as well as emphasize commanders and leaders’ responsibilities for ensuring their Soldiers receive prompt medical attention as soon as possible after an injury.

DoD policy changes in June 2010 implemented mandatory event-driven protocols following exposure to potentially concussive events in deployed environments. Events mandating an evaluation include any Service Member in a vehicle associated with a blast event, collision, or rollover; all personnel within close proximity to a blast; or anyone who sustains a direct blow to the head. Additionally, the command may direct a

medical evaluation for any suspected concussion under other conditions. All new medics and Physician Assistants at the Army Medical Department Center and School are being trained on their roles in supporting this policy. During my recent visit to Afghanistan with my fellow Surgeons General in February 2011, discussions with Warriors and medical personnel at a number of sites lead me to conclude that these protocols are aggressively endorsed by commanders and are being complied with.

The Army along with the DoD is implementing computerized tracking of these events for the purposes of providing healthcare providers with awareness of an individuals' history of proximity to blast events, allowing for greater visibility of at risk Soldiers during post-deployment health assessment, informing Commanders, and to provide documentation to support Line of Duty investigations for Reserve and Guard members. The program from August to December 2010 has documented 1,472 Soldiers. We are working hard to overcome the technical barriers for complete data input. My fellow Surgeons General and I saw this first hand in our trip to Afghanistan last month. We saw, as well, the complete commitment of all field commanders, small unit leaders, and medical professionals to the implementation of these protocols.

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. Some examples of the current research include medical standards for protective equipment, measures of head impact/blast exposure, a portable diagnostic tool for TBI that can be used in the field, blood tests to detect TBI, medications for TBI treatment, and the evaluation of rehabilitation outcomes. The TBI Research Program leverages both DoD and civilian expertise by encouraging partnerships to solve problems related to TBI. The DoD partners with key organizations and national/international leaders, including the VA, the Defense Centers of Excellence for Psychological Health and TBI, the Defense and Veterans Brain Injury Center, academia, civilian hospitals and the National

Football League, to improve our ability to diagnose, treat and care for those affected by TBI.

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 touchpoints 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. Some have been published, such as the landmark studies on concussive brain injury and PTSD by Charles Hoge, Carl Castro and colleagues or the recent publication of a forerunner program to the CBHSOC in the 3<sup>rd</sup> Infantry Division by Chris Warner, Ned Appenzeller and their co-workers. These studies will be discussed further later.

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.

Under the leadership of Major General Patricia Horoho, the Deputy Surgeon General, 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, DUIs, 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. Integral to the success of the CBHSOC is the continuous evaluation of programs, to be conducted by the PHC.

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, under the leadership of Major General David Rubenstein, 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.

As mentioned previously, the results of a recent Army study published in January in the *American Journal of Psychiatry* by Major Chris Warner, Colonel Ned Appenzeller and colleagues report on the success of pre-deployment mental health support and coordination of care that dramatically reduced adverse behavioral health outcomes for over 10,000 Soldiers who received pre-deployment support prior to deployment compared to a like group of over 10,000 Soldiers who were deployed to the same battle space but were unable to receive the pre-deployment behavioral health assessment and care coordination. These results show the Army, as part of its Comprehensive Behavioral Health System of Care Campaign Plan, is moving in the right direction implementing new policies and programs to enhance pre- and post-deployment care coordination for Soldiers. This study demonstrates the ability to bridge the gap between identification through pre-deployment screening, as required by the National Defense Authorization Act for FY 2010, Sec. 708 and actively managing and coordinating care for Soldiers with existing behavior health concerns to insure a successful deployment that benefits the Army and continued support to Soldiers and Families.

The results are significant and provide the first direct evidence that a program that combines pre-deployment support and coordination of care that includes primary care managers, unit surgeons and behavioral health providers is effective in preventing adverse behavioral health outcomes for Soldiers. The study results move away from a perception of use of mental health screenings by Army and DoD as a tool to “weed out” Soldiers and service members deemed mentally unfit, to one of use and integration of behavioral health screenings as a routine part of Soldiers’ and service members primary

care during deployment. Coupled with insights provided by Walter Reed Army Institute of Research (WRAIR) researchers, such as Dr. Charles Hoge and COL Carl Castro about the relationship between concussive injury and PTSD as well as seven years of annual surveys of BH problems and care in the deployed force through the WRAIR Mental Health Advisory Teams, we are making giant steps forward in prevention, early recognition, and mitigation of the neuropsychological effects of prolonged war on our Soldiers and Families.

Much of the future of Army Medicine will be practiced at the Patient-Centered Medical Home (PCMH). The PCMH is a model of primary care-based health improvement and healthcare services being adopted throughout the Military Health System and in many venues in civilian practice. I commend the Air Force for taking the lead on some PCMH practices. The PCMH will be the principal enabler to improve readiness of the force and continuity of access to tailored patient services. It is a design that the Army will apply to all primary care settings.

Dr. Paul Grundy, Director of Healthcare Transformation at IBM, pointed out that “a smarter health system forges partnerships in order to deliver better care, predict and prevent disease and empower individuals to make smarter choices.” In his estimation, the PCMH is “advanced primary care.” According to Dr. Grundy the PCMH can build trust between patient and physician, improve the patient experience of care, reduce staff burnout, and hold the line on expenditures.

The Medical Home philosophy concentrates on what a patient requires to remain healthy, to restore optimal health, and when needed, to receive tailored healthcare services. It relies upon building enduring relationships between patient and their provider-doctor, nurse practitioner, physician assistant and others-and a comprehensive and coordinated approach to care between providers and community services. This means much greater continuity of care, with patients seeing the same physician or professional partner 95% of the time. The result is more effective healthcare for both the provider and the patient that is based on trust and rapport.

The PCMH integrates the patient into the healthcare team, offering aggressive prevention and personalized intervention. Physicians will not just evaluate their patients

for disease to provide treatment, but also to identify risk of disease, including genetic, behavioral, environmental, or occupational risk. The healthcare team encourages healthy lifestyle behaviors, and success will be measured by how healthy they keep their patients, rather than by how many treatments they provide. The goal is that people will live longer lives with less morbidity, disability and suffering.

Community Based Medical Homes (CBMHs) are part of the Army's implementation of the Patient Centered Medical Home. CBMHs are Army operated primary care clinics located in leased space in the off-post communities in which many of our active duty Families live. These clinics are extensions of the Army Hospital and staffed by government civilians. Active duty Family members receive enrollment priority. This initiative was undertaken to improve access and continuity to healthcare services, including behavioral health, for active duty Family members by expanding capacity and extending MTF services off-post. The Army has grown and consumption of healthcare services is on the rise as a result of the war. These clinics will help Army Medicine improve quality of care and the patient experience; improve value through standardization and optimization of resources enabling operations at an economic advantage to the DoD; and improve the readiness of our Army and our Army Families. Clinics are placed where Families lacked access to Army primary care services and currently 17 clinics are being developed in 13 markets. Recently clinics supporting Fort Campbell, Fort Sill, Fort Stewart and Fort Bragg have opened and initial feedback has been outstanding.

The CBMHs build upon and are in many ways the culmination of a MEDCOM-wide campaign to closely monitor and reduce barriers to access and continuity; improve clinic productivity through standardization of administrative operations and support; to leverage improved health information management tools like AHLTA; and to incentivize commanders and providers to provide the right kind of care so as to improve individual and community health and outcomes of healthcare delivery in accordance with evidenced-based practices for chronic illness.

We are adopting other methods as well to ensure better outcomes for patient care. At the MEDCOM, we have implemented a performance-based adjustment model

(PBAM) to increase hospital and department responsibilities for how our funding is spent in health improvement and the delivery of health care services. PBAM creates a justifiable budget by a business planning process that links to outputs, such as volume or complexity of procedures. With the need for greater accountability and transparency, the MEDCOM has used PBAM to create performance measures that are consistent and can be compared across our facilities. We have experienced gains in total output, gains in provider efficiency, and increases in coding accuracy all aimed at improved outcomes of care – a more effective system for our beneficiaries and the Army. Incentives which are built into the program have measurably improved health and compliance with science – or – evidence-based care for chronic disease like diabetes and asthma.

Army Medicine is committed to using evidence-based practices which provide the most effective treatment for the variety of medical issues confronting our patient population and especially those issues caused by the almost 10 years of war such as pain management. An Army at war for almost a decade recognizes it has accumulated significant issues with acute and chronic pain amongst its Soldiers. In August 2009, I chartered the Army Pain Management Task Force to make recommendations for a MEDCOM comprehensive pain management strategy. I appointed Brigadier General Richard Thomas as the Task Force Chairperson. Task Force membership included a variety of medical specialties and disciplines from the Army, as well as representatives from the Navy, Air Force, TRICARE Management Activity, and VA.

The Pain Management Task Force developed 109 recommendations that lead to a comprehensive pain management strategy that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain. The Army Medical Command is operationalizing recommendations through the Pain Management Campaign Plan. I am proud to say that Army Medicine was recognized by the American Academy of Pain Medicine with the Presidential Commendation for its impact on pain medicine in the United States.

An important objective of the Pain Management Task Force calls for building a full spectrum of best practices for the continuum of pain care, from acute to chronic, which is based on a foundation of the best available evidence based medicine. This

can be accomplished through the adoption of an integrative and interdisciplinary approach to managing pain. Pain management should be handled by integrated care teams that use a biopsychosocial model of care. The standard of care should decrease overreliance on medication driven solutions and create an interdisciplinary approach that encourages collaboration among providers from differing specialties.

The DoD should continue to responsibly explore safe and effective use of advanced and non-traditional approaches to pain management and support efforts to make these modalities covered benefits once they prove safe, effective and cost efficient. One way to achieve an interdisciplinary, multimodal and holistic approach to pain management is by incorporating complementary and alternative therapies - integrative approaches - into an individualized pain management plan of care to include acupuncture, massage therapy, movement therapy, yoga, and other tools in mind-body medicine. To best address the goal of patient-centered care, providers must work in partnership with patients and Families in providing health promotion options while maintaining efficacy and safety standards. This integration needs to be methodical, appropriate, and evaluated throughout the process to ensure the best potential outcomes.

While the Pain Management Task Force has worked to expand the use of non-medication pain management modalities, as combat operations continue, more Soldiers are presenting with physical or psychological conditions, or both, which require clinical care, including medication therapy. Consequently, some of them may be treated for multiple conditions with a variety of medications prescribed by several health care providers. While the resulting “polypharmacy” - the use of multiple prescription or other medications - can be therapeutic in the treatment of some conditions, in other cases it can unwittingly lead to increased risk to patients. New Army policies and procedures to identify and mitigate polypharmacy have reduced the risk of these factors in garrison and deployed environments.

Polypharmacy is not unique to military medical practice and is also a patient safety issue in the civilian medical community. The risks of polypharmacy include overdose (intentional or accidental); toxic interactions with other medications or alcohol; increased risk of adverse effects of medications; unintended impairment of alertness or

functioning that may result in accident and injury; and the development of tolerance, withdrawal, and addiction to potentially habit-forming medications.

US Army Medical Command has issued guidance for enhancing patient safety and reducing risk via the prevention and management of polypharmacy. For example, Soldiers and Commanders are educated to take responsibility for, and active roles in, ensuring effective communication between patients and primary care managers to formulate treatment plans and address potential issues of polypharmacy. Annual training on managing polypharmacy patients is required for clinicians who prescribe psychotropic agents or central nervous system depressants. And through the electronic health record, patient health information, including prescriptions, is shared among providers to increase awareness of those patients with multiple medications.

Evidence-based science makes strong Soldiers and we rely heavily on the US Army Medical Research and Material Command (MRMC). Under the leadership of Major General James Gilman, 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.

MRMC is also the coordinating office for the DoD Blast Injury Research Program. The Blast Injury Research Program is addressing critical medical research gaps for blast-related injuries and is developing partnerships with other DoD and external medical research laboratories to achieve a cutting-edge approach to solving blast injury problems. One of the program's major areas of focus is the improvement of battlefield medical treatment capabilities to mitigate neurotrauma and hemorrhage. Additionally, the program is modernizing military medical research by bringing technology advances and new research concepts into DoD programs.

We created a systematic and integrated approach to better organize and coordinate battlefield care to minimize morbidity and mortality, and optimize the ability to provide essential care required for casualty injuries – the Joint Theater Trauma System (JTTS). JTTS focuses on improving battlefield trauma care through enabling the right patient, at the right place, at the right time, to receive the right care. The components of the JTTS include prevention, pre-hospital integration, education, leadership and communication, quality improvement/performance improvement, research and information systems. The JTTS was modeled after the civilian trauma system principles outlined in the American College of Surgeons Committee on Trauma *Resources for Optimal Care*.

Effectiveness and efficiency are also enhanced by electronic tools. 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 Office of the Surgeon General (OTSG) works closely with Defense Health Information Management System of Health Affairs/TRICARE Management Activity in pursuing additional enhancements and fixes to AHLTA. The OTSG Information Management Division also continues to implement the MEDCOM AHLTA Provider Satisfaction Program, which now provides dictation and data entry software applications, tablet computing hardware, business process management, clinical business intelligence, and clinical systems training and integration to the providers and users of AHLTA. OTSG is taking the EHR lead in designing and pursuing the next generation of the EHR by participating in DoD and Inter-agency projects such as the EHR Way Ahead, the Virtual Lifetime Electronic Record Pilot Project, Nationwide Health Information Network, In-Depth EHR Training, and VA/DoD Sharing Initiatives. We are aligned with the Air Force's COMPASS program in ensuring that our providers and our clinics have the best and most user-friendly EHR.

The Medical Command was reorganized in October 2010, to align regional medical commands (RMCs) with TRICARE regions with the resulting effect of improved readiness and support for the Army's iterative process of providing expeditionary, modular fighting units under the ARFORGEN cycle. We are well on the way to standardizing structure and staffing for RMC headquarters to provide efficiencies and ensure standardized best practices across Army Medicine. Three CONUS-based regional medical commands, down from four, are now aligned with the TRICARE regions to provide health care in a seamless way with our TRICARE partners.

In addition to TRICARE alignment, each region will contain an Army Corps headquarters, and health-care assets will be better aligned with beneficiary population of the regions. Each RMC has a deputy commander who is responsible for a readiness cell to coordinate and collaborate with the ARFORGEN cycle. This regional readiness cell will reach out to Reserve Component elements within their areas of responsibility to

ensure that all medical and dental services required during the ARFORGEN cycle of the Reserve units are also identified and provided.

In recent years, the Army has transformed how it provides health care to its Soldiers, with improvements impacting every aspect of the continuum of care. The Patient Centered Medical Home and the Warrior Transition Command are examples of the Army's strong commitment to adapt and improve its ability to provide the best care possible for our Soldiers and their Families. We have a duty and responsibility to our Soldiers, Families, and retirees. The level of care required does not end when the deployed Soldier returns home; there will be considerable ongoing health care costs for many years to support for our wounded, ill, or injured Service members. They need to trust we will be there to manage the health related consequences of over nine years of war, including behavioral health care, post-traumatic stress, burn or disfiguring injuries, chronic pain or loss of limb. We will require ongoing research to establish more effective methodologies for treatment. Army Medicine remains focused on developing partnerships to achieve the aims of the MHS as we work together to provide cost effective care to improve the health of our Soldiers. The goal is to provide the best care and access possible for Army Families and retirees and to ensure optimal readiness for America's fighting forces and their Families.

Lastly, I would like to join General Casey in expressing support for the military health care program changes included in the FY 2012 Budget. The changes include modest enrollment fee increases for working-age retirees, pharmacy co-pay adjustments, aligning Defense reimbursements to sole community hospitals to Medicare consistent with current statute, and shifting future Uniformed Services Family Health Plan enrollees into the TRICARE-for-Life/Medicare program established by Congress in the FY 2001 National Defense Authorization Act,

In closing, over the past 40 months as the Army Surgeon General I have had numerous occasions to appear before this subcommittee, meet individually with you and your fellow members and interact with your staff. I have appreciated your tough questions, valuable insight, sage advice and deep commitment to your Army's Soldiers and their Families. Thank you for this opportunity to share Army Medicine with you. I am proud to serve with the Officers, Non-commissioned Officers, the enlisted Soldiers

and civilian workforce of Army Medicine. Their dedication makes our Nation strong and our Soldiers and Families healthy and resilient.

Thank you for your continued support of Army Medicine and to our Nation's men and women in uniform.

*Army Medicine: Building Value ... Inspiring Trust*